

HAND SURGERY NEWS

A publication of the American Association for Hand Surgery

Spring 2015

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MESSAGE FROM THE PRESIDENT

It is hard to believe that the year is almost half over. Time does not stand still nor do issues that require our attention. One of the largest issues that came to fruition over the last couple of months was the termination of the publishing contract with Springer and the signing of a new contract with SAGE. This is an extremely positive and forward moving initiative that promises to improve our journal, *HAND*. The receptive and innovative nature of SAGE aligns with the American Association for Hand Surgery, our journal, and the affiliate countries of Brazil and Argentina. The number of article submissions is increasing dramatically. Our virtual impact factor continues to rise. The scientific merit of our articles have increased exponentially.

As we have grown so have our needs. SAGE enthusiastically embraced our commitment to the journal's excellence and recognized our desideratum, making our partnership with them essential. SAGE be-



Michael W. Neumeister, M.D.

(continued on page 3)

SAVE THE DATE
2016 AAHS ANNUAL MEETING
January 13-16, 2016

AAHS
American Association for Hand Surgery

DGH
The German Society for Hand Surgery

Westin Kierland Hotel • Scottsdale, Arizona

FROM THE EDITOR



Thomas Hughes, MD

I am happy to announce a few changes to the newsletter of the AAHS. After multiple discussions, the board has decided to implement these changes to improve the Newsletter and make it more relevant to the members.

To begin with, the name will change to Hand Association News. The “quarterly” is being dropped from the name to reflect the change in publication frequency to 3 times per year. It was felt that it was valuable to members to have:

1. An issue to report on the annual meeting;
2. An issue to discuss the summer board meeting; and
3. An issue to prepare for the upcoming annual meeting.

It also gives us the flexibility to add an issue if there are items of information that are deemed important to the membership.

Secondly, I am happy to announce the addition of an assistant editor in John Fowler. John will assume (or has already assumed) responsibility for the round table discussions. He will arrange for the topics, moderators, and contributors to this feature in each newsletter. I am sure he would welcome suggestions for topics from our members.



**New Assistant Editor
John Fowler, MD**

I hope our members will find that these changes improve our newsletter. The goal is that by decreasing the frequency, it will be denser with new information and that members will find it keeps them sufficiently informed on the status of the Association.



HAND SURGERY Quarterly

President

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Editor

Thomas Hughes, MD

Assistant Editor

John Fowler, MD

Executive Director

Sarah Boardman

Managing Editor

Lorraine M. O’Grady

Hand Surgery Quarterly is a publication of the American Association for Hand Surgery and is published strictly for the members of AAHS. This publication is designed as a forum for open discussion and debate among the AAHS membership. Opinions discussed are those of the authors or speakers and are not necessarily the position, posture or stance of the Association.

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2015 Research Grant Recipient

Christine Novak, PT, PhD
University of Toronto
Toronto, Ontario, Canada

Cold Exposure Responses in Hand Trauma Patients with Cold Sensitivity

*Hand
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News*

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PRESIDENT'S MESSAGE *(continued from page one)*

comes our official publisher January 1, 2016...stay tuned for great new ideas for the journal, HAND.

While still focused on global hand health and outreach mission trips, the AAHS is growing our educational curriculum fulfilling requests from our members to provide new material to improve their practice. A new series of webinars have started under the guidance of Josh Abzug, our Education Committee Chair. Josh has also initiated an entire lecture series with one of our outreach destinations, Kumasi, a city in the Ashanti region of south Ghana, Africa. Thanks to the efforts of Don LaLonde, Kusami represents a partner country that deeply appreciates our interest in helping their surgeons and therapists learn and teach hand surgery and rehabilitation.

Also on the educational front, we have partnered with Touch Surgery to provide educational interactive mobile apps that allow learners to work through various surgeries via simulation. This will allow a basic verification of proficiency (VOP) prior to entering the operating room and performing

While still focused on global hand health and outreach mission trips, the AAHS is growing our educational curriculum fulfilling requests from our members to provide new material to improve their practice.

live surgeries. This technology can and will be used not only in our own centers but also throughout the world at each mission trip so the local surgeons can learn our techniques before patient interaction. Again, this promises to be another exciting development in moving the AAHS forward.

Our relations with other hand organizations remain excellent. A leadership meeting is scheduled with the ASSH this fall to help define and act upon common goals and concerns; working together to help all hand surgeons!

The AAHS is strong! We are growing in numbers and depth. I look forward to sharing all the new initiatives with all of you in January in Arizona.

Mike Neumeister, MD,
FRCSC, FACS

Calendar

2015

June 10, 2015

Peripheral Nerve Injuries –
Management of Acute and
Delayed Injuries Webinar

June 17-20, 2015

XX FESSH Congress
Milan, Italy

November 7-8, 2015

Foundation for Orthopaedic
Research and Education
(FORE) Frontiers in Upper
Extremity Surgery
Tampa, Florida



2016

January 13-16, 2016

AAHS Annual Meeting
Westin Kierland Hotel
Scottsdale, Arizona

May 26-28, 2016

36th Brazilian Congress of
Hand Surgery
São Paulo, Brazil

September 22-24, 2016

AAHS/DGH Joint Congress
Frankfurt, Germany

October 24-28, 2016

IFSSH-IFSHT Joint
Congress
Buenos Aires, Argentina

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Hand Surgery Endowment

Thanks to the generosity of AAHS members, the Hand Surgery Endowment is now less than 10% away from its fundraising goal of \$1,000,000.

Please consider making a donation or pledge to support its mission to promote global hand health.

Details on the [Hands at Work](#) Project and programs which HSE dollars support may be found on the [Endowment website](#).

