Pain control is an essential aspect of providing comprehensive care to our patients. There may be profound implications when inadequately managed, especially in the postoperative setting (1). In the background of an opioid epidemic, clinicians and healthcare providers should consider alternative methods to control pain.

CONTINUED ON PAGE 6
Workers’ compensation? We can do that too!
The Yurconic Agency has an exclusive and competitive workers’ compensation program for PA Podiatric Practices.

- Potential group dividend opportunity
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Members of PPMA receive a 15% discount through PMAP

The Podiatric Medical Assurance of Pennsylvania (PMAP) professional liability insurance program utilizes PICA as its underwriting insurer and services policies through The Yurconic Agency.

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President's Message

Over the past six months, your PPMA Board has been immersed in the debate created by the APMA's actions relating to access to the USMLE and the effort to have the AMA recognize Doctors of Podiatric Medicine as “Physicians”. The core issue in these debates has been whether we should take qualifying exams created to test allopathic doctors’ knowledge of their curriculum as opposed to our own qualifying exams created to test our knowledge of podiatric curriculum. This entire topic will be debated in the APMA House of Delegates in three months, but I want to focus on another, and I feel, more urgent issue.

While the body of podiatric medicine engages to define what we are called, we seem to be ignoring another, and in our Board’s opinion, bigger problem within the profession of podiatric medicine. That problem is student recruitment.

For the past two decades Pennsylvania Podiatric Medical Association has been involved in student recruitment. Our efforts caused the APMA to create a student recruitment project almost two decades ago. Our motions caused APMA to created “books” on our profession which were sent out to college advisors. That effort, over a number of years, increased the pool from below 500 to a level in the realm of 900. PPMA followed that program with Residency Genesis; the effort to grow residencies to address the vacuum created by the decision to go to three year residencies.

Four years ago, PPMA led a new effort to, once again, grow student recruitment by donating $25,000 to APMA at the House of Delegates. That effort led other states to donate to APMA; however whatever program was created has not resulted in growth of the student pool.

Currently APMA is pursuing a program in “Career Awareness” and, ostensibly, the AACPM is in charge of student recruitment. The upshot of this review of our efforts is that no matter who is in charge, the student pool is not growing and without growth and competition for seats, the future of the profession is adversely affected.

This month, our Board determined that we can no longer rely on someone else to boost our numbers. Just as in politics, all progress begins at the “grass roots”. We have initiated a grass roots effort to increase the student pool by committing our own time to this issue. Right now, in January, we are in the first month of the recruitment cycle for the class which will begin in September of 2022.

Due to this urgent need and tight time line, we have adopted a 90 day grass roots recruiting program.

In cooperation with the Temple University School of Podiatric Medicine, each of our Board members will commit to using their best efforts (in view of COVID) to contact three college advisors and either make an in person visitation, or produce a Zoom presentation to their undergraduate science students. TUSPM is producing a “how to” zoom to educate the Board members. TUSPM Recruitment officers will demonstrate the way to contact a college or college interest club; discuss length of time that an effective presentation should take; provide presentation material and present a “run through” of the recommended presentation.

PPMA, during this time period, will focus its social media on target student markets which would be receptive to information on the profession of podiatric medicine.

During this grass roots effort, each PPMA Board member and consultant has committed to using their best efforts to schedule and hold a meeting with three colleges which are of their choice. The colleges can be local to the member or remote. The Board member will complete an appointment sheet which will log any

CONTINUED ON PAGE 4
The Goldfarb Foundation has released the ProSeries

ProSeries bundles all the study tools you’ll need to successfully prepare for In Training Exams (ITE), certification through ABFAS, ABPM, or individual state licensing exams. ProSeries saves you time, money, and headaches!

Click here for additional information.
Dr. John Marty, ProSeries Developer

The GoldFarb Foundation partners with FootDocDana to introduce RESIDENT PRO to students preparing for March results. Video yields over 300,000 views on YouTube proving that the public is interested in the podiatry field.

Visit FootDocDana on www.youtube.com/ and look for our sponsored video “The Study Hack that Changed my life”

PRESIDENT’S MESSAGE

CONTINUED FROM PAGE 3

interested student e mail addresses. TUSPM will be responsible to follow up with these contacts.

Members can, if they choose, offer a “shadowing day” subject to the member’s evaluation of the interested student. The shadow can be virtual.

I am presenting the details of this program to each of you, as this effort to recruit new students does not have to be limited to Board members and Consultants. Any PPMA Member can become involved in this project.

