ABPM

The American Board of Podiatric Medicine

Summer 2018 no. 5

semi-annual UPDATE

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American Board of Podiatric Medicine - ABPM

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American Board of Podiatric Medicine

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The American Board of Podiatric Medicine

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Marc A. Benard, DPM
Executive Director, ABPM

Executive Director's Thoughts

A 22+ year perspective

At the beginning of 2019, after more than 22 years as the organization's Executive Director, I will assume a different role, that of Assistant Director and Special Consultant to the ABPM. In reality, though, my affiliation started many years before I became Executive Director. In 1985, I was elected to the BOD of the American Board of Podiatric Orthopedics (ABPO). Since that time I've been privileged to serve the organization in many different capacities over the last 33 years. Given that tenure, I have been asked to reflect on my years in the ED position.

For those who may recall, prior to 1993 the organization was the American Board of Podiatric Orthopedics. Then as now, and despite a name change, we remain one of two certifying boards recognized by the Council on Podiatric Medical Education through the Joint Committee on Recognition of Specialty Boards (the other being ABFAS). My nomination and election to the ABPO Board of Directors was the likely result of having established myself in the area of podopediatrics, with an emphasis on congenital and acquired neuromuscular conditions, encompassing podiatric biomechanics and surgery. By then I had seven years of volunteer service with the Baja Project for Crippled Children, with a track record of volunteerism and a passion for clinical biomechanics.

As a new director I was brought on to the ABPO Examination Committee, which I was eventually asked to chair. That led to the structure and vetting process by which committee members are selected to the present time. I smile when recalling that while Chair I felt that the Examination Committee made a great leap in expanding to a total of eight diplomates, each with both broad knowledge as well as a separate area of specific clinical expertise. Today, the Examinations Committee has more than tripled in size and consists of the Qualification subsection, Certification subsection, In-training subsection and Sub-Committee for Amputation Prevention. Committee

~ continued on page 11

Melissa J. Lockwood, DPM
Marketing Chair, ABPM

Ever Evolving Membership Benefits

Greetings! I am excited to reach out to our diplomates as the Marketing Chairman for the ABPM Board of Directors. We have been working hard so far in 2018 to implement many positive changes to our identity within the podiatric community. Some highlights include:

1. Updates to our amazing ABPM APP including a new, comprehensive Reference Guide for normal values (both laboratory and biomechanical!) AND even more sample questions for you to use as you prepare for our exams!

2. A focused, concise member survey asking our constituents what is IMPORTANT TO YOU with respect to ABPM, educational opportunities, and any barriers to your success as a diplomate.

3. Speaker's Bureau and "ABPM on the Road" – we are reaching more and more members of interest both within the podiatric and complimentary medical fields!

What's ahead?

I am excited for the Marketing committee to meet and strategize about how to use the results of our survey and drive forward with more public awareness of ABPM and our member diplomates. We are also pushing ahead with our third CAQ examination and marketing our THIRD available pathway to achieve the added qualification in Amputation Prevention and Wound Care. Finally, the Marketing committee is ever committed to assisting in the public awareness of the importance of our credential!

Until next time,

Melissa J. Lockwood, DPM
Marketing Chair, ABPM

The ABPM Member Dashboard is There for YOU

The ABPM dashboard has been updated to better serve the needs of the membership. Members can use the dashboard for a variety of functions including, but not limited to:

- Your Profile
  - Edit Your Profile
  - Link your website address to your profile (appears under "Find a Doctor")
  - Change Your Password
- Documents For Healthcare
  - Memorandum for Healthcare Industry
  - CPME Recognition of Certifying Boards
  - MOC Program Outline
  - Primary Source Verification
- Advertising Guidelines and Logos
  - ABPM Logo
  - ABPM Board Certified Logo for Website use

To access the dashboard simply go to the ABPMed.org website, select Member tab at top and then Dashboard. Insert your username and password. If you have questions or concerns please contact headquarters at 310-375-0700.