[Make your donation or pledge.](#)

HAND THERAPISTS CORNER:

2015 AAHS Annual Meeting in Review

Lisa M. Cyr, OTD, OTR/L, CHT

The 2015 AAHS Annual Meeting took place in sunny Nassau at the Atlantis resort. It started in the usual fashion, with an eclectic array of Instructional Courses; Who Needs Therapy and Who Doesn't: Practical Applications to Optimize Outcomes, Raynaud's & Cold Sensitivity - Is There a Solution?, Treatment Options For Finger Arthritis, Shoulder & Elbow Assessment, Fragility Fractures, Scaphoid Fractures, CMC Osteoarthritis, Dupuytren's Disease, and Maximizing Economics in a Changing Health Care Environment. Combined, these were attended by about one third of the registered attendees who made it in to the Bahamas early enough to wake up for these sunrise sessions and glean some cutting edge tidbits on a topic of interest.

We were then greeted with a stimulating performance by the drum line of an award winning local high school marching band to start the general session. This was the first of many musical performances interspersed throughout the meeting. These performances included harmonica solos by our own Past President and talented musician, Mark Baratz. He did a wonderful job inspiring us both intellectually and musically throughout the meeting and was somehow even able to engage most of us in a four part harmony!

After an introductory welcome from Program Chairs Thomas Hughes, Christine Novak, and Kristin Valdes, the

2014 Vargas Award Winner Gayle Severance, took the stage to receive the Vargas Award memento. Unfortunately, she did not get a chance to share the highlights of her incredible, life changing mission to Kumasi Ghana, but we have already reserved a spot for her on the 2016 Agenda to share details of her experience with us.

Jane Fedorczyk, the invited ASHT President, shared a thought provoking introduction to her research related to "Embracing Technology in Hand Therapy". This was followed by an enlightening physician/therapist panel on "Hand Injuries in Athletes". The panelists shared their personal experiences and expertise regarding the treatment of both professional athletes and weekend warriors, and the decision making process employed to determine when each athlete could return to her/his particular sport. "Hand Surgery and Therapy Tips and Pearls to Optimize Patient Outcomes", another combined physician / therapist session was next. The

His [Michael Hayton] extensive work with professional athletes provided the framework to discuss many of the ethical considerations and clinical reasoning involved when determining when to allow the athlete to return to competition.

panelists demonstrated excellent problem solving skills, and communication between the two disciplines to effectively represent the collaboration that is imperative to ensure optimal functional outcomes for our patients.

Dr. Michael Hayton, our Invited Guest Lecturer, continued the injured athlete theme with his talk "When Can I Play Doc?" His extensive work with professional athletes provided the framework to discuss many of the ethical considerations and clinical reasoning involved when determining when to allow the athlete to return to competition. Dr. Hayton's use of humor and personal anecdotes kept us all enthralled in spite of our pre-lunch grumbling stomachs.

After a break for lunch, Specialty Day resumed with the therapists and surgeons splitting up for some individualized professional development. The therapist workshop began with a presentation by Susan Michlovitz covering some of the therapeutic concepts tailored to injured musicians. Aviva Wolff was slotted to present on sensorimotor and neuroplastic interventions related to upper extremity orthopedic conditions, but was unable to attend the meeting at the last minute, due to her own acute orthopedic condition. Kristin Valdes stepped in and did a commendable job presenting Aviva's fascinating talk. The remainder

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Hand Therapist

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of the therapists' afternoon session was dedicated to an informative hands-on lab comprised of application of elastic tape. Variations in application technique can potentially help facilitate or inhibit muscle function, enhance proprioception, reduce pain and /or help unload irritated neural tissue. Tandra Marik did a great job guiding the therapists through application subtleties to target the appropriate goal.

Drs. Randip R. Bindra, and Asif M. Ilyas chaired the "AAHS

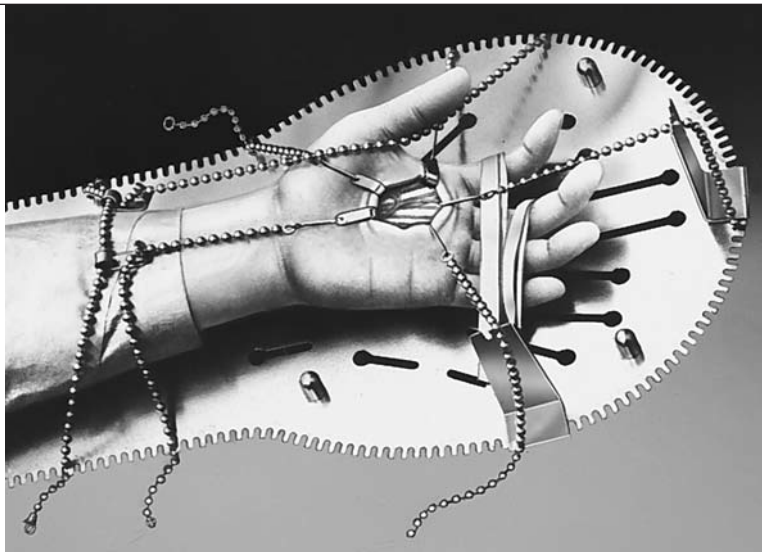
Principles of Internal Fixation in the Wrist and Hand Surgeons Workshop". This workshop combined brief lectures and labs which enabled the participants to learn techniques for internal fixation and technical pearls in wrist and hand fractures. The international faculty of

experienced physicians; Alex A.J. Kocheta, Marc J. Richard, Charlie F. Leinberry, Hilton P. Gottschalk, Kim Mezera, David Dennison, Jerry I. Huang, John R. Fowler, Adam Watts, Jeffrey Lawton, Asif M. Ilyas, Michael

S. Bednar, and Jaiyoung Ryu, led the educational sessions which were then practiced in a hands-on sawbone workshop.

The engaging topics of Specialty Day set the stage for the remainder of the conference. The combination of music, humor and thought provoking topics presented by dynamic speakers all contributed to an educational and interesting conference. In spite of the growing size of these annual meetings, they continues to uphold the ideals of the Association as a place to network with colleagues from around the globe while sharing relevant research pertaining to the fields of Hand Surgery and Hand Therapy. I hope you'll join us in Scottsdale, AZ for the 2016 meeting January 13-16!

