

POLICY PROPOSITION 2-24: SINGLE CERTIFYING BOARD IN PODIATRIC MEDICINE AND SURGERY

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**Remaining eligible co-sponsors indicated through the survey circulated by the sponsor are undergoing a verification process and will be listed when that process is completed.*

STATEMENT OF PURPOSE:

The American Podiatric Medical Association (APMA) has promoted the vision of a single certifying board in podiatric medicine and surgery (i.e. Vision 2015) and podiatric physicians overwhelmingly favor a single certifying board as seen in a recent online poll and the proceedings of the APMA's Board Certification Summit (March 2023). However, there has been no official policy establishing the directive or a pathway from the APMA.

In 2003, the Council on Podiatric Medical Education (CPME) consolidated all postgraduate residency training programs into the Podiatric Medicine & Surgery for 24 and 36 months (PM&S-24 and PM&S-36), ensuring that all residents were trained in both specialties. In 2011, the CPME created the Podiatric Medicine and Surgery Residency (PMSR) program which is a standardized, 36-month experience. A vast majority of programs offer the added credential in Reconstructive Rearfoot and Ankle (RRA) surgery. Less than 10 programs nationwide do not offer this added credential, and even many of those few programs provide training in RRA procedures but cannot meet the Minimum Activity Volume (MAV) required by CPME 320. Therefore, for more than 20 years, all podiatric residents have completed programs that met CPME standards and criteria in both podiatric medicine and surgery.

One board in podiatric medicine and surgery helps to create parity with the American Board of Medical Specialties (ABMS) which has only one recognized member board for each of the ACGME-approved residency specialties.

Two recognized boards in podiatric medicine and surgery is confusing for the profession, hospitals, and the public since there is a single residency training model. Additionally, two separate boards for the same residency program creates unnecessary costs and testing procedures affecting podiatric physicians and teaching institutions.

According to the APMA Bylaws (Section 8.0), "the House of Delegates shall be the legislative and governing body of this association." Additionally, the House of Delegates shall have the

authority to “approve policies, positions, propositions, resolutions, or otherwise take action as necessary in the name of the association.”

ADOPTED POSITION:

It is the policy of the American Podiatric Medical Association (APMA) to support the immediate cessation of the issuance of a Certificate of Added Qualification (CAQ) in surgery and the unification of the two currently recognized certifying boards into a single administrative entity resulting in a single unified certifying board in podiatric medicine and surgery.

POLICY PROPOSITION 3-24: ECONOMIC BURDENS NEGATIVELY IMPACTING SUSTAINABLE PHYSICIAN PATIENT QUALITY CARE

SPONSORED BY: Florida Podiatric Medical Association

CO-SPONSORED BY: New Jersey Podiatric Medical Society
New Mexico Podiatric Medical Association

ENDORSED BY: American Board of Multiple Specialties in Podiatry

STATEMENT OF PURPOSE:

Physicians' viability is unsustainable given the continued decreased reimbursements and increase in monetary penalties. There are several contributing factors as noted below. These challenges and realized negative impacts have adverse effects on our patient population and the quality care challenging providing healthcare needs. We are rapidly approaching a juncture that will be difficult to reverse. At a time when there is a major concern for physician burnout and early retirement, ongoing initiatives are major contributors accelerating this process.

Congress, through various legislation, has over the years mandated physician cuts in reimbursement. Penalties associated with enacted performance criteria/MIPS have resulted in increased burden and escalating requirements associated with commensurate penalties resulting in decreased payments to providers. This has been an ongoing trend with no relief in sight. MIPS and similar policies, while creating additional administrative burden and cost pressure for physicians, have yet to demonstrate true measurable benefits in the way of improved quality of beneficiary care or improved outcomes.