NEW! Pathology Specific Biomechanical Exam Templates

By: Stephen M. Geller, DPM

Have you ever given someone something you thought would help only to find them using it in a completely unexpected manner? This is exactly what happened when the American Board of Podiatric Medicine provided residency directors with a full-page comprehensive biomechanical examination form. This checkbox form contained hip-to-toe measurements, both non-weight bearing and weight bearing, and in gait. The unexpected outcome was that these forms separated biomechanical examinations from the physical examination performed for most complaints. In reviewing these forms at residency on-site evaluations, there were inadequacies that led to misinterpretations of the examination findings or lack of supporting documentation for the given diagnosis.

CPME 320: Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies (the document governing residency programs) contains multiple MAVs, including biomechanical examinations. However, at no point does the definition of the biomechanical cases state that a biomechanical examination is from the hip to the toe.

Patient's present with a specific complaint and not all pathology requires a hip-to-toe examination to be comprehensive relative to the causative factors. Residency training is to impart advanced knowledge so that when in practice, the graduated resident will be able to perform pertinent aspects of the biomechanical examination and identify all contributing factors. This information is used to minimize risk of complications in plan of care. First year residents will be less familiar with the presenting pathology and require more guidance through a more thorough exam to identify those causative factors. A senior resident may require less guidance and identify all causative factors much faster.

With the development of electronic medical records (EMR), the use of forms that are separate from the electronic documents is increasingly difficult. To bring the biomechanical examination into the physical examination where it belongs, EMR templates for pathology specific biomechanical examinations have been created by ABPM Director, Stephen Geller, DPM. **These templates consist of: Pes Planus; Pes Cavus; Hallux Valgus; Hammertoe, Lesser Metatarsal and Intermetatarsal Pain; and Proximal Examination.** The templates are modular, being combined to comprehensively evaluate the pathomechanics of a specific patient. For example, a patient complaining of neuroma symptoms with a low arch would begin with the Pes Planus template and where indicated insert the template for Hammertoe, Lesser Metatarsal, and Intermetatarsal Pain. If at the completion of this examination the findings do not fully explain the pathomechanics of the foot, then the Proximal Examination template is added.

Say goodbye to that ill-fated comprehensive biomechanical examination form and hello to biomechanics returning to the customary examination. Your patients will thank you.

The NEW Biomechanical Examination Templates are now available on www.ABPMed.org under the Residents/Directors tab

On the Go

(L-R) Drs. Steve Goldman, W.E. Chagares and Gina Painter pictured with Dr. Brad Wenstrup as he receives an APMA Award for Excellence at the 2018 APMA House of Delegates in Washington D.C.

W.E. Chagares, DPM presents both the Professional Development and Why Certify lectures to podiatry students at William M. Scholl College.

Lester Jones, DPM with podiatry students at the ABPM Podiatry Student Mixer held at Western University.

Nicole DeLauro, DPM and David George, DPM with podiatry students at the ABPM Podiatry Student Mixer held at New York College of Podiatric Medicine.

more On the Go

James Stavosky, DPM gives the ABPM Why Certify presentation to podiatry students at the Arizona School of Podiatric Medicine.

Bryan Roth, DPM and James Stavosky, DPM with podiatry students at the ABPM Podiatry Student Mixer held at the Arizona School of Podiatric Medicine.

(L-R) Beth Jarrett, DPM, W.E. Chagares, DPM, Coleen Napolitano, DPM and Dan Evans, DPM attend the ABPM Podiatry Student Mixer at William M. Scholl College.

Nicole DeLauro, DPM gives the ABPM Why Certify presentation at the Young Physicians Program held during the New York Podiatric Clinical Conference.

2018 CAQ Examination Completed

Congratulations to the following ABPM Diplomates

Omer Aci
Charlton Adler
Jean Archer-Colella
Vincent Arloro
Richard Berliner
John DeStefano
Joshua Hill
Jon Humphers
Heather Jensen
Ashish Kapila
Charles Kattan
Annaliese Lembach
Amanda Lernor
Lena Levine
Chantal Lorio
Louis Mahairas
Daniel McGee
Maria Mejia-Perez
Ashley Miller
Jared Moon
Shahrzad Nazarian
Jon Oliverio
Payam Rafat
Jesse Riley
Daniel Rindner
Raafat Samaan
Christopher Schroeder
Matthew Spiva

ABPM Expands Eligibility Criteria for the Certificate of Added Qualification (CAQ) in Amputation Prevention and Wound Care

By: Lee C. Rogers, DPM

The ABPM is now in its third year of offering the Certificate of Added Qualification (CAQ) in Amputation Prevention and Wound Care to our diplomates. The CAQ is a mechanism to demonstrate to patients, peers, hospitals, and payers that a podiatrist has obtained specific expertise in limb salvage and wound care. Already the ABPM has been informed by some CAQ holders that the certificate has helped them obtain and/or enhance hospital privileges or become panel members at wound care centers.