The combination of music, humor and thought provoking topics presented by dynamic speakers all contributed to an educational and interesting conference.



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AROUND THE HAND TABLE

Panel Discussion: Managing a Hand Surgery Practice in a Changing Healthcare Landscape

Ray: Thanks everyone for participating in the call. So as we all know, two weeks have passed since the Senate left town without taking action on legislation to permanently repeal the Medicare sustainable growth rate formula for reimbursement. It's obvious that Medicare cuts will always be a concern for us as physicians. I believe that the high deductible health plans out there will also cause problems by shifting more of the financial responsibility on the patient. What are some of the other challenges faced by us as hand surgeons that you foresee over the next three to five years, and which ones worry you the most?

Lana: I would be curious to know what percentage of our patients are Medicare covered relative to the complexity and time required and how this compares with patients from the private insurance pool. Because I think that's one of the biggest challenges that I have - figuring out whether to stay opted in or not participate with Medicare. Financially, is that worth it, given the amount of work put in and the corresponding returns? Different physicians probably look at it differently based on their unique situation. It would be helpful (but likely impossible) to know what should be expected and what to anticipate with Medicare.

Ray: I think that will obviously play an important role in how we as physicians respond to the changes in the Medicare cuts. I

The Panel

Raymond Raven, MD, MBA, Moderator
Managing Partner
Orthopaedic Surgery Specialists
Burbank, California

Brian Divelbiss, MD
Managing Partner, Dickson-Diveley Orthopaedics,
Leawood, Kansas

Lana Kang, MD
Orthopaedic and Hand & Upper Extremity Surgeon
Hospital for Special Surgery
New York, New York

Adam B. Shafritz, MD
Adam Shafritz, MD
Associate Professor of Orthopaedics
University of Vermont
South Burlington, Vermont

Jonathon Tueting, MD
Faculty
University of Wisconsin School of Medicine and Public Health
Madison, Wisconsin

am personally concerned about patients who have PPOs with high deductible plans, which is shifting more of the financial responsibility on them since that makes up the majority of my payor mix. There are lots of other challenges that we face as physicians, particularly hand surgeons over the next three to five years. Although Medicare cuts and shifting patient responsibility will affect our bottom line, what do you think about recent talks about performance measures and shifting to 10?

Brian: The ICD-10 issue is certainly something where there

are a lot of scary numbers out there about how much extra time it's going to cost you and how much money it will cost your practice. I guess I'm preparing for the worst but hoping that it's not going to be as bad as some of the doomsayers that I hear. I think it's going to happen and we're going to have to figure out how to do it as efficiently as possible and hopefully technology will be developed that will help us. I know it's going to be exceedingly painful come October, if they go through with it. We have a six-

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month plan of trying to get our clinic online and get all of our medical assistants and all of our PAs and nurse practitioners up to speed as much as possible to try to help the physicians. If what they say is true, then it's going to be a problem come October. We'll get through it. The rest of the world uses it so we can figure it out. It's certainly going to be a change that goes right to the bottom line when you're not as efficient.

Ray: My group is made up of five surgeons and we have actually taken out a line of credit to help mitigate any losses in revenues that we may see as a result of this change.

Brian: How big of a line of credit are you taking?

Ray: Three month's revenue. Is anyone else concerned to the point where you're expecting losses in revenue or delays in revenue as a result of the changes?



What are some of the ways we, as hand surgeons, can mitigate these challenges and address some of the uncertainty that we face in this changing healthcare landscape?

-Raymond Raven

Adam: Being an employed physician in a large, multi-specialty academic group, we're not as concerned about these issues of revenue stream as it applies to these changes. The reason for this is with the large amount of physicians and practitioners involved you can spread the risk out. With regards to ICD-10 rollouts and preparation for this, certainly we're all preparing for that. However, in the event that an additional coder needs to be trained or financed, that salary will be financed over a group of twenty practitioners. That's one of the advantages of being an employed physician. However, the downside of being an employed physician is the loss of autonomy and the inability to control the patients who walk in the door and what their insurances are. So unlike Lana, who may decide whether or not it's worthwhile to opt in or to limit the number of patients that she sees from certain federal insurances, we do not have the ability to do that, and so that ultimately may affect our bottom line as a salaried physician because when the dollars shrink the dollars just shrink.

Ray: That's a great point. One way to deal with some of the challenges that we face as hand surgeons is to just put yourself in a situation where you're somewhat shielded, either in a big group or hospital-based practice or some kind of health system.

What are some of the ways we, as hand surgeons, can mitigate these challenges and address some of the uncertainty that we face in this changing healthcare landscape?

Jon: Like Adam, I'm in a multi-specialty group in an academic center and don't have as much autonomy and don't have the freedom to be as agile as some surgeons in the private practice setting do. But on the flipside, we are working to address the uncertainty at the University of Wisconsin by committing heavy financial resources and planning ahead for a lot of these challenges. We've made some pretty significant strides with ICD-10 and we are pretty much compliant or close to it. For two years we've been working on it and we've been implementing it through HealthLink, which is our EPIC systems based EMR.

In addition, we are trying to manage our expenses in a strategic way. One of the ways that we've done that is we have a subspecialty, almost orthopedic-only hospital that is opening in August of this year. It's had been many years in development. We're going to try to manage our expenses and we think that we'll be able to, in the face of declining reimbursements, run a hospital that's far more efficient than the big academic center at the University of Wisconsin. This hospital will be obviously much smaller than the big academic center, but also geared towards subspecialty care in orthopedics, with a smattering of outpatient general surgery, urology, and ENT.

