Dear Members of the AOA,

At the recent South African Orthopaedic Association (SAOA) Congress, Pradeep Makan, the South African President asked me to give my Presidential Installation Address, “Developing Leaders – Training Thoroughbreds” as the GT du Toit lecture. Those of you in Boston that heard the original presentation will probably agree with me that it was requested for the horse racing videos and not for the leadership content! Following the talk, I was approached by the CEO of the SAOA who congratulated me on the talk and proceeded to share that the SAOA was not currently in a position to foster leadership development, but hoped to add this important skill development in the future.

I did not think much about it at the time, but as I reviewed e-mails on my flight home, I saw further information on the upcoming AOA | USC APEX Leadership Certificate Program. Enrollment for the 2019 cohort is now open. This got me thinking about the AOA and what a unique organization it is, and the benefits it provides to us.

We are fortunate to be members of an organization that allows leaders the opportunity to expand our non-clinical skills. We should not take this for granted.

I know my career has been significantly and positively impacted by participating in the Northwestern University Kellogg leadership modules early in my AOA career. That initial exposure to leadership education has served me incredibly well. It sparked a desire for lifelong leadership education and has given me tools that I subsequently have used, previously as the Residency Director, and now as the executive vice chair in the Department of Orthopaedic Surgery at Washington University in St. Louis.

I believe the AOA | USC APEX Leadership Program can have the same impact on current and future orthopaedic leaders today. Additionally, as it is being developed with an eye towards modern expectations and efficiencies, it will accomplish this with less time away from home than the Kellogg or Booth sessions.

In a perfect world I might have sought an Executive MBA, but for a variety of personal and professional reasons I did not want to commit the time and resources needed to achieve an MBA. Thus, the AOA offerings allowed me to receive additional education that has served me very well.

I hope you will seriously consider the upcoming APEX offering as an option that can fulfill similar needs for your career.

Rick W. Wright, MD, FAOA

Visit www.aoassn.org/APEX for details.
So, like some of you reading this, I sit in on a 6:30am Fracture Conference at my home institution. (80% of success is showing up, right?) In the last several years it has become obvious to me that we are in the midst of an epidemic! No, not in spine, but rather PERIORTHOProsthetic fractures! Virtually every Monday conference, patients from the weekend are presented with a fracture around their total hip or total knee. These are no small problems to fix for the surgeon, and carry significant morbidity and mortality for the patient and costs for society. Though not as common, a vexing postoperative complication for us, spine surgeons, is PROXIMAL JUNCTIONAL KYPHOSIS. This occurs when the upper level of fixation (or one level above) of a longer spine construct will fracture, resulting in recurrent kyphosis. We (the surgeon and the patient) just spent hours correcting their deformity to get a good result!

Why is this happening? Technique can play a role, but the elephant in the living room is osteoporotic bone adjacent to our implants that fails! Until recently, I did not know that supracondylar bone density around a total knee prosthesis decreases by 15-20% and stays there.[1] Understandably, I live under a rock, but as orthopaedic surgeons and leaders we need to consider this a HUGE problem that needs to be addressed. And if your spine patient is treated perioperatively with three months of parathyroid hormone, their risk of proximal junctional kyphosis decreases from 15.2% to 4.6%.[2] (Yagi et al, Osteoporosis International, 2016). There is tremendous potential impact on our patient outcomes related to BONE HEALTH!

How to affect this impact? I believe the idea of PREOPERATIVE OPTIMIZATION of our elective patients shows tremendous promise. Preop optimization means truly improving a patient’s health before surgery rather than just ‘clearing’ them. We need to decrease their risks which lead to better outcomes, less readmissions, and lower costs. It is not a time limited process and could take months for certain patients.

This idea seems to be gaining traction around the country, we have hired two internists in our orthopaedic department at WVU for this very program.

The obvious disease targets for preoperative optimizations are diabetes and obesity, so improving Hemoglobin A1c’s and BMI’s seems to be a no brainer. But guess what? Osteoporosis with its long-term comorbidities and costs is every bit as much of a public health problem. Optimization is profoundly relevant to BONE HEALTH! Are we not asking the bone to do something when we operate, such as heal, maintain rigidity, or hold fixation devices or implants?

Orthopaedic surgeons have the ability to assess risk for osteoporosis, order and interpret appropriate tests such as 25(OH) Vitamin D and DXA, recommend nutritional supplements, and assess fall risk. If medications are needed, programs such as fracture liaison services using the AOA Own the Bone program may be ideally suited to provide this care.

Drs. Dirschl, Bunta, Jeray, and Anderson have led AOA’s Own the Bone program (www.OwnTheBone.org) with a team of dedicated staff and institutions across the country. As practicing orthopaedists as well as leaders, we need to raise our collective level of professional anxiety regarding BONE HEALTH for our patients. Own the Bone is arguably the best vehicle for us as orthopaedic surgeons to put air in the tires, gas in the tank, hire a driver, or drive it ourselves!