To be eligible to sit for the CAQ exam, a diplomate must meet one of the following three criteria; completion of a fellowship, documented experience, or case documentation. Fellowships must be CPME approved and 1 year or greater in length with a focus on limb salvage or wound care. If you complete an unapproved fellowship, you may still qualify under the documented experience category. Documented experience must be post-residency and hospital-based, like a wound care center or Veterans Affairs clinic. A letter documenting at least 1000 hours in hospital based wound care is required. The letter should be completed by the hospital CMO, department chief/chair, fellowship director, or other acceptable director-level designee. The case documentation process was added this year to expand the eligibility to include diplomates who perform office or private practice-based wound care. Diplomates applying via case documentation review must first pass the case review process to eligible to sit for the CAQ examination.

The examination fee is $295. An additional fee of $200 is required for diplomates applying through the case documentation review process. Annual dues for active and emeritus diplomates are otherwise unchanged.

The 2019 CAQ exam will be on March 8th and the application deadline is November 20, 2018.

For more complete information, please visit the ABPM website under Exam Info and click on "CAQ in Amputation-Prevention." Contact the Board headquarters if you have more specific questions about eligibility requirements.

CAQ Pathways

ELIGIBILITY

CPME Approved Fellowship in wound care, limb salvage or similar designation for 1 year or longer

1000 Hours of documented experience in hospital based wound care

Case Documentation submission of 10 post-residency cases for review

EXAMINATION

Computer-based multiple choice examination at a Pearson Vue testing center

CERTIFICATE

Certificate of Added Qualification in Amputation Prevention and Wound Care

Major Subject Area	Approximate Exam Weight
Diabetes Including the pathogenesis of diabetic foot problems, prevention and diabetic emergencies	10%
Wounds Including pathogenesis, differential diagnosis, risk factors, classification, standard of care, advanced treatments, surgery and HBOT	38%
Peripheral Artery Disease Including risk factors, diagnostics and management	12%
Infections Including diagnosis, classifications and treatment	14%
Charcot Foot Including diagnosis, imaging, classifications and treatment	8%
Pathomechanics Including wound genesis, offloading treatment, surgical management, orthopedics/pedorthics	18%

PASSED! VA Provider Equity Act (HR-1058) VA Mission Act of 2018

On June 6, 2018, President Donald Trump signed the Mission Act of 2018. This is a landmark piece of legislation that incorporated in it some specific language related to the podiatry service at the Veterans Administration.

Podiatry became a service at the VA over 40 years ago. At the time our profession was very different. Podiatrists were put into the same pay scale as optometrists and bound by that structured pay table ever since. As podiatry evolved, it became increasingly apparent that there was going to reach a time when the advancement of the profession would outpace the ability to compensate podiatrists appropriately as compared to their civilian counterparts. Efforts were made for over 10 years to change the way podiatry is compensated at the Veterans Administration and each time this was presented, it ended unceremoniously for a myriad of reasons. It literally takes an act of Congress to effect the change needed to bring podiatry to where it should be. Over the past few years, the efforts began to develop more and more traction until its culmination with the signing of the Act in early June.

A lot of people made this bill a reality. Two we should focus on are Hon. (Dr.) Brad Wenstrup, one of the congressman from southwest Ohio and Ben Wallner, the lobbyist from APMA that championed the cause and pushed this effort across the finish line. As a result of the passage of this bill, podiatry's growth has finally been recognized. Our increased responsibility of call, resident supervision and training programs, integrated health care participation, we will now be included in the Physician and Dentists pay scales and paid on a scale equal to our medical and dental counterparts.