I am asking you to consider dedicating an afternoon to support the profession’s future. If you call the office and indicate to Judy that you would like to be involved, we will call you and link you up with the education Zoom and a college.

As important as our testing and title issues may be, full classes in our podiatric medical schools are the future of the profession.

I am asking for your help!

From the Membership Director’s Desk

Jenna Clay

Has your contact info, including email address changed?

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SOLO
Non-Opioid Pain Management for Podiatric Physicians and Surgeons

CONTINUED

acute and chronic pain. A multimodal approach to pain management is essential to reducing opioid requirements, minimizing adverse events from opioids, and hopefully increasing patient satisfaction.

Local Anesthetics

Short-acting and long-acting local anesthetics can be used in a variety of clinical applications to provide non-opioid-based pain management. Local anesthetics have a unique benefit with overall low risk compared to oral medications. Local anesthetics can be administered via subcutaneous injection or topical application. Injectable local anesthetics are often administered during in-office procedures and pre-and post-operatively in the operating room to decrease postoperative pain and oral medication requirements. A significant amount of utility is provided by a local anesthetic infiltrated into an area of pain. It can provide adequate analgesia for several hours to days depending on the type and amount of local used. Depending on the clinical application, the determination to use a short-acting versus long-acting local anesthetic should be made. A diagnostic nerve block can also be a versatile tool for addressing painful symptoms for patients with idiopathic pain to a particular foot or ankle region. A literature review by Griffioen et al in 2018 found that regional blocks provided superior pain relief compared to opioids following a lower extremity fracture (2). There is also evidence within the orthopedic literature pertaining to total hip arthroplasty (THA) and total knee arthroplasty (TKA) that demonstrate the effectiveness and benefits of postoperative regional anesthesia. A study by Marques et al in 2014 showed that infiltration of local anesthetic following THA and TKA shortened hospital stays, reduced opioid consumption, led to earlier mobilization, and reduced vomiting (3). The study also concluded that receiving local anesthetic infiltration lowered pain scores at rest compared to controls after 24 and 48 hours (3). Postoperative local anesthetic blocks have provided significant postoperative analgesia after foot and ankle surgery (4). Patients who receive a popliteal fossa block have better pain scores, a more prolonged analgesic effect, and decreased opioid requirements in the immediate postoperative period (5). The popliteal fossa block was also found to have better pain scores and reduced opioid requirements than the ankle block (5).

NSAIDs

NSAIDs work by inhibiting cyclo-oxygenase (COX), diminishing post-injury hyperalgesia. Mild to moderate pain can typically be treated with an oral NSAID or acetaminophen. Studies performed by Pogatzki-Zahn et al (2014) and Nonaka et al (2016) demonstrate NSAIDs to be more effective in postoperative pain control compared to acetaminophen (6,7). While these may not be benign medications in terms of potential renal and GI side effects and platelet inhibition, the use of selective COX-2 inhibitors decreases that risk. They also note that the harmful side effects of acetaminophen are often underestimated in terms of possible liver damage (6,7). Some may also argue that NSAIDs are detrimental to the early phases of bone healing. However, more long-term data is needed. A study by Cozowicz et al in 2018 found that COX-2 inhibitors and NSAIDs were associated with the strongest individual effect in opioid dose reduction. NSAIDs have also been shown to reduce opioid requirements following ankle fracture surgery (8). Effective pain control is critical during the first two days following ankle fracture surgery because patients, on
average, consume the most opioids during this time. A study by McDonald et al in 2018 found that the addition of the NSAID Ketorolac significantly reduced postoperative pain while concurrently reducing opioid requirements (9). They also found that patients experienced less pain during postoperative days one to two, and the addition of Ketorolac maintained minor discomfort for up to four days postoperatively. The patients in their study found greater patient satisfaction with their pain management, less hypersensitivity, and fewer paresthesias when treated with a multimodal pain regimen, including NSAIDs (9).

With increasingly strict regulations on narcotic prescriptions and high addiction potential, the multimodal approach to postoperative pain control is critical. Each patient is a unique case and requires thought to their co-morbidities, planned procedure, and anticipated postoperative pain to determine the optimal regimen to control their symptoms. It is imperative to discuss expectations with your patient, especially regarding postoperative pain. Opioid contracts are increasingly utilized and serve as a good starting point for this discussion. For patients who have chronic pain, referral to pain management pre- or post-operatively can also be considered. By not solely utilizing opioid-based medications, we can reduce opioid dependency and provide better outcomes for our patients.