Phew…. Thank you for listening. I have to leave now and find some PTH to put on my morning cereal….
AOA Reaches Out to Young Students to Encourage Diversity in Orthopaedics

At the recent AOA Annual Leadership Meetings in Boston, the AOA held its first Community Outreach Project to strive for more diversity in orthopaedics.

Students from the Boys & Girls Club of Boston attended the AOA Opening Ceremony and participated in an intimate session led by eight AOA Members: Jasmin McGinty, MD, FAOA; Scott E. Porter, MD, MBA, FACS, FAOA; Melvyn A. Harrington Jr., MD, FAOA; Robert H. Wilson, MD, FAOA; Charles L. Nelson, MD, FAOA; Toni M. McLaurin, MD, FAOA; Amy L. Ladd, MD, FAOA; and E. Anthony Rankin, MD, FAOA. These AOA Members shared personal stories, insights and encouragement from their journey through college, to medical school and into orthopaedics.

During the brief introductions, the physicians took the opportunity to bond with the kids by chatting about basketball, favorite teams and a little about their background.

The students indicated that a common struggle for them is a lack of readily identifiable and tangible mentors or a mature academic support system. Many of them are the first in their family to go to college and their elder family members cannot offer the experiential advice that many of their fellow students receive. This can understandably lead to feelings of isolation or of being overwhelmed.

The AOA members related stories from their respective backgrounds. “No one in my family went to college before me,” said Dr. Porter. “I had one of the biggest families in our county growing up, but no one could help me with my homework.” His experience at an HBCU (historically black college/university) helped him with the transition. “For me the HBCU was an extension of my environment at home which made it better.”

The AOA members identified helpful ideas for these young students as they start to think about taking their education further. Dr. Ladd pointed out that there are first-generation American clubs and “first to go to college” clubs. “They are extremely supportive organizations,” she said.

Dr. Wilson was also first in his family to go to college. “Every step of the way I was naive. I didn't know anything. I didn't know when I got into medical school that I had to do a residency. I didn't know what a residency was!”

One of the students took this opportunity to ask, “What is a residency?” AOA members briefly explained the difference between medical school, residencies, internships and fellowships and outlined how many years are typically involved with each. After listening to the amount of time involved, many of the kids looked a bit shocked. Dr. Ladd assured them, “The hours are long but the years are fast.”

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Membership Diversity (cont.)

“I look at it like a stair-step,” continued Porter. “Whatever “step” I was on, I enjoyed it to the fullest. Regardless of whether you go to medical school or not – you’re eventually going to be 34. The difference is, you can be 34 and do all the things you want to do, or not!”

Dr. Rankin and Dr. McLaurin gave some historical perspective. Growing up during segregation, Dr. Rankin wasn’t allowed to step foot on the University of Mississippi campus back then. Dr. McLaurin spoke about how, as late as the mid-1960s, some hospitals, like Grady Memorial in Atlanta, were physically divided in two. “The hospital was referred to as ‘The Grady’s’ – black Grady and white Grady,” she said. “There were black nurses from the Grady ‘colored’ nursing school, but they could not take care of white patients, and there were no black doctors. I know that seems like a million years ago to you guys, but what seems sort of normalish – us sitting in this room – would not have existed fifty years ago.”

One of the students spoke about her anxiety and her struggle with failing. “Did you ever find failure getting the best of you? When I fail, it’s hard for me to move on. Like, I beat myself down.”

Dr. Wilson said, “Wow, that’s kind of . . . normal! Yeah, it’s going to be tough. I’ll use a basketball analogy: Some guys say, ‘Well this ball is too slippery.’ Well, everybody is playing with the same ball! Come on man, just play!”

Dr. McGinty spoke about the importance of finding the right support systems. “I went to a tiny historically Southern Baptist school in North Carolina, and I just happened to identify a mentor at the institution that really supported me. They knew who I was, they remembered me. They saw that I was a good student...it was this connection that really helped me achieve what I needed to achieve.”

Shortly after the session, Dr. Porter received an e-mail from Regina Mendez, one of the students. The 16-year-old said, “It was inspiring for me to see surgeons who all share the same racial commonality as myself.” She expressed her gratitude for being provided with “loads of knowledge” at the session.

The AOA recognizes the lack of diversity in the profession of orthopaedics as a critical issue. This session is one of many AOA efforts supporting increased diversity within orthopaedics. The AOA’s 2019 Leadership Institute will be a Diversity Workshop designed to create diversity champions. For more information about this and other diversity initiatives, visit aoassn.org.
Revising Thoughts on Revision: Lessons From the ASG Fellowship

Susan Bukata, MD, FAOA and Neil P. Sheth, MD, FAOA

The AOA’s Austria-Swiss-German (ASG) Traveling Fellowship tour promotes international travel for the exchange of medical ideas. Earlier this year, Drs. Bukata and Sheth joined two other orthopaedic surgeons in touring orthopaedic centers in Austria, Switzerland and Germany for almost four weeks. Below is their leadership project report.