Policies such as sequestration that were to have sunset continue to be renewed to the detriment of the provider community. As the cost-of-living index/CPI has risen, practice expenses have escalated. CMS has not adjusted the Medicare conversion factor upward to address these expenses. However, at the same time CMS has decreased the conversion factor. "When adjusted for inflation, Medicare physician payment has effectively [declined](#) (PDF) 26% from 2001 to 2023 (AMA News wire July 7, 2023, Kevein B. O'Reilly)." There appears to be no relief in sight with continued downward economic pressure. Combined and individually these multi negative impacts have resulted in challenges for physician sustainability and the patient community.

ADOPTED POLICY:

The American Podiatric Medical Association (APMA) supports an initiative to continue to work with other allied specialties to collectively advocate for an equitable resolution to the rapidly emerging crisis* associated with the confluence of performance criteria/MIPS penalties, continuation of sequestration, and stagnation of the Medicare conversion factor. APMA will explore coordinating efforts with other stakeholders utilizing its consultants and

lobbying entities to address these issues along with other stakeholders and their resources to direct discussions with congressional leaders. Economic and critical issues negatively impacting physicians with resultant ramifications will be prioritized.

It is the policy of APMA that economic and critical access issues which negatively impact podiatric physicians will be prioritized, and that the magnitude of these issues, the severity of the negative ramifications to our patients and the critical nature of this rapidly approaching crisis for podiatric physician sustainability will be addressed, and finally that the potential and apparent damage by inaction will be communicated to those empowered to facilitate change prior to irreversible negative ramifications.

**The definition of "crisis" as defined in the purpose statement was added to the policy following its adoption.*

POLICY PROPOSITION 4-24: ESTABLISHMENT OF RE-ELIGIBILITY PATHWAYS FOR BOARD CERTIFICATION IN PODIATRIC MEDICINE AND SURGERY

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STATEMENT OF PURPOSE:

There are podiatric physicians who for a multitude of reasons were unable to achieve board certification by a Council on Podiatric Medical Education (CPME)-recognized board and currently do not have access to these boards. These include the length of their training program, type of training program, and other circumstances. The lack of recognized board-certification opportunities for these podiatric physicians may impact their ability to practice.

Board certification is an earned credential, but necessary to access the full potential of medical practice. Podiatrists who are not certified by a CPME-recognized board, and sometimes not certified by a CPME-recognized board in podiatric surgery, may have difficulty obtaining hospital and surgical privileges and becoming credentialed by commercial payers.

Eligibility criteria for board certification in medical or podiatric specialties includes completion of an ACGME-accredited or CPME-approved residency program, respectively.

However, unlike medical residencies which have been standardized for decades, rapid evolution and advancement of podiatric residency training has occurred during the timeframe of current podiatrists' careers. In the 1970s and 1980s, podiatric residency training programs were limited and most frequently only 1 year. From approximately 1990 until 2002, there were multiple types of podiatric residency programs that led to differing eligibility among the then recognized certifying boards (Table 1). In 2002, residencies were standardized to 2 or 3 years and included both podiatric medicine and surgery (Table 2). In 2011, residencies were standardized to 3 years and included both podiatric medicine and surgery with/without the added credential in Reconstructive Rearfoot and Ankle (RRA) surgery. Fewer than 10 programs in the US do not offer the added credential and are located mainly in New York State.

There are two CPME-recognized certifying boards. The American Board of Podiatric Medicine (ABPM, formerly the American Board of Podiatric Orthopaedics and Primary Podiatric Medicine or ABPOPPM) is recognized by the CPME to certify in the specialties of primary podiatric medicine and podiatric orthopaedics and has approximately 6200 active diplomates. The American Board of Foot and Ankle Surgery (ABFAS, formerly the American Board of Podiatric Surgery or ABPS) is recognized by the CPME to certify in the specialty of podiatric surgery and has approximately 7500 diplomates (in all categories).

Additionally, the largest non-CPME-recognized certifying board is the American Board of Multiple Specialties in Podiatry (ABMSP) which certifies approximately 4500 podiatrists in seven different medical and/or surgical areas of podiatric practice.