References:
Elliot R, Pearce CJ, Seifert C, Calder JD. A prospective, randomized trial is a continuous infusion versus single bolus popliteal block following major ankle and hindfoot surgery. Foot Ankle Int. 2010; 31(12):1043-1047.

21st Annual Joint National Podiatric CAC-PIAC Representatives’ Meeting

I recently attended the 21st Annual Joint National Podiatric Carrier Advisory Committee (CAC)-Private Insurance Advisory Committee (PIAC) Representatives’ Meeting, held in-person and virtually on November 12, 2021, on behalf of our association. The meeting featured experts and leaders on both private and public insurance issues, as well as opportunity to hear from our colleagues around the country and discuss new and ongoing trends and challenges that might impact our members.

Attendees were first updated on the CY 2022 Medicare Physician Fee Schedule Final Rule from Cindy Moon, MPP, MPH, vice president at Hart Health Strategies and APMA Health Policy and Practice Consultant Jeff Lehrman, DPM. Of significant concern to members is the possible up to 9.75 percent reductions to Medicare provider reimbursement for 2022, due to expiration of the temporary increase for 2021, the Medicare sequester reductions that were suspended for COVID-19, and the PAYGO sequester reductions.
Meeting Wrap Up

Significant advocacy is underway to avert these reductions, including an APMA eAdvocacy campaign for members and APMA working with other stakeholders to lobby Congress and CMS to avert these reductions. Write to Congress to at www.apma.org/eAdvocacy.

Additionally, the final conversion factor is 33.5983. The estimated impact on podiatrists for 2022 not including scheduled payment reductions is +1 percent. CMS also finalized the following changes:

- Retain all Category 3 services on the Medicare telehealth services list through December 31, 2023;
- Allow physician assistants bill directly for services they perform, as required under law; and
- Delay onset of AUC penalties until January 1, 2023 or the January 1 that follows the end of the Public Health Emergency, whichever is later.

Members can learn more at www.apma.org/Medicare.

APMA private insurance consultant Kelli Back, Esq., also updated attendees on ongoing issues for Medicare Advantage and commercial plans. She noted the following key highlights:

- No Surprises Act: Ensures patients are not obligated to pay more than the in-network cost sharing under their commercial health plan in certain situations when out-of-network providers furnish services and sets forth a process for non-contract providers and insurers to come to agreement on payment amounts. This will be effective January 1, 2022. Learn more about the No Surprises Act on January 11, 2022 in a Webinar hosted by APMA. Register at www.apma.org/Webinars.
- Medicare Advantage continues to be problematic for providers with onerous record requests and frequent denials. APMA and other medical specialty societies recently met with CMS to address member concerns.
- Ms. Back also reminded attendees that Advanced Beneficiary Notices (ABN) are not appropriate for use with Medicare Advantage plans and should only be used with Medicare Fee-For-Service.

Given that record requests are one of the biggest sources of headaches for our members, Ms. Back spent a good amount of time reviewing the reasons for data mining and what providers can do when they receive onerous record requests. She also reviewed the significant advocacy work that APMA has done and will continue to do on behalf of APMA members to resolve this burden. Members can learn more about responding to Medicare Advantage Record Requests in the July/August issue of APMA News or log on to www.apma.org/MedicareAdvantage.

Attendees also heard directly from and were able to pose questions to two Noridian carrier medical directors (CMDs), Gary Oakes, MD, and Larry Clark, MD. Drs. Oakes and Clark addressed member questions about the LCD process and development changes, concerns about amniotic injection denials, and other critical CAC concerns.

Health Policy and Practice Chair Ed Prikaszczikow, DPM spent time addressing best practices for CAC and PIAC representatives. Some of Dr. Prikaszczikow’s advice is also relevant to every member, such as:

- Know the Medicare Program Integrity Manual and understanding the Local Coverage Determination and Local Coverage Article Process
- Use APMA resources and communicate with both APMA and your state association regularly
- Stay in the know by subscribing to private and public payer newsletters.

Ross Taubman, DPM, President and Chief of Medical Officer of PICA, addressed how members can benefit from administrative defense coverage (ADC), via PICA or another medical malpractice carrier. ADC can be used to help with coding and billing audits from both public and private payers, state board investigations whether related or unrelated to a malpractice claim, decertification from an insurance plan, and more.

He covered how important it is to know how your billing compares to your peers in a region or nationally, having competent and well-trained billing staff is, and that all providers should implement and follow good, written corporate compliance and documentation practices.