Brian: What you're doing in Wisconsin in your clinic, I think is really going to the paradigm that people in private practice are going to have to move to. Where you have people helping

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you so that you can see the maximum number of patients, because it really is all about trying to be more efficient. I think there's going to be a critical access problem and we're going to be asked to see more people and take care of more people and we're going to get paid less for every unit of work that we do. So if we want to maintain an income, we have to be more efficient. What you've set up at the university in terms of your trainees and residents to help you be more efficient and see the volume of patients. I really think that's ultimately going to be here in private practice - you're going to need to do that to maintain where you're at today.

Jon: It's not necessarily my preference to see quite so many patients in my outpatient clinic. On some level, it's much more comfortable and even perhaps better patient care to see somewhat fewer patients. Hand surgeons in general see a lot of primary care hand. These are things that a well-trained nurse practitioner or athletic trainer (under my direct supervision) should be able to manage. I try to use these people to increase patient volume even though they may not necessarily generate surgeries, but they may generate referrals from primary care doctors who may not be as comfortable managing simple primary care hand problems. This type of practice building is really important and my clinic efficiency is improved by having these people see a lot of the things that I know may not result in revenue in the operating room. They will hopefully

develop referrals and allow me to continue to see more patients that may need surgical care.

Ray: Jon, you did mention you're using mid-levels to increase efficiency and to decrease costs in your practice. Brian, you discussed the importance of creating a balance scorecard, and I believe it is extremely important for any company, especially in healthcare, to develop a one, a three and a five-year plan. What have you done for your practice and your group as far as strategic planning for the next three to five years? And how have you used your balanced scorecard to help you identify areas where you can improve?

Brian: I've been managing partner in our group for about three years. Up until I took the position, we never really had any strategic planning. We just went to work and there were always patients to see. There was no need to look forward. Since I've come on board we've been in the process of trying to have a more strategic focus to get people to look forward. We finally have our first crack at a balanced scorecard up and running with all of our data. So I don't really have a lot of results yet with the data to be able to try to move the organization, but I am trying to push people to look forward. If we're not looking ahead we're going to find ourselves in a situation where our opportunities to remain in private practice are going to be severely limited. I would say for us it's been a process of doing what we should have always been doing,

but it's hard to get people who are within a couple years of retirement to really put all of their energy into that.

Lana: Can I talk about two things that are somewhat related - one is quality and the other one is pay for performance. I think one of the things that our current health care system is struggling with is that there's no standardized or agreed upon way of measuring quality. So without that, our system doesn't know exactly what it's doing. From the patient's perspective, quality may be affected by whether he or she is evaluated by the doctor or another provider. Does it matter how long the wait is, and how long they see the doctor? Or is it the warm, fuzzy, non-tangible feeling a patient gets from their experience, even if for only five or ten minutes, which contrib-

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If we're not looking ahead we're going to find ourselves in a situation where our opportunities to remain in private practice are going to be severely limited.

-Brian Divelbiss

utes to how well they rate their physician or their experience? The other thing is pay for performance. As upper extremity microvascular surgeons, we may not need to worry about this as much as total joint surgeons or spine surgeons because those subspecialties are able to have greater sample sizes of single procedures and more definable parameters, such as infection. But while the government speaks about pay for performance, they can't even figure out how to accurately measure performance. Until measures for pay for performance are uncontested, proven, and sufficiently agreed upon, pay for performance seems fabricated and unfounded. Our profession and not the government need to continue to propose measurements of quality.

Another important question we now need to ask is who is the customer? Are we talking about a business perspective? Because we can't really define what are the requirements for quality unless we know the customers' needs, and I think all of that has so many variables in terms of demographics, in terms of age and in terms of occupation.

Ray: As I've come to appreciate, value in healthcare has been misunderstood and continues to be very difficult to measure. We've used limited evaluation of outcomes and the challenge is to accurately determine what things cost. If we could define value around the patient/customer in a well-functioning healthcare system the creation of value should determine the rewards for providers. That's

what I firmly believe. By using a simple formula that opened my eyes during business school, we can understand what value in healthcare should look like and develop rules to measure it. If we defined value as outcomes divided by cost of services, multiplied by the "patient experience," we can easily appreciate the importance of not just outcomes but the patient experience as part of the "quality" variable. The measurement of outcomes right now is definitely an important part of the equation, but I believe that there are areas that are left out, such as indicators of function. You mentioned quality and you mentioned performance measures; what do you think about the importance simple things like when the patient was able to stop taking pain medications or

when they returned to sport or to work? How important are those as far as quality is concerned and do you think we're doing patients a disservice by focusing on "measured care," which may have the disadvantage of really only improving "measured care" rather than improving the individual patient care?

Lana: I don't have an answer but I do feel that our role is to be involved in calling these administrators out and saying, "No, that's not a quality measurement." Or "No, that's not a measurement of performance." At the very least we need to do that. Simple things in our profession don't have to be so complicated. Somebody needs to say that, and if we can do that and if our legislators and patients could really understand it, that would be huge.

Ray: Let's switch gears for a moment. Jon, you're a tech savvy guy. There are a bunch of emerging technologies right now, and consumer-driven medicine is a trend that is shaping the healthcare industry. What are your concerns about that and how are you planning to deal with issues such as patients requesting certain tests or certain treatments based on what they're learning and reading about on the internet?

Jon: In response to how we're measuring quality in the outpatient world at least, (it's a little bit different for the inpatient world), but in the outpatient world, most of what we're looking at and what seems like people are paying attention to in



Until measures for pay for performance are uncontested, proven, and sufficiently agreed upon, pay for performance seems fabricated and unfounded. Our profession and not the government need to continue to propose measurements of quality.

-Lana Kang

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One of the challenges we face is really understanding what patients expect and making sure that we're able to meet their expectations, or at least understand their expectations so that they can understand what's realistic in terms of outcomes.