There are many podiatrists who maintain certification through more than one of the aforementioned certifying boards, although the exact number is unknown.

The ABPM has a standing Hospital and Surgical Privileges Committee which responds to inquiries and takes action on behalf of its diplomates. The ABPM has observed a steady increase in the requests for assistance from many podiatric physicians unable to obtain initial privileges or face nonrenewal of hospital privileges, which threatens their practice, their livelihood, and the foot and ankle health of the public by limiting access to qualified podiatric physicians.

The ABPM receives frequent inquiries and requests for assistance from diplomates and other podiatrists in the following categories:

- A. DPM does not meet initial appointment criteria to hospital medical staff because either medical staff bylaws or delineation of privileges specify qualification or certification by only the ABFAS.
- B. DPM receives notification of non-renewal of hospital or surgical privileges due to expiration of a time-limited certification waiver in the medical staff bylaws, most commonly 5 years.
- C. DPM who completed previous CPME-approved training of less than 3 years requests to sit for examination.

CPME Document 220, Standard 5.2 states, "The specialty board shall require candidates for certification to have successfully completed a minimum of three years of CPME-approved residency training." Thus, recognized specialty boards have no discretion in creating re-eligibility pathways. While this change related to residency training requirements was made with the specialty boards, the APMA House of Delegates, and the profession, and input from the community of interest, the effect of reduced access to recognized board certification is now becoming known.

The American Board of Medical Specialties (ABMS) allows Member Boards to create processes to re-establish board eligibility for MDs. Requirements vary by Member Board and can include completion of pre-approved topic specific activities or modules, assessment of knowledge or practice performance, payment of fees, supervised practice, program director attestation, or retraining in an accredited residency program for a limited time.

Table 1. CPME-approved Podiatric Postgraduate Training ~1990-2002

Program	Abbreviation	Length	Training	Board Eligibility
Rotating Podiatry Residency	RPR	1 year	Medicine	None
Podiatric Orthopaedic Residency	POR	1 year	Medicine	ABPOPPM
Primary Podiatric Medicine Residency	PPMR	1 year	Medicine	ABPOPPM
Podiatric Surgery Residency - 12	PSR-12	1 year	Surgery	ABPS
Podiatric Surgery Residency - 24	PSR-24	2 years	Surgery	ABPS
Podiatric Surgery Residency - 36	PSR-36	3 years	Surgery	ABPS

Table 2. CPME-approved Podiatric Postgraduate Training 2002-2011

Program	Abbreviation	Length	Training	Board Eligibility
Podiatric Medicine & Surgery 24	PM&S-24	2 years	Medicine and Surgery	ABPOPPM or ABPS (Foot)
Podiatric Medicine & Surgery 36	PM&S-36	3 years	Medicine and Surgery	ABPOPPM or ABPS (Foot and RRA)

Table 3. CPME-approved Podiatric Postgraduate Training 2011-present

Program	Abbreviation	Length	Training	Board Eligibility
Podiatric Medicine and Surgery Residency	PMSR	3 years	Medicine and Surgery	ABPM or ABFAS (Foot and/or RRA)

ADOPTED POSITION:

It is the policy of the American Podiatric Medical Association (APMA) that the profession and the public would benefit from a podiatric board certification re-eligibility pathway.

The APMA House of Delegates requests that the Specialty Board Recognition Committee (SBRC) Council on Podiatric Medical Education (CPME) 220/230 Ad Hoc Committee consider creation of procedures to allow recognized boards to open eligibility to examine podiatric physicians who completed any CPME-approved residency training program.