Finally, as in years past, attendees spent time discussing regional concerns in both the public and private insurance spheres. This key feature allows representatives to share experiences and collaborate on solutions to common issues. In the public insurance arena, the biggest areas of concern are the continued DME same and similar denials, coverage for wound care, and amniotic injections/skin substitutes. For private payers, bundling and reimbursement issues for Medicare Advantage versus Original Medicare, denials or reimbursement reduction for claims billed with the -59 or -25 modifiers, DME audits, prior authorizations, and record requests.

During the meeting, Iowa CAC Rep Theresa Hughes, DPM, was recognized as the “CAC-PIAC Rising Star of the Year.” She was also elected to serve as APMA’s new CAC Chair. Tennessee CAC Rep Ira Kraus, DPM was recognized as “CAC-PIAC Representative of the Year.” More information on is available at www.apma.org/CACPIAC2021.
Novitas has posted the long-awaited finalized LCD and Article for “Surgical Treatment of Nails” effective 1/30/2022.

In summary, as your MPMA CAC representative, I provided in writing numerous recommendations as did I engage the APMA Health Policy and Practice and suggested changes to the policy several months ago (during the draft process).

Additionally, via the Webex CAC Open Meeting for Novitas, I provided verbal testimony about the numerous concerns in the proposed policy. Supportive arguments were provided to justify changes prior to the finalized version. Article - Response to Comments: Surgical Treatment of Nails (A58961) (cms.gov)

The updated policy is not effective until January 30, 2022 for those that utilize these CPT codes 11730, 11732, 11750, and 11765.

All MPMA members should review the LCD and LCA (Billing Article) to better understand the changes.

The most significant change addresses the frequency of performing these procedures. Be aware of an “8-month” period where you can’t bill the same T Code (TA-T9).

However, the carrier states that under certain circumstances, exceptions may be considered.

This is from the LCA “For a medically necessary repeat nail excision on the same finger or toe, use modifier 76 (repeat procedure or service by the same physician or other qualified health care professional) or modifier 77 (repeat procedure by another physician or other qualified health care professional). The medical record documentation must be specific to the indication, such as ingrown nail of the opposite border or new significant pathology on the same border recently treated. Compliance with the use of modifier 76 and modifier 77 may be monitored and addressed through post payment data analysis and subsequent medical review audits.”

It is my understanding that APMA will provide additional information since a similar policy is applicable for First Coast (another major Medicare carrier). The plan is to review this on the next MPMA membership Zoom in January.

The future LCD link is here: LCD - Surgical Treatment of Nails (L34887) (cms.gov)

The future LCA link is here: Article - Billing and Coding: Surgical Treatment of Nails (A52998) (cms.gov) •
Confronting the Common Barriers of Delegation Head On

LYNN HOMISAK
SOS Healthcare Management Solutions, LLC
www.soshms.com

Some of you may recall a very dated (1965) TV commercial “Mother, please! I’d rather do it myself!” The message of course was to get relief from a particular aspirin, rather than suffer the headache-induced stress brought about by (in this case), an interfering mother. Undoubtedly, many of us are “I’d rather do it myself” people, and while our intent is not to grouch on those around us, there is a refusal or resistance to change our ways. Enter Effective delegation. The answer to the “DIY” cry!

To clarify – delegation is not just about unloading tasks because you don’t want to do them or because they are too difficult or boring. It is about carefully selecting, empowering, and trusting capable individuals to take on specific tasks. Then transferring the decision-making responsibilities to the assignee in such a way that they are granted full ownership of it. It’s intention? To help reclaim your time, reduce your stress, and increase efficiency and productivity – all of which can lead to added practice value.

While there are tremendous advantages to delegating, the push-back (or barriers) by naysayers are not far behind. Of course for some, it’s nothing more than benign habit (“I’ve always done it myself”), an unwillingness to change, or fearing a loss of control. Others believe “I’m the best; no one else can do it like I can!” And include the standard refrain, “it’s easier just to do it myself.”

Many doctors, by their own admission, have found it particularly difficult assigning hands-on tasks to their staff. Perhaps because they feel a duty and obligation to their patients, or a combination of reasons listed. Additionally, there is the fear they could risk malpractice. Others that might consider delegating do not want to take (or claim not to have) the time to train. My favorite though, is the worry of patient
disapproval. (“Patients expect ME to treat them, not my staff.”) I don’t doubt that a handful of patients may prefer the doctor’s attention; however, the ability to convince them ultimately rests on how the doctor presents. If a physician is confident that his or her well-trained staff are capable of performing a particular task, it follows that patients will too. Few would question a dental assistant prepping for a root canal. In fact, you would be surprised if the dentist was the one who cleaned your teeth.

