Incorporating Pedorthic Services into Podiatric Practices

In podiatry, pedorthists can be the ideal physician extenders.

BY D. CHARLES GREINER, DPM

"I used to think that I really knew how to treat biomechanically challenged feet…..and then I became a Certified Pedorthist and I realized how much more I could do to help my patients."—Justin Wernick, DPM, C.Ped

Podiatrists and Certified Pedorthists have been circling in the same orbit for decades. Sometimes they see patients jointly, at other times on a referral basis and, occasionally, as competitors. This should not be surprising considering the training, scope of practice and the conditions that they each treat. The natural intersection of these two healthcare professions has developed, in part, by the overall changes in healthcare and, in particular, the expanding surgical focus in podiatry. The relationships that have developed between them, however, range from benign mocking to harmonious patient care partners. Thankfully, some of the previous rancor is quickly yielding to respect due to changes occurring within both professions as well as the introduction of innovative programs from companies like OHI and its Central Casting service.

For doctors who graduated podiatry school prior to 2005, adding pedorthic services to their practices might have seemed unnecessary or even redundant. For those practitioners, orthopedic training and the development of a very balanced approach to patient care was commonplace. Biomechanical assessments were an essential service and the use of devices including foot orthoses, SMO's, AFO's and modified footwear were staple components of most podiatric treatment protocols. Residency programs provided podiatrists balanced exposure to both surgical and non-surgical treatments. This approach to training has transformed dramatically over the last 10 years, as have other important aspects of practice.

For starters, the focus on orthopedic management of lower extremity ailments has been greatly diminished in podiatric educational circles. While it's true that DPM students continue to experience outstanding orthopedic rotations in podiatry schools, the Residency experience focuses almost entirely on surgical patients. Continuing education has also 'downshifted', offering little in the way of educational opportunities that enhance or refresh biomechanical knowledge. Younger practitioners no longer possess the broad familiarity or experience that every podiatrist would benefit from in effectively treating non-surgical patients. Ironically, the largest patient segment for podiatry practices are those with some type of biomechanical deformity or deficit. They tend to be the most profitable patient segment as well.

The administrative and operational aspects of medical practices have also changed dramatically over the past decade, with even bigger changes coming. These new realities place increased demands on podiatric physicians and their staffs. Administrative burdens, EMR requirements and increased time pressures are all having a direct impact on patient care and outcomes. While the value of using the broad array of available corrective devices and other DME modalities is generally understood, incorporating them into practice settings has become challenging for many practitioners. Casting for and fitting braces and fitting footwear are time-consuming in an environment where most practices have been forced to reduce time with patients.

This combination of diminished skill development and time and administrative constraints has produced an environment where adding the services

Continued on page 94

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Pedorthic *(from page 93)*

of a C.Ped is a fundamental necessity for the growing number of practices who see comprehensive, holistic care of their patients as crucial for success.

The use of physician extenders such as physician assistants, nurse practitioners and others is relatively common in other areas of medicine. Many medical disciplines recognized long ago that a variety of services could be provided that did not require the full MD credential or training. In podiatry, pedorthists are the ideal physician extenders. Their training, scope of practice and ability to help manage orthopedically challenged patients is perfectly aligned with a growing practice need. It is fair to say that in almost every podiatric practice, a C.Ped can make an impactful contribution.

There are two basic ways that podiatrists can add certified Pedorthic services to their practices; the employment model and the leasing model. There are pro's and con's to each. In the employment model, the C.Ped becomes a full time employee. C.Ped salaries range from $40,000 to $60,000 on average depending on location, experience and other factors. Most malpractice policies would also require a rider to add the additional clinician to the policy. Then there are the added costs associated with benefits, professional development and credentialing. Typically, a full time C.Ped also requires the allocation of physical office space on a full time basis in order for the clinician to effectively see patients and adjust devices. The number one advantage to this approach is the scheduling flexibility that having someone in your office every day affords. This is a convenience for your patients and is also easier for your administrative staff. The downside of this model is the added operational and staffing cost.

The C.Ped leasing model, pioneered by OHI's Central Casting Program, provides podiatrists with a highly skilled C.Ped on an as-needed basis, driven by the patient requirements of the practice. In this model, the practice pays only for the hours of service actually provided. Podiatrists schedule the C.Ped to be in their practice on specific days for a specified number of hours. The office staff appoints patients that require casting, dispensing, shoe fitting or adjustment services at these scheduled times. In some cases, on-demand scheduling is also available. In the leasing model, practices are not burdened with any of the fixed and ongoing expenses that are required in the employment model. In the Central Casting program, all of the employee benefits, professional development costs, malpractice insurance and travel costs are borne by OHI. The practice simply pays for the time they use.

In both models, podiatrist and C.Ped practitioner have a very detailed understanding of the practice philosophy, the types of patients and treatment modalities assigned to the C.Ped and the overall rules of engagement with the rest of the staff. In the OHI model, C.Ped's will often shadow the podiatrist one or two days and then discuss recommended approaches to patient care to ascertain whether there is good alignment, both clinically and personally, prior to formal, regular scheduling.

As per-patient time is ever squeezed while better patient outcomes move into sharper focus, the addition of pedorthic services to podiatric practices is an idea whose time has come. While there are different approaches to executing this operationally within the practice environment, there is no doubt that the average podiatric patient will see benefit from this practice strategy. **PM**

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Making the Case for an In-Office C.Ped

I originally brought a C.Ped into our office simply to free up myself and my assistants in order to concentrate on other aspects of our workday. What I have discovered is that the addition of this very skilled clinician has achieved much more than just shifting of workloads. It has been very helpful having my Central Casting C.Ped available to collaborate with me on reviewing the best brace and footwear options for patients after I have made the diagnosis. The benefits to the practice have been increased revenue as well as better patient compliance and acceptance of the prescribed product. I'm also assured that my patients are receiving the best device because of the quality of the vendors my C.Ped and I deal with. All paperwork, compliance forms and ordering manuals are supplied by OHI and are completed with the highest level of skill and knowledge by my C.Ped before being presented to me for further input and approval. Our patient outcomes have never been better and the C.Ped is available for follow-up care and brace adjustments on each and every patient. I would highly recommend the addition of a C.Ped into any busy podiatric practice—D. Charles Greiner, DPM •

Dr. Greiner is past president, fellow and board member of AAPPM. He is board certified by the ABPS and a fellow of ACFAS. He is a third generation podiatrist in private practice in Southern Ohio.