-Raymond Raven

quality are whether or not we're meeting patient expectations. A lot of the online physician rating services are really only looking at that. How you set patient expectations obviously determines what kind of grade you get. You could have patients that expect that every time they're seen by a doctor and they have wrist pain that they ought to have an MRI. Obviously we would not think that's necessary every time, and clearly that is not cost-effective quality care. There need to be ways for us to set that expectation and educate patients ahead of time and also when we're seeing them in the clinic. Just because somebody else had an MRI or somebody told them that they should have an MRI, we can't order it for something as non-descript as "dorsal wrist pain." I would agree with Lana that we need to be more specific about what we're using to measure quality. Quality incorporates things that we've already talked about - value and how we're actually spending the medical dollar in addition to whether or not we're meeting patient expectations. In addition to whether or not we

have treatment outcomes that are making a difference for patients. I think it's incredibly complex and things are slowly moving in that direction, but there needs to be more progress.

Ray: One of the challenges we face is really understanding what patients expect and making sure that we're able to meet their expectations, or at least understand their expectations so that they can understand what's realistic in terms of outcomes. Patient-consumers are turning to the Internet and physician review sites to see what doctors have been able to do for other patients. We often find that physician review sites don't analyze meaningful information. They're more subjective as opposed to objective. But the objective measures are one thing that we're having trouble with putting a finger on. There are some organizations out there trying to address this problem now and the question is, as Lana stated, who is going to be deciding what the appropriate performance measures are and how they should be incorporated into pay for performance models? That is certainly something that we need to be thinking about as practicing physicians.

I want to move to a question about musculoskeletal medicine in general. We're all aware that over the past several years, while hospitals have witnessed a reduction in inpatient volume there has been a corresponding rise in outpatient facilities. The number of hospital-based practices has increased, and physician groups continue to join hospital systems or foundations. However, A big percent-

age of what we do as hand surgeons can be managed in an outpatient setting, and that percentage is likely to increase over time. The shift to outpatient settings has been largely driven by advances in technology and anesthetic techniques, which has allowed us to perform procedures in a safe cost-effective and efficient manner, often with better patient and surgeon satisfaction. This is good news for proponents of value-driven healthcare, since the cost of treatment in outpatient facilities for things like surgery, therapy and imaging can be as much as 60% less than the same services performed in the hospital setting. So let's discuss some of the challenges that one might expect hospitals to face and some of the ways that solo practitioners and small to midsized groups like mine and Brian's can take advantage of the changing landscape and maintain a competitive advantage. To ask the question more directly, hospitals have seen a declining number of outpatient procedures and we as physicians, especially hand surgeons, have the ability to choose where we want to do our procedures. What are some of the ways that we can remain competitive by leveraging this trend?

Brian: I think one of the important things that we can do as hand surgeons, especially when it comes to outpatient surgery, is gain-sharing. Gain-sharing is working with your hospital to actively manage the costs of supplies that you utilize. If there is a way that physicians can be aware of product X or product Y

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and what they cost, does it matter if we use a different product to reduce the cost and everybody benefits from the results of that. That's a great way of managing this shift to outpatient surgical procedures.

Ray: Brian, in your practice how much of your practice is conducted done in a hospital setting and how much is done in outpatient surgery centers?

Brian: We are partial owners of the orthopedic hospital where I do about 90% of my cases. For me it functions like an ASC, but we also have inpatient beds and we do total joints there. The main hospital that I am affiliated with is where I do about 10-15% of my cases. The main hospital has a financial stake in our orthopedic hospital, so we gain-share in the building of that orthopedic hospital. In one way the hospital was not necessarily happy to see all of these cases leave, but it's actually allowed them to buff up other service lines and make them able to use their ORs for other things. It's turned out fine for them. Jon, you're going to find that when you have a facility that is focused totally on orthopedics it will be so much more efficient than you can be at the main hospital. That's why we've been able to partner with our hospital and everybody is winning. We're providing a higher level of care with less infection rates, and are more efficient at our private facility.

Ray: I hope you're right. I know that in building our hospital we implemented the lean profits planning, as pioneered by Toyota way back when. It was

quite an interesting process to be a part of, and it is all centered around the moving part, which is the patient. Centered on exactly what happens to the patient every step of the way. From the minute they make the turn from the street into the parking lot to the time that they walk out of whatever door it is in the hospital. I think it'll be interesting to see how this type of planning process comes to life.

Ray: Lana, do you do most of your cases at a surgery center or at the main hospital?

Lana: I do it in what we call an ambulatory surgical setting. It's on the first floor so it's easier for the patients to go in and out. The hospital has demonstrated collaborative efforts to create an ambulatory surgery center, in which the surgeons have 49% ownership. Seeing all the changes in New York, I don't think the big companies and the big names are going to go away. My guess is that they want to buy out everything and then break it up into more efficient vehicles. I do believe that ambulatory surgery centers are more efficient and more cost-effective and patients prefer that over having to go to a large hospital. There are many logistics in how to present these health care products. For example, it remains to be determined the effect a brand name has on the sustainability of large expensive health care institutions. Obviously, marketing plays a significant role.

Brian: I think one of the difficult things for the hospitals is this competition against these other

smaller entities. For instance, in our smaller orthopedic hospital, the difference is not as much for something like a carpal tunnel, but if you were to do a total joint at an orthopedic hospital it actually costs the insurance company about half as much as it does to go to one of the main hospitals. Eventually that inequality will go away. When the dollars continue to get cut that landscape is going to change. I don't know what that's going to look like, but it's a significant cost difference between something done at the main urban hospital, what the insurance pays and what they would pay even in inpatient orthopedic hospital.

Ray: This is what bothers me actually quite a bit. I own a surgery center and I have patients with certain health plans that won't allow me to do their cases at my surgery center, even though my center's fees are much less than what the hospital bills for the same services..

Lana: Is that based on pure contract negotiations?

Ray: Exactly.