Every successful endeavor has a form of this hierarchy. The auto shop has ‘Bud’ the seasoned mechanic who takes on engine repairs and assigns ‘Jimmy’, the young new hire, oil changes and flat tires. The Executive or Head Chef manages the kitchen while sous chefs, line cooks, and prep chefs work many jobs to prepare restaurant meals. The bank president rarely if ever works the teller position. Brad Pitt has a stunt double; and as good as he may be, you will never see Tom Brady kick a field goal.

To be clear, some resistance is valid because not everything can (or should) be delegated. There are indeed limits and stepping over that line is unacceptable. However, no one is suggesting that staff perform bunion surgery, suture-close capsules, administer injections, or deep wound debridement, all which of course, would define unprofessional, even unlawful conduct. There are tasks, however, that can be considered suitable.

Conscientiously select those jobs that can be directly trained/learned and are personally comfortable for you to let go (administrative or patient hands-on). Once staff have become capable and confident in their performance and can prove that they are able to handle more, they’ll need one-on-one instruction and guidance. For example, show them and explain how to prep a patient for a procedure, apply pads post-palliative, acquire preliminary patient history, assist in surgical procedures, and with adequate training and supervision are achieved, take orthotic impressions. Being able to delegate such tasks allows for simultaneous revenue streams. While you are giving an injection, they can productively apply and instruct a patient in proper night splint use.

Proper delegation requires three critical steps:
1. Choose the right person when delegating assigned tasks. Expect some initial mistakes, remembering that mistakes (recognizing and correcting them) are part of learning and development. Keeping in mind, that too much leniency or mistakes unchallenged will result in YOU re-doing the work - accomplishing nothing.

2. Be sure to clarify and manage (not micromanage) the job. Detail the reasons why and how something needs to be done and insist on quality as an end result. Remember, people are not mind-readers, so unless you successfully communicate your expectations, they cannot possibly understand how best to meet them. If you are vague, they are left to their own interpretation and that is a set-up to fail. Then review and supervise their progress.

3. Provide Incentive; praise, and reward the action – especially for a job well done. Everyone likes to feel their work and efforts are appreciated. Spell out what in particular they are being commended for by saying, “Sue, the patient history you took today was very thorough...made my work much easier!” Rewards (not for simply doing the task – but excelling at it) are a great morale builder. In fact, self-confidence, appreciation and rewarding good behavior often results in repeated good behavior.

If the barriers that prevent us from letting go are self-induced, so too are the remedies that can allow us to reverse course and welcome the help of others. Just think of it. Reduced demands of your time. Increased efficiency and productivity. Additional revenue opportunities. A more fulfilled, confident, reputable and devoted staff. Less stress; less headaches. All because of the decision to put that “do it yourself syndrome” to rest. And without the use of any OTC medicine. Plop, plop, fizz, fizz – Oh what a relief it is! •
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<tr>
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<td>Transdermal Therapeutics, Inc.</td>
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<td>877-581-5444</td>
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<tr>
<td>The CORE Group</td>
<td><a href="http://www.coregroupmedical.com">www.coregroupmedical.com</a></td>
<td>800-650-4234</td>
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<td>WEBSITE</td>
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<td>Horizon Therapeutics</td>
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### PRACTICE SUPPORT/ SOFTWARE/EHR/BILLING

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<tr>
<td>Legally Mine</td>
<td><a href="http://www.legallymineusa.com">www.legallymineusa.com</a></td>
<td>801-477-1750</td>
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<td>Providence Management, Inc.</td>
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<td>856-753-0913</td>
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<td>Sammy Systems</td>
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<td>516-766-2129</td>
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### SURGICAL INSTRUMENTS

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### SURGICAL PROCEDURES

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### WOUNDS

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<td>SeaGlass Medical</td>
<td><a href="http://www.seaglassmedical.com">www.seaglassmedical.com</a></td>
<td>443-831-6899</td>
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14 PPMA Update January/February 2022
Exhibitor Spotlight

PICA
Treated Fairly

PICA is the nation’s leading provider of medical professional liability insurance for podiatric physicians in the United States. For 40 years, we have provided medical malpractice coverage while supporting and enhancing the podiatric profession through sponsorships, risk management seminars and annual scholarships for podiatric medical students, to name a few.