W.E. Chagares, DPM
Treasurer, ABPM

ABPM Treasurer's Report 2018

The ABPM portfolio, accumulated over 25 years of prudent stewardship, was valued at $1.84 million at the end of calendar year 2017. This reflects approximately 59% of the 2018 budget and reflects sound financial parameters relative to non-profit organizations.

Our board continues to run efficiently in terms of work force and the associated expenditures. Nevertheless, the increasing administrative demands of our continually growing membership and board activities have necessitated staff increases accordingly. Dr. Marc Benard, ABPM's Executive Director and Chief Finacial Officer for over 22 years, will be retained by the Board as a special consultant. Headquarter's full-time staff will be seven individuals, with one part time employee. Ongoing consultative services include an IT firm, examination delivery firm, psychometrician, marketing consultant, webmaster, bookkeeper, CPA, database manager, legal counsel, and others.

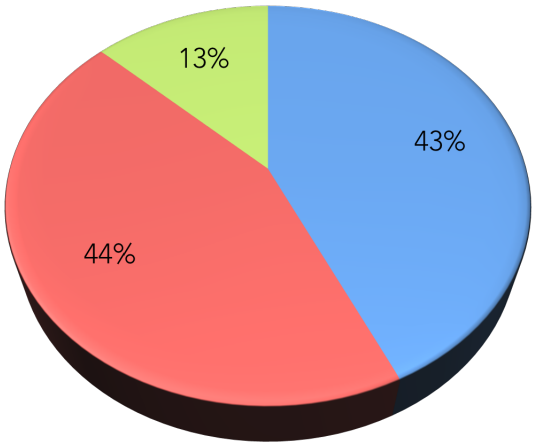
A comparative of total assets between 2016 and 2017 reveals:

Year-end 2016 = $2,745,237
Year-end 2017 = $2,007,368

It should be noted that in August 2017, ABPM purchased a building in Hermosa Beach, CA and relocated its headquarters to much needed increased space.

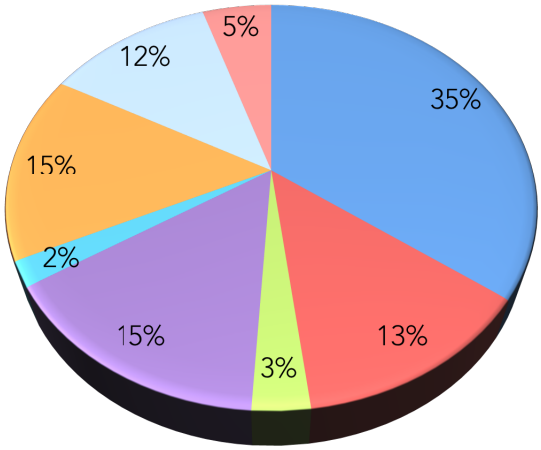
The accompanying pie charts reflect the percent allocations for income and expenses for year-end 2017.

Budget Summary Income



- Operations
- Examinations
- Case Documentation Review

Budget Summary Expenses



- Administration
- Operations
- Board of Directors
- Communications & Marketing
- Other Comm. / Liason Meetings
- Examination Committee
- Examination
- CAQ

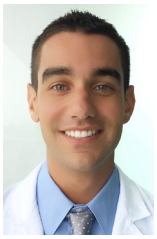
Our growing membership recognizes the value of board certification and the ongoing maintenance of that certification. The administration of headquarters, as well as the myriad committee and liaison activities needed to both maintain and expand the organization necessitates that annual dues (re-registration) be required of the membership. These activities include but are not limited to:

- Headquarters staff salary and other headquarters' overhead
- Consultants (legal, accounting, database oversight, credentialing, etc.)
- Committee and Liaison Activity (e.g. JCRSB, RRC, CPME, APMA BOT, COTH, AACPM, Credentialing, Budget, Board of Directors, Bylaws, Case Documentation Review, APMSA, CREC, etc.)
- Speakers Bureau activity
- Ongoing interaction with outside agencies verifying member status
- Involvement in CPME-320 rewrite to ensure specialty requirements for the ABPM are retained and well-represented

It should be noted that the cost of examination development and delivery are covered by examination fees and are not augmented by members' dues. Furthermore, member dues have not increased for the past 10 years as a result of prudent stewardship, and will not increase for the foreseeable future. Lastly, ABPM members' timely submission of annual dues is important and appreciated by the ABPM staff. On a practical level, timely submission also avoids attendant late fees, notices of suspension, verification issues, etc.