Lana: Because that would be dumb for the insurance plan.

Ray: That's exactly my point. One of my biggest frustrations is negotiating with plans. I have a very difficult time trying to get two of the three HMOs in the area to provide me with contracted rates for services, which are actually much less than the rates they have with the hospital, mainly because I don't do the same volume as the hospital does. Here we are in an era where we're trying to reward

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value. Great outcomes, low costs, efficient care with excellent patient satisfaction, and I'm still fighting with HMOs that are giving better contracts to the hospital because they have negotiating power because they have a bigger share of the market. What do you do in a situation like that? Do you partner with the hospital or do you sit and do what you can to accumulate enough data to prove to the insurance companies, in this case the HMOs, that you're providing better value for their patients.

Brian: I would say yes to the data. That ultimately is going to be the key. From what I have been told from the major insurance player in our market is that when they look at the total healthcare spending, the amount that they spend on orthopedics is actually relatively small. So

they're willing to pay more to the larger urban hospitals for their orthopedics if they get a better rate on cardiology or some of these other things that are actually a bigger spend of the pie. That's not going to be sustainable forever. Eventually your lower cost and higher value product is going to win out. The fear I have is are we going to be able to hold out until that day comes. One of the things that we're trying to do is to work initially with the large corporations who are self-insured to demonstrate the improved patient outcomes and lower costs that our facility can offer. If we can show positive results in this arrangement then it will put us in a much better position to go into a private payor and say, "Listen, this is what I saved Corporation X by doing that."

Lana: We probably have a higher quality product if value is what we're basing it on. But we are still financially a significant portion of healthcare dollars. Our role is to argue that we're getting people back to work, and that the value in that is worth the dollar value.

Ray: Most of the healthcare dollars spent is on elderly patients, end-of-life care, and chronic conditions. Because of that, if the hospitals can get a break on those things, they don't really care so much about elective procedures; it's not as big of an emphasis on cost-cutting measures as opposed to patients receiving care in the ICU or having multiple services involved towards the end-of-life.

We all know most of the dollars

in healthcare are spent on chronic conditions and end-of-life, it's not orthopedics. You would expect hospitals to try to cut costs on all levels, regardless of what the service line. It looks like they're just negotiating costs down on one end and giving some concession on the other end.

Ray: Jon and Adam, you are both in systems where you're somewhat shielded, and that comes with a certain loss of autonomy, but there's some advantages there. I, as a private practitioner, am managing a five person group. I actually like the autonomy that I have, but it's at the expense of having to deal with these issues more directly than being shielded and having the negotiation power of a larger institution. What would you tell a recent graduate coming out of hand surgery training today? How would you advise them or what advice would you give them on what kind of practice model you see as the more sustainable model in the future?

Adam: You ask a loaded question. I think a lot of it depends on geography. If you are practicing in a large urban area, I think you're viability as a private practitioner or in a small group is very very very different than if you are in a very rural area. You're beholden to the institution where you are practicing. I think it's very difficult in a rural area to be a private practitioner with privileges at a hospital that does not employ you. With overhead costs going up and reimbursements going down, it's not a long-term sustainable



At least where I am in Vermont, we are seeing the death of the private practitioner and of groups that were in private practice; they are now becoming hospital employees.

-Adam Shafritz

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situation. At least where I am in Vermont, we are seeing the death of the private practitioner and of groups that were in private practice; they are now becoming hospital employees. The first question to ask is where they see themselves, in a large city or in a small rural environment? I think how you decide on your employment situation will be determined by that.

Ray: Jon, you're in place that's sort of a hybrid of the two, wouldn't you say? It's somewhat of a big city but you have reach into rural areas. What would you advise someone coming out of training who is going into practice in an area like where you are?

Jon: I think I'd have to advise them to go where their interests are. If they have interests in teaching and in education and contributing to academics then I'd encourage them to try to be a part of an academic center that has some private practice elements and has the ability to have control over their destiny on some level. If they're interested in private practice they should join a multi-specialty group that really has a pulse of what's going on in healthcare and the issues we've been talking about.

Brian: I've never worked in anything other than the single group that I have worked in since I got out of my fellowship. I very much enjoy the autonomy. I will say that if I did not have access to the orthopedic hospital and have ownership possibilities there, I would be an employed physician. Just for the things

that Adam is talking about – the overhead, the percentage of my total income that comes out of my regular practice versus what I am able to generate out of the hospital. That percentage of my private practice revenue continues to decline. If I had no access to ancillary income I would have a much better deal being an employed physician. I'm very fortunate. Not everyone has access to that. If you don't have access to ancillary income it's very difficult. It's almost impossible to be in private practice with overhead requirements, IT requirements and the regulations we have to deal with.

Ray: That's one of the most frustrating things for me. Healthcare has never operated like businesses in other marketplaces. We can do all we can to run our businesses like an electronics company or a Fortune 500 company, but we face regulations and other unique factors that make it difficult for us to succeed like companies do in other marketplaces. Joining a hospital in a rural area is probably the better way to go. If you want to be in private practice it's best to be in a city or a large urban environment.

So do we sell our practices to hospitals? Do we join health systems? Or do we remain independent? We have a diverse group of people with different experiences and so I think it's going to be hard to come up with a consensus. I will say that it's much easier to create value and to be nimble, quick to adapt as an independent entity than it is for a hospital system. Where do you think we should go if our

goal is to create value and to decrease costs in healthcare? Do we do it in the big academic centers or the large health systems? Or do we do it as small groups when it comes to outpatient services in particular?

Lana: I'm frustrated, as you are, but I'm also not surprised given that it is healthcare. It's not a pure commodity. That makes it more challenging and fascinating. We can incorporate these concepts and principles of business, but it is still health.