PICA is a member of ProAssurance, the fourth largest provider of medical professional liability insurance in the country. With corporate headquarters located in Birmingham, AL, it operates in 50 states and the District of Columbia and has nearly 1,000 employees in 31 offices across the country. ProAssurance stock trades on the New York Stock Exchange under the symbol PRA. To learn more about ProAssurance, click here.

PICA is rated A “Excellent” by A.M. Best Company, the leading rating agency for the insurance industry. We are endorsed by the American Podiatric Medical Association (APMA) and the American College of Foot and Ankle Surgeons (ACFAS), the American College of Foot and Ankle Orthopedics and Medicine (ACFAOM) and several state podiatric medical associations.

We offer a variety of discounts, such as part-time, new practitioner, risk management, non-surgical and leave of absence, other insurance products through ProAssurance Agency, outstanding customer service and expert claims handling with a seasoned team of specifically approved defense counsel. Consulting and brokerage services are available to meet the growing demand for financial, operational and strategic support.

Founded by podiatrists, for podiatrists, PICA is committed to protecting and supporting podiatric physicians in every aspect of their practices. We will take the time to assess your needs and assist you in choosing the policy coverage that best suits you. PICA has the expertise and resources to protect you and your practice like no other company.

picagroup.com

40 YEARS OF PROTECTING PODIATRIC PHYSICIANS
Starting my first year at Temple University School of Podiatric Medicine, I had several preconceived notions about my academic career expectations. Many people talked to me about the challenges and difficulties that podiatry school may bring. I would hear from family members experienced in the medical realm, from peers in my undergraduate program, and from my mentors within the field itself. While preparing for the academic challenges ahead, everyone I spoke to described this time as challenging, scary, fast-paced, overwhelming, and competitive. I certainly knew that I was nervous to start podiatry school but was unsure of the specific challenges that it may bring.

As I wrap up my first semester at TUSPM, I would say that many of my expectations came true—but there were lots of pleasant surprises along the way. Personally, the most significant adjustment that I had to make was the time commitment. The change in my daily schedule from my undergraduate studies was drastic. For most of this first semester, my program consisted of 8 AM-5 PM classes filled with brand new information and studying through the pertinent information until approximately 10 PM daily (if I was lucky enough to end so early). The weekends became a great time to play catch up or study for an upcoming exam. It most definitely felt very overwhelming at times and was very fast-paced. Although this schedule change was daunting at first, this was something that I just had to get used to. It has ultimately made me a much more efficient person, but unfortunately, there was not much free time other than rare occasions with more significant breaks between exams.

When my class did have free time, it was nice to socialize and have fun with my peers. To my surprise and liking, the cut-throat competition aspect of my expectations did not hold. I felt that no one tried to hold anyone else back. We all try to help each other the best that we can. Whether in the anatomy lab discussing our dissections together or sharing Anki flashcard decks, I found that everyone was very humble and generous. The upperclassmen have also been extremely helpful on things to look out for, and so many outstanding tutors are willing to help you in any way possible.

Overall, it was a very challenging semester, but I have been feeling very privileged that I have gotten this opportunity to advance my education. There were times when coursework was piling up so high that it felt impossible for me to complete the assignments. However, it felt gratifying knowing that the hard work I put in was worth it and that I could triumph over these difficulties. Moving forward, I can’t wait to get the chance to work hands-on with patients and get more immersed and involved within the field of podiatry!
APMAPAC Contributions

The APMA Political Action Committee (APMAPAC) is a nonprofit, bipartisan fundraising committee through which member podiatrists and students support federal candidates who champion podiatric medicine's issues before the US Congress.

Nell Blake $150  Paul Lorincy $300  PA - Bucks Mont Division
Walter Buck $100  R. Martin $25  POD MED ASSN $500
Gregory Bentzinger $10  James McGuire $150  PA - Central Division
Michaele Crawford $250  Richard Meredick $150  POD MED ASSN $150
John Dahdah $300  Stephen Mills $200  PA - Delaware County
Kirk Davis $500  Sabrina Minhas $350  POD MED ASSN $750
Michael Davis $500  Thomas Morris $150  PA - Phila. County Division
David Flannery $150  Julie Mrozek $150  POD MED ASSN $1000
Raymond Fritz $100  Edward Murray $150
Joseph Gershey $150  Daniel Olson $50  Jane Pontious $50
Gerald Gronborg $326.49  Anita Onufer $500  Gary Raymond $500
Arthur Helfand $150  John Orlando $100  Thomas Rocchio $150
Kimberlee Hobizal $200  Thomas Ortenzio $200  John Salahub $150
Bradford Jacobs $75  Brooks Peters $50  David Scalzo $300
Lawrence Kassan $150  Mark Pinker $300  I. Schifalacqua $150
Neal Kramer $100
Steven Kreamer $100  PA - Berks County POD MED
Charles Langman $100  ASSN $1000  Bradly Shollenberger $150
Rick Simon $100  Joseph Smith $300  Stephen Soondar $100
Michelle Sparks $500  Brian Szabo $100  John Turrisi $75
William Urbas $150  David Warner $100  Robert Weber $150
Eric Wolfe $500  George Yarnell $100  Todd Zeno $150

