Podiatry as a Partner in Primary Care
NYSPMA HEDIS Project

Podiatry has long tried to position itself as a specialist. This reason for this may be that the term "specialist" has long been associated with that of an "expert" in a particular discipline, and compensation was historically higher for specialty care. Indeed, the current APMA public relations positing of podiatry includes the campaign "Todays Podiatrist- Physician, Surgeon, Specialist".

Over the past 3 years, the New York State Podiatric Medical Association has met with the medical directors of most of the larger insurance carriers in the state of New York, had had 2 meetings with the New York State Department of Health as well as representatives of the Governor's office. These meetings have provided great insight on how important policymakers view podiatry's role in healthcare. Additionally, our insurance consultants Florman-Tannen and our legislative consultant Harold Iselin has been monitoring the changes in healthcare delivery in New York and has been advising NYSPMA on the necessary advocacy and required steps to ensure Podiatry as a specialty is well positioned to thrive in the new healthcare realities.

As a result of the above, what has become increasingly clear is that prevention of disease and earlier intervention is being incentivized. Primary care services screen and prevent, while specialty care is being looked at as expensive over-utilized services used to treat conditions that may have been preventable in many cases. It is anticipated that our healthcare system will move away from fee for service reimbursement to a pay for performance model of care. Because of this, it is paramount that podiatry can partner with primary care to provide prevention and screening services to prevent disease, improve outcomes and lower healthcare costs.

NYSPMA has long maintained that podiatry is well positioned to partner with primary care to achieve this. Healthcare delivery is being increasingly evaluated by clinical practice measurements. One such measurement is called a HEDIS

measurement. HEDIS measurements are used by insurance payers to determine if certain important prevention services are being done. These measurements are important to insurance companies and payers as they are graded by them. Insurance companies are highly motivated to obtain good HEDIS scores by their network physicians. They will intervene to ensure this occurs. We have been told by countless insurance medical directors that if there was a HEDIS measurement for diabetic foot disease, much greater attention would be given to the condition and a greater utilization of podiatry services would be the result.

In 2011 the NYSPMA approached APMA to ask them to advocate for the development of a HEDIS measurement for the diabetic foot. APMA decided not to pursue this.

At this time no direct HEDIS measurement is available to measure the care podiatrists provide to diabetic members. Because of this, podiatry has not focused on the HEDIS measurements currently available that they could participate in to provide more complete care, more primary care, and improve the relationships with insurance companies by helping them obtain better HEDIS scores.

The chart below represents the current HEDIS measurements available for the diabetic patient.

Table 6: Diabetes HEDIS Criteria

Measure	Care, screening, or test needed
Comprehensive diabetes care Age 18-75	Yearly screening of the following: • HbA1c testing • HbA1c result > 9.0 = poor control • HbA1c result < 8.0 = good control • LDL-C • LDL-C result < 100 • Retinal eye exam • Nephropathy screening test or evidence of nephropathy • Blood pressure collected as 2 measures < 140/90 < 140/80

We have been told by medical directors that podiatrists actually bring down an insurance plans HEDIS scores by not checking and ensuring that the patient actually received these services. There are more HEDIS opportunities for podiatrists to participate in other than diabetes. For example, we were told by a medical director that if we diagnosis a patient with a stress fracture, and refer the patient back to the primary care doctor for a bone density test that would meet a HEDIS measurement. These are areas of opportunity for podiatry to partner with primary care, better integrate as part of the team approach to care, and improve relationships with insurance companies and policymakers.

Indeed, many of the diabetic HEDIS measurements could have an impact on lower extremity disease. Knowing if a patient has renal disease would alert the podiatrist that Charcot foot incidence increases. Knowing a patient has a poor cholesterol panel may alert the podiatrist to vascular risk.

Understanding which HEDIS measurements an insurance company would like podiatrists to look at, and educating podiatrist to draw the labs or referring the patient back to the PCP for these services would help move podiatry towards that essential “partner with primary care” positioning vital to our future.

My proposal is to have our insurance committee and our insurance consultants prepare a survey to distribute to insurance company medical directors asking them which HEDIS measurements they would like podiatrists to pay attention to, draw labs for, provide themselves or refer for. We would also ask for guidance on how to documents these measurements in the patients records to assist insurance company reporting.

Once we identify the appropriate HEDIS measurements, we should set up a committee to investigate how each of these measurements affects lower extremity health. A report on this would then be prepared.

The next step would be educating our membership in partnership with the Foundation for Podiatric Medicine with a lecture at our clinical conference, written materials and perhaps a webinar.

I believe these steps would advance our goals of “partnering with primary care”.

Respectfully submitted,

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