I think it's similar to my opinion on technology in medicine. At a past hand society meeting, a Silicon Valley guest speaker proposed that new apps and gadgets can be used to fix things. People want a quick fix and people want an app, but that's not how humans work. People want these cures for

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If they're interested in private practice they should join a multi-specialty group that really has a pulse of what's going on in healthcare and the issues we've been talking about.

-Jonathan Tuetling

arthritis but there are other intangibles involved in quality. Sometimes patients just want their hand to be held and for you to believe in them, even if you don't give them the right answer or a cure to whatever they have.

I think if we do the right thing, whether it's in private practice, academics, or a combination of both, I think the private practice practitioner is not going to lose their stand. And I think that hospitals are going to be weakened if they fail to recognize the value of that. I don't think it's either/or. I don't think it's black or white. If we just stick with the value part of it then that will declare itself in face of the economics.

Ray: I share the same concerns as Brian, that this is the way things should go and hopefully eventually will go in the way of rewarding value and quality, but it may be that it takes so long that private practitioners and small groups competing with the larger systems are going to lose out.

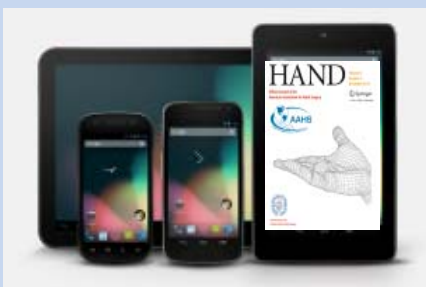
Brian: Regarding the hospital

system versus private practice versus entrepreneurial ways in which we do business. I think one of the fundamental problems in medicine, in reimbursement in medicine, is third party payers. I think that is what clouds things tremendously. Because if you think about it -if you take your car to Jiffy Lube, you're going to pay X dollars for this level of service and Y dollars for something else. And you, as a consumer, decide what you're willing to spend. When you go to a car dealership, you buy a certain brand of car with the expectation of the price. In medicine you don't know and the consumers don't know. They don't know what they're going to be charged up front. I think that's one of the confounding issues right now that we're probably going to have to face in the next five to ten years. How do we manage this?

Ray: I found actually with these new high-deductible plans where the burden is shifted towards the patients, especially in the early part of the year, patients are asking what it's

going to cost for their services. At the beginning of the year patients are less likely to demand an MRI but once they meet their deductible, "I want an MRI for my toe pain." I agree with you that it's a problem, but I think in the future we can be sure that patients are going to be more aware of what their healthcare costs are, or what their potential healthcare out of pocket expenses will be. I think a lot of them are going to make decisions based on it. I'm seeing a trend right now. I have patients who have chosen to not do certain procedures and have elected others based on cost. I think that's a trend that we can expect more, especially for elective procedures and outpatient medicine. The question is, is it better for us to try to get these services done in a large health system with a bunch of red tape and regulations that decrease the efficiency and increase costs, or is it better for them to be done in an outpatient setting with more nimble facilities providing the services?

I want to thank everyone for participating in the discussion.



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AAHS Next Webinar: Wednesday, June 10th, 8:00-9:30 PM EDT (US & Canada) Peripheral Nerve Injuries: Management of Acute and Delayed Injuries

Introduction and Overview:	Robert Spinner, MD, Moderator
Understanding Treatment Options for Peripheral Nerve Injury: Direct Repair, Autograft, Allograft	Jonathan Isaacs, MD
Nerve Transfer Options:	Amy Moore, MD
Tendon Transfer vs. Nerve Repair:	Peter Tang, MD
Rehabilitation Following Peripheral Nerve Injuries:	Christine Novak, PT, PhD
Q&A, Discussion and Case Presentations:	Robert Spinner, MD, Moderator

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AAHS Job Board

Orthopedic Hand Surgeon Sacramento, CA ACHIEVE extraordinary outcomes

When you're part of Mercy Medical Group, a multi-specialty group with more than 375 healthcare providers in the Sacramento region and a service of Dignity Health Medical Foundation, you'll be able to do more than just care for your patients. You'll have the opportunity to develop and participate in health, education and wellness programs that will help improve the lives of people throughout your community...and beyond. If you want to achieve extraordinary outcomes, join us today.

We are currently seeking a fellowship-trained provider for our busy Orthopedic Surgery Department. Our doctors provide services to patients at Dignity Health Medical Foundation's Mercy Medical Group locations throughout Sacramento. The successful candidate must be fellowship-trained in Hand Surgery and be BC/BE in Orthopedics. Surgeries will be performed at Mercy General Hospital (www.mercygeneral.org). Call of 1:5 is required, with Hospitalists available 24/7.

Our Medical Foundation is aligned with one of the largest health systems in the nation and the largest hospital system in California. All of our outpatient medical offices are equipped with a full electronic medical records system and our physicians benefit from excellent primary care and consultation support and a collegial, supportive environment. This shareholder-track opportunity offers a very competitive compensation and benefits package, including bonus potential and a very desirable retirement plan.

Sacramento is one of the fastest growing cities in the nation and one of the most affordable places to live in California. The area offers a wide variety of activities to enjoy, including fine dining, shopping, biking, boating, river rafting, skiing and cultural events. Lake Tahoe, the Pacific coastline, San Francisco, the vineyards of Napa and Sonoma Valleys and the historic Gold Rush towns of the Sierra foothills are all within easy driving distance.

Contact: For more information, please contact:

Colin Harris, Sr. Physician Recruiter
Phone: 888-599-7787
Email: providers@dignityhealth.org
www.mymercymedgroup.org
www.dignityhealth.org/physician-careers

Hand Surgery Position, Department of Plastic Surgery Cleveland Clinic -Hand Surgery Main Campus Cleveland, OH

Cleveland Clinic has a faculty position available for a well-qualified Hand and Upper Extremity Surgeon with a special interest and advanced fellowship training in Hand Surgery, Elbow Surgery, and Complex Arthroscopy.