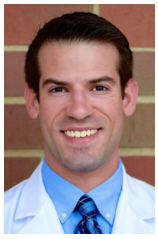
Annual Merit Award Recipients Honored

ABPM congratulates this year's Annual ABPM Graduate Merit Award Recipients



RYAN APT
Barry University
School of Podiatric
Medicine

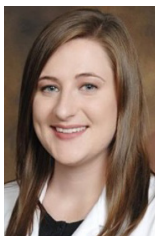
NATALIE CORIATY
California School
of Podiatric Medicine
at Samuel Merritt
University



ZACH COHEN
Des Moines University
College of Podiatric
Medicine and Surgery

LAUREN SCHNACK
Kent State University
College of Podiatric
Medicine

TYLER REBER
Midwestern University
Arizona, School of
Podiatric Medicine



STACY STACHURA
New York College
of Podiatric Medicine

JACLYN SCHUMANN
Dr. William M. Scholl
College of Podiatric
Medicine at the Rosalind
Franklin University of
Medicine and Science

CATHRINE STARK
Temple University
School of Podiatric
Medicine

DANA DAY
Western University
of Health Sciences
College of Podiatric
Medicine

This award is given annually to an outstanding student graduating from each of the nine podiatric colleges. Selections are made with recommendation from the Dean of each college, specified criteria, input from faculty and information provided by the student. Each candidate selected must exhibit high standards of professional conduct, probity, academic achievement and moral rectitude. This includes punctuality, timely completion of all assignments, positive and favorable evaluations and a GPA of at least 3.5. The candidate is to exhibit aptitude in Podiatric Medicine and Podiatric Orthopedics which includes but is not limited to dermatology, biomechanics, sports medicine and infectious disease.

Each recipient receives a certificate and a $2,000 award from ABPM.

ABPM Board members present the awards to these outstanding students.
Congratulations to each of these deserving recipients.

(Executive Director's Thoughts ~ continued from page 1)

members are vetted for geographic diversity, practice setting diversity, experience with residency training and specific clinical expertise.

In 1992 there was an emphasis in allopathic medicine in promoting residency training in primary care. In response to this, a decision was made by the APMA House of Delegates to recognize a specialty in "primary podiatric medicine". Ultimately a joint proposal by the ABPO and a primary medicine constituency resulted in approval by the JCRSB as the testing entity in that specialty. The next step in my journey toward the Executive Director position occurred in 1993, when I was officially hired by the now ABPOPPM to assume the role of Examinations Consultant.

My role as Examinations Consultant was more systems-based and developmental in nature, with oversight of actual examination administration, development of additional question formats and managing the question pool. I also interfaced more with headquarters staff.

In 1996, as a result of the Board's dissatisfaction with its management firm, I was elected as the ABPOPPM Executive Director. The directors felt that the organization required closer oversight and administration, especially with the increased role requested of the certifying boards in developing residency models and standards and, concurrent with the expansion of the profession, as liaisons to other national committees. I had a clear understanding of everything related to our examination processes, as well as the professional landscape and where our board was situated within that landscape. I agreed to temporarily hold the Executive Director position for a maximum of two years, until the BOD found a proper administrator to succeed me. That was over 22 years ago. During that initial two years I found that while I acquired the needed administrative skills, what the organization most needed, and what I provided, was an executive administrator who really cared about the organization's future success, including the value of its certification to its membership, the legitimacy of its certification process to credentialing organizations and the importance of its role in shaping residency training. In addition, now an administrator, I had a deeper understanding of the value of a committed board of directors and, for an organization of our size, the essential need to get the best from each director. This is an area of professional growth that has probably given me the most personal satisfaction. I've been extremely fortunate in that regard, with engaged, supportive and committed directors through the years. We've also benefitted from a committed staff and excellent consultants, several of whom have been with the organization for over 15 years. These platitudes are neither rhetorical nor obligatory – they are simply true.