POLICY PROPOSITION 5-24: PREVENTIVE FOOT EXAMINATIONS/CARE

SPONSORED BY: New Mexico Podiatric Medical Association

CO-SPONSORED BY: Florida Podiatric Medical Association
Michigan Podiatric Medical Association
Oregon Podiatric Medical Association
Pennsylvania Podiatric Medical Association

STATEMENT OF PURPOSE:

Preventive foot examinations and care are recognized as important components for the maintenance of health especially in diabetic and aging populations. Regular foot examinations can detect common foot problems, functional decline, and is recommended for preventing falls and amputations. The independent study conducted by Duke University published in *Health Services Research* found that, in a large Medicare sample, coordinated care between podiatrists and lower extremity clinical (LEC) specialists substantially reduced amputation rates compared with care only provided by other health professionals, while care provided by podiatrists alone was also highly protective of undergoing amputation in those with severe LECs(1). Numerous barriers to accessing foot care services have been documented in publications identifying the perceived barriers by both patients and health practitioners.(2,3). These barriers are negatively impacting the public's health leading to decreased access to preventive foot examinations/care and to shifts in the workforce that have not been directly addressed by the DPM profession.

DPMs, who are the recognized foot experts, are especially aware of the many barriers faced by patients and providers in America's healthcare system relating to preventive foot examinations and care. Within the podiatric medicine profession, there is declining participation rates especially by younger DPMs for providing preventive examinations/care and increasing numbers of non-DPM providers identifying opportunities for providing these services that are needed by an aging population. There are increasing numbers of "foot nurses" appearing nationally to fill this void independent of DPM/physician supervision and without any standardization of training or certification along with changes in CMS preventive care policies for non-DPM/physician providers that raises concerns for public safety of patients. DPMs disagree on the role of these "foot nurses" and non-DPM providers with some accepting and embracing their role, while others view them as competition and oppose their practice.

There are variations in insurance benefits and reimbursements for preventive foot examinations and care (AKA routine care) that are key factors adding to the decline in DPMs providing these services. For many decades, these variations have been the source of uncountable hours of work by APMA staff and members advocating for these preventive examinations/care and attempting to develop consistent coverage and reimbursement policies. While APMA has recommended to the Centers for Medicare & Medicaid Services (CMS) a pilot demonstration to test coverage and payment for a Comprehensive Diabetic Lower Extremity Evaluation/Examination (CDLEE) preventive service, no benefit currently exists under the

Medicare program. A report on the steps taken in support of the position below should be provided to the 2025 House of Delegates.

ADOPTED POSITION:

The American Podiatric Medical Association (APMA) supports the concept of a comprehensive lower extremity exam for patients at risk for amputations and falls including people with diabetes or peripheral arterial disease (PAD) with risk stratification to guide at risk foot care visits and will explore coordinating efforts with stakeholders to identify a strategic plan for removing barriers currently present impacting preventive foot evaluations/care. APMA further supports modifications to the public and private insurer policies to reimburse for yearly comprehensive lower extremity exams in these patient populations and reimbursement for regular visits based on risk stratification.

1. Sloan FA, Feinglos MN, Grossman DS. Receipt of care and reduction of lower extremity amputations in a nationally representative sample of U.S. Elderly. *Health Serv Res.* 2010 Dec;45(6 Pt 1):1740-62. doi: 10.1111/j.1475-6773.2010.01157.x. Epub 2010 Aug 16. PMID: 20722748; PMCID: PMC3026956.
2. McPherson, M., Carroll, M. & Stewart, S. Patient-perceived and practitioner-perceived barriers to accessing foot care services for people with diabetes mellitus: a systematic literature review. *J Foot Ankle Res* 15, 92 (2022). <https://doi.org/10.1186/s13047-022-00597-6>
3. Crocker RM, Palmer KNB, Gomez C, Armstrong DG, Marrero DG. A qualitative study of barriers to care-seeking for diabetic foot ulceration across multiple levels of the healthcare system. *J Foot Ankle Res.* 2022 Aug 6;15(1):56. doi: 10.1186/s13047-022-00561-4. PMID: 35932076; PMCID: PMC9356391.