The successful candidate will hold a joint appointment in both our Departments of Orthopaedic Surgery and Plastic Surgery. The candidate must be Board Certified in Orthopaedic Surgery, and hold, or be eligible for, the certificate of added qualifications in surgery of the hand. Proficiency in complex elbow surgery and arthroscopy is highly desirable. The individual would develop a significant specialty focused practice, while also being involved in the full spectrum of hand and upper extremity surgery. The applicant should have a strong desire and interest in teaching residents and fellows; as we sponsor several accredited training programs.

A faculty appointment at a rank commensurate with experience is available at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

Frank A. Papay, MD, FACS, Chairman, Dermatology and Plastic Surgery Institute

Allison T. Vidimos, RPh, MD, Chair, Department of Dermatology

The same vitality that charges Cleveland Clinic extends to almost every aspect of life in Greater Cleveland. The melting-pot culture that has helped establish Cleveland as a vibrant and versatile metropolitan area adds a unique flair to the lifestyle here. The Cleveland area is a very comfortable and affordable place to live with a variety of available activities, excellent school systems, world renowned orchestra, theater district and entertainment, and a great

place to raise a family.

Interested candidates should submit an application online by going to www.clevelandclinic.org/physician-recruitment

Contact: Interested candidates should submit an application online by going to www.clevelandclinic.org/physician-recruitment

Orthopedic Hand Surgery Position Atlanta, Georgia

The Southeast Permanente Medical Group is seeking an additional hand surgeon to join the newest department in our very busy, growing multi-specialty group. This is an immediate opening. Since the orthopedic surgery department's creation in 2013, it has grown quickly and is comprised of 12 providers, including two hand surgeons. We are now moving forward with the final phase of departmental hiring and expansion to all of our specialty office hubs. The position offers an excellent opportunity for input and professional growth, as well as outstanding colleagues!

The Southeast Permanente Medical Group is a large multi-specialty group with over 600 clinicians working together in a unique integrated care model. We enjoy a collegial atmosphere across specialties, providing excellent care to over 270,000 patients insured by Kaiser Permanente. Our comprehensive electronic medical record allows for close collaboration among clinicians. We offer a competitive salary, generous retirement package, paid time off, health, dental, vision, and life insurance, long and short term disability, relocation allowance, and more.

We are proud to be an EEO/AA employer M/F/D/V. We maintain a drug and nicotine free workplace and perform pre-employment substance abuse testing.

Contact: Please contact Kim Lanzillotti, Senior Recruiter, at kim.g.lanzillotti@kp.org, or apply online at www.tspmg.com.

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LEADERSHIP PROFILE: Peter Murray, MD



Dr. Peter M. Murray, MD is president elect of the American Association for Hand Surgery. He has served in numerous leadership roles for the AAHS including Vice President, Treasurer and Director at Large as well as chairing the inaugural Hand Surgery Review Course for the Association which has become a Friday afternoon tradition at our annual meeting.

Dr. Murray is Professor and Chair of the Department of Orthopedic Surgery, Mayo Clinic, Jacksonville, Florida. He is a hand and microsurgeon with primary interests in free tissue transfer and peripheral nerve reconstruction. He is a Director of the American Board of Orthopedic Surgery, a member of the Orthopedic Surgery Residency Review Committee of the ACGME. He completed his residency training in orthopedic surgery at the University of Iowa Hospitals and Clinics followed by a fellowship in hand and microsurgery at Mayo Clinic, Rochester, MN. Prior to returning to Mayo Clinic, Dr. Murray had a distinguished career in the United States Air Force. His decorations include the United States Air Force Meritorious Service Medal and

the United States Air Force Commendation Medal. He is the author of over 125 scientific publications. His previous positions at Mayo Clinic Florida include Director for Education, Mayo Clinic Florida, overseeing the day to day operations of all student, resident and staff educational activities on that campus.

"I have thoroughly enjoyed my time on the Hand Association Board. It has been extremely rewarding to see the organization grow and I have made friendships with great people that will last a lifetime. This is a unique organization that facilitates collaboration among plastic, general and orthopedic hand surgeons, worldwide. I am looking forward to my presidential year."

AAHS Job Board (continued)

Orthopedic Hand Surgeon Orlando, FL

Orlando Health Orthopedic Institute, a dynamic, academically oriented orthopedic surgical group is seeking a qualified ACGME hand fellowship trained BC/BE orthopedic hand surgeon to join our progressive, established practice. The practice is supported by non-operative physicians as well as physician extenders and is based at our state-of-the-art Orthopedic Institute with on-site imaging and occupational/physical therapy. We have an accredited residency program as well as trauma / sports fellowships and education of the residents and fellows is required. Once employed, our new associate will receive academic appointments at the University of Central Florida and Florida State University. Academic pro-

ductivity is encouraged and is supported by our orthopedic research division. This employment opportunity offers a highly competitive base salary with a productivity based bonus schedule and a sign on bonus/relocation package. Additional compensation from hand call coverage (no general ortho trauma call) as well as an excellent benefits package and malpractice insurance is also offered. Orlando Health is the largest non-profit academic healthcare system in Central Florida with a network of five hospital campuses. This provides a strong referral base which will allow an energetic individual to develop a professionally satisfying, lucrative practice. The city of Orlando offers world class entertainment and dining, professional sports, year-round recreation with watersports and nearby beaches, and

is a wonderful city in which to build a practice and raise a family. Salary will be commensurate with experience. Contact: Please send inquiries, a CV, and three letters of recommendation to: Brett Lewellyn MD
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To include your job posting on the AAHS website and in the next issue of Hand Surgery Quarterly, please visit <http://handsurgery.org/job-board.cgi>.



2015 AAHS ANNUAL MEETING

January 21-24, 2015
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In Collaboration with
BSSH The British Society for
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All photos from the annual meeting are available at:
<http://meeting.handsurgery.org/photos-2015.cgi>

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