Total: $13,711

Please note: Due to the delays in posting APMA contributor reports, it may take until the next issue to see your contribution.

MY COMMITMENT TO APMAPAC - 2022

Check here if this contribution is drawn on: ☐ 12-Corporate Account
Enclosed is my voluntary, personal political contribution of:
☐ $25 (Student)  ☐ $75 (Young Physician)  ☐ $150
☐ $300  ☐ $500  ☐ $1,000  ☐ $2,500  ☐ $5,000

Name______________________________________________________APMA# _____________________
Address________________________________________________________________________________
State_________________Zip________________E-mail Address__________________________________

☐ Check  ☐ Credit Card  ☐ Other
Credit Card Number: ________________________
Expiration Date___________Signature______________________________________

IMPORTANT: These are suggested amounts. You may contribute more, less, or not contribute without concern of being favored or disadvantaged. This information is required for contributions of $200 or more by the Federal Election Campaign Act. *Federal election law does not permit corporate contributions to be used for donation to candidates for federal office. Political contributions are not deductible for income tax purposes.

Mail your contribution to: APMAPAC, 9312 Old Georgetown Road, Bethesda, MD, 20814
PRACTICES FOR SALE

PRACTICE FOR SALE NORTHEAST PA: Opportunity to purchase practice only or practice and real estate. Easily grossing $250,000. The doctor is retiring after 40+ years. Very active non-surgical practice. Contact 570-253-1540 or elmdpm@verizon.net.

WHAT IS A POLITICAL ACTION COMMITTEE?

A short history of political action committees can be found at “Fiscal Note” (see below). PPMA operates the PPMA PAC and encourages donations to the APMA PAC. The importance of PAC’s relates to “access”. The ability to contribute to a candidate on behalf of the podiatric profession, both in Pennsylvania and nationally, cannot be overstated. The ability to make contributions allows us to be known, not as an individual, but as a profession.

PPMA’s position has always been to encourage members to go to the local fund raising events for an incumbent or candidate. That golf outing, or hot dog roast will give you a chance to meet the man or woman for whom you vote. That is personal exposure is important to the candidate or incumbent. PPMA PAC will support your effort. Send us the fundraising notice and we will send you the check to deliver so you can make that local, and most important, person to person connection.

“The textbook definition of a political action committee is a tax-exempt 527 organization that pools contributions from donors to direct funds into campaigns for or against candidates, ballot initiatives, or proposed legislation. PACs are technically referred to in federal election law as “separate segregated funds” because contributions are kept in bank accounts independent of any corporation, association, or union treasury.

PACs have evolved for more than 75 years. In 1907, Congress adopted the Tillman Act, restricting corporate contributions to political campaigns. The 1943 Smith-Connally Act extended that prohibition to labor unions. That same year, the Congress of Industrial Organizations (CIO) formed a “political action committee” to raise money for President Franklin D. Roosevelt’s reelection. Because the money was voluntary contributions from union members and not from the union’s treasury, CIO’s seminal PAC did not violate the Smith-Connally Act and, thus, a new way to finance political campaigns emerged.

It wasn’t until the Federal Election Campaign Act (FECA) of 1971, and its 1974 amendments, however, that PACs became a significant component in campaign financing. FECA allowed corporations, trade associations, and labor unions to directly form political action committees and set limits on amounts a corporation, union, or individual can contribute. In soliciting smaller contributions from a larger pool of individuals, PACs could generate substantial funds for candidates.

Following the 70s reforms, political action committees proliferated from about 600 in 1975 to nearly 4,000 in 2010, to more than 4,600 now.

The PPMA Update is a digital publication of the Pennsylvania Podiatric Medical Association and the next issue will be March/April 2022. Advertising rates can be found on www.ppma.org.
Meet Mansi Patel, DPM

What made you choose podiatry as a profession?
It's a diverse field, in which you have the flexibility of choosing what you want to do and how you want to practice.