In general, I've never been one to spend significant time "looking back", though it's an important task. One needs to know where one has been to better understand where one is going. The BOD conducts strategic planning retreats periodically for that reason. But I tend to live in the present and focus on current and future projects, be they Board related, or humanitarian related (the Baja Project for Crippled Children; Rotary International, etc.). When pressed to look back, however, I take a healthy measure of satisfaction in what our organization has accomplished during my 33 years with it. Where ABPM has been concerned the missteps have been few and minor. We've made, and continue to make, a difference for our members and our profession. I thank all involved, past and present, for your contributions.

In closing, as I was asked to provide my perspective as the ED rather than merely rendering a history lesson, I'll share this: As a result of my training and practice experience, it has always been impossible for me to separate surgical from non-surgical care from the perspective of understanding foot and ankle function. Clinical biomechanics is the bedrock on which both stand and is equally applicable, with respect to preventative offloading, to wound care and limb salvage. In the end, structural and functional improvement relies on an in-depth understanding of clinical biomechanics. We, as THE regional specialists of the foot and ankle, have an ethical imperative to use this knowledge in order to make appropriate clinical decisions. The alternative results in the practitioner trying to fit the patient to what he or she happens to know how to do. As the saying goes, "When all you have is a hammer…..". Sadly, with respect to residency training, and notwithstanding the needed expansion of and advances in it, I've observed all too often that residents rely on two dimensional, static images, taken in bilateral stance, to make patient care decisions that require, primarily, thorough biomechanical assessment, including in large part, gait analysis. I regularly lecture to many residents nationally. I'm not overstating when I share that despite their overall training and vast improvement in clinical medicine, their deficiency in understanding foot and ankle function is alarming, despite their significant interest in honing their surgical skills. Worse, they do not know that they do not know. I bring this up because the process will soon begin to review CPME 320, the document that specifies the clinical re-

quirements to be achieved over three years of residency training. During the process the so-called "community of interest" provides commentary prior to its release. My concern, and I'm not alone in this, is that if the training model is not fortified by increased attention to in-depth knowledge of foot and ankle function, we will find ourselves working to the detriment of our patients. For those old enough to appreciate what I'm writing, the void created in the orthopedic community 50 years ago that enabled podiatry to flourish both in non-surgical foot care as well as surgical care augmented by better overall attention to function, is now being ceded to non-podiatrists by younger DPMs either willingly or unwittingly, simply because they do not know that they do not know. You, as part of that community of interest, need to make your concerns known to the CPME in the development of the new 320 document. After all, if not you, who? And if not now, when?

In closing, we are in a better place as an organization than ever before, and I'm happy to have been a part of it. I look forward to ongoing service as the organization's Assistant Director and Special Consultant.

LOOK FOR THE ABPM AT UPCOMING 2018 EVENTS

August 10-12, 2018 | **PRESENT Residency Summit (East)** | Marriott Glenpointe Hotel Teaneck, NJ
September 28-30, 2018 | **PRESENT Residency Summit (Midwest)** | Chicago Oak Brook Hill Marriott (Oak Brook, IL)
October 10-20, 2018 | **PRESENT West – Superbones/Superwounds** | Aria Resort & Casino (Las Vegas, NV)
November 7-10, 2018 | **PRESENT – Desert Foot** | Phoenix Sheraton (Phoenix, AZ)
November 9-10, 2018 | **Goldfarb Clinical Conference** | Valley Forge Casino Resort (King of Prussia, PA)

For more information, please visit our website at www.ABPMed.org

David H. George, DPM
Editor, ABPM

Editor's Note

Welcome to the Summer edition of the ABPM Member Newsletter. In this issue you will be updated on our expenses and income in the Treasurer's Report. Dr. Steve Geller provides a refreshing overview of the biomechanical examination and Dr. Lee Rogers presents the expanded eligibility criteria for the CAQ in Amputation Prevention and Wound Care. The Chairman of the ABPM Marketing Committee presents an update on marketing projects and a look into future aspirations. Dr. Marc Benard will be stepping down at the end of this year as Executive director and provides us with a twenty-two year plus perspective of his thoughts and experiences.

The ABPM BOD is pleased to provide the ABPM Graduate Merit Award to one outstanding member from each of the nine colleges, sincere congratulation to each on this very special achievement.

Wishing you and yours a very Happy Summer Season.

Sincerely,
David H. George, DPM
Editor