What can we do to encourage young persons to pursue a career in podiatry?
We can encourage them to shadow offices and residency programs. Perhaps we can even visit undergraduate campuses to make them to increase awareness.

Who has been a strong mentor or supporter of your career/journey?
I’ve had many supporters. My family has been there for me. They always reminded me that it’s all worth it, no matter how tough it is.

What do you like to do outside of work?
Soak in all the moments with my one-year-old daughter. I enjoy dancing, wedding coordination, DIY projects, and traveling.

How have you helped patients improve their health?
I educate my patients as much as I can. I always explain things to patients in terms they can easily understand. Additionally, I encourage them to do their own research outside of the office from trustable sources that include videos.

How did you select the area in which you are providing care?
My husband did his residency in Philadelphia and is currently in fellowship. I joined him after medical school when I got a residency a little outside of Philadelphia in South Jersey. The city of Philadelphia has been our home for 5 years now.

How can we encourage patients to practice wellness and preventative care while remaining safe (COVID)?
- Education! Education! Education! I can't say that enough. We can always send out informational fliers, emails, videos etc. to remind them that if they can't physically attend the doctor’s office, it doesn't mean they shouldn't take care of themselves.

Is there any advice that you would like to share with our members that have been a game changer in improving the care you provide, communicating with patients, increasing revenues/decreasing expenses that would be helpful for others to learn?
- Join local and professional physician Facebook Groups. It is the best way to share and get information. Listen to the white coat investor podcasts. Share your knowledge with your colleagues. Ask them questions! You learn a lot from other people’s experiences, so always think of them as a resource.

Where did you go to school?
New York College of Podiatric Medicine
Better coverage is afoot.

Complete Voluntary Benefits for Qualified PPMA Members

During this **SPECIAL VOLUNTARY ENROLLMENT** period you can prepare for the unpredictable with guaranteed issue, employee-owned, **whole life, disability, critical illness, and accident insurance** policies for both doctors and employees.

- Get Group discounted benefits paid through payroll deduction
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- Customize your policy based on age and need
- Prepare for the unpredictable

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- Fully insured plans
- PPO plans
- Qualified HSAs
- Electronic enrollment & billing

*This program is currently offered to practices located in Pennsylvania.

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Social Media Highlights

FOLLOW US ON SOCIAL MEDIA | Like, share, and comment on our posts to help build awareness of PPMA and recognize our members!

Thanksgiving Message from Sharon Dei-Tumi, Class President - TUSPM Class of 2024

Thanksgiving is around the corner and as an immigrant, I have come to appreciate the two main questions that are paramount to this season: "what breathable clothes can help conceal all the food I plan to eat?" and "who will be featured on the Macy’s Thanksgiving Day Parade?" Of course, there is the occasional "what am I thankful for?"

Prepping pies for St. Francis Assisi Soup Kitchen and JFT Veterans Service.
Anyone want to guess how many pies we are preparing to donate? 😁

#FlashbackFriday
2021 #YearInReview
Student Spotlights
Membership Spotlights
Events
Anniversaries
What do you want to see more of in the new year?
#podiatrist
Upcoming Events

26th Annual FAPA Seminar in the Sun
FEBRUARY 19-22, 2022
Iberostar Paraiso Maya and Grand Resort, Riviera Maya, Mexico (16 CECH)

73rd Region Three Scientific Meeting
MAY 4-7, 2022
Harrah’s Atlantic City Hotel and Casino, Atlantic City, NJ (25 CECH)

17th Annual Montana Meeting
SEPTEMBER 7-10, 2022
Doubletree Missoula-Edgewater, Missoula, MT (12 CECH)

50th Annual Clinical Conference
NOVEMBER 3-6, 2022
Valley Forge Casino Resort, King of Prussia, PA (26.75 CECH)

Annapolis Meeting
DECEMBER 2-4, 2022
Historic Inns of Annapolis, Annapolis, MD (12 CECH)

Upcoming PPMA Meetings

APMA HOUSE OF DELEGATES 2022
March 12th and 13th in Washington, DC

PPMA HOUSE OF DELEGATES 2022
June 10th thru the 12th in State College, PA

INAUGURAL DINNER FOR DOUG HUTSON, DPM
November 5th at the Valley Forge Casino Resort

PPMA BOARD MEETINGS
Wednesday, March 2
Wednesday, September 14

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Mark E. Pinker, DPM
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TUSPM Student Rep
Samantha (Sami) Cooney
samantha.cooney@temple.edu

Upcoming Events