We started our leadership project trying to look at quality in orthopaedic care and how we define it and report it in our health systems. Quality is defined in the dictionary as, “the standard of something as measured against other things of a similar kind; the degree of excellence of something.” In our world of mass data and electronic health records, the search is happening around the globe for measurements of quality that can be easily reported and can stand as a measurement of the healthcare that we provide. In orthopaedics, much of this focus has turned to arthroplasty; arguably one of the most successful and effective procedures performed by orthopaedic surgeons.

In its pursuit of reliable excellence, the world of total joints developed measurement tools and outcomes reporting to try to improve upon something that in many ways already had a tremendous success rate. Registries and databases were developed and reports of these metrics for individual surgeons and physicians are released to the public in many countries, including the United States (partly because this data actually exists). In medicine, we need to report some metrics to help us choose cost effective, life quality improving treatments for our patients and to produce reliable results. We choose outcomes such as infection rates, revision rates, length of stay, DVT prophylaxis success, mortality, and readmission, partly because we have made it easy to measure these. At the heart of this, everyone agrees that they want to provide quality care to their patients. However, one unintended consequence of this reporting is punishing the providers who deal with the complications of these procedures, and it was surprising to us that this problem existed in every health system we encountered.

In every region of every country we visited as well as within the National Health Service (NHS) of our British Fellow, Dr. Thomas Moores, complications requiring joint revisions were routed to academic centers of excellence. In the United Kingdom, the NHS uses a spoke and hub hierarchy that concentrates complex cases, particularly those requiring revision or managing infection, into a few centers around the country. In Germany, Switzerland, and Austria, many total joints are done in small community practices similar to what we see in the US. Whether these joints are paid for by the national health system or by private insurance, when there is a complication that requires a revision, these cases are deemed by the original providers as too complex to manage in the setting where the primary joint was placed. Cases are then transferred to the larger, mostly academic medical centers for revision care. This is very similar to the environment we experience in the US. Management of revision cases as well as management of infection cases are very costly to the institutions that provide this care. As the number of patients with total joint replacements is growing rapidly in every country, so

To the public, who do not understand the subtleties of this statistic reporting, the same surgeons and institutions who were being referred complex cases by their community peers because of their expertise and advanced skills appear as though their patients suffer a much higher rate of infection and complications than the patients of these community peers.

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Change Management and the EMR — Epic Lessons Learned

Charles A. Goldfarb, MD, FAOA

The electronic medical record (EMR) is one of the most important tools in the everyday life of every physician. EMR interactions are continuous and efficiency in those interactions affects our lives in very tangible ways. An ideal EMR makes us more efficient, will allow us to see more patients, will allow us to bill most effectively for the care we provide, and may allow us to leave the office a bit earlier each day.

A new EMR represents perhaps the most significant alteration to the daily routine that any of us will experience. Many of us have undergone an EMR change, if not more than one, in the last 10 years. If you have not, you likely will. The successful implementation of a new EMR requires careful change management as much is at risk including physician satisfaction, patient safety, and office billings. A poor implementation has high risks including physician retention, key employee retention, financial success, etc. Herein we will outline a few of the key concepts of change management that have the potential to smooth the transition to a new EMR.

First, and perhaps most simplistically, leadership must recognize and verbalize an understanding of both the importance of the transition and the stress that it will create for all office employees, physicians included. This is a major change to daily routines and work flows and it will cause frustration. It will also typically require additional work hours for training/implementation over the months leading up to the EMR change.

Second, preparation for the transition should begin as early as possible, hopefully years in advance of the transition. The workflow of the new EMR will affect every aspect of patient care. It will affect how a patient checks in at the front desk, how the patient is roomed, may require additional personnel for appropriate efficiency, and the list goes on. It affects things like surgery scheduling, clinic billing, coding, and collections. Each layer of the office staff must, therefore, be engaged. Workflows must be reconsidered- this is an opportunity to reassess all aspects of patient flow. To neglect the non-clinical side is to invite failure. Yet, major changes will risk the office culture due to these new workflows and altered patient interactions. Anticipate these changes in culture and work to mitigate the negative effects while promoting the positive ones.

Third, be transparent. Explain the reasoning behind the EMR change. For some transitions, the need will be self-evident but still should be discussed. In other situations, the need for change is less clear and, in these situations, it is even more important to explain and to obtain employee buy-in. Once the employees and physicians understand the rationale for the change, many will step up and engage fully in the transition. Your key employees will help to develop new workflows, educate the staff, and smooth the transition. This is a wonderful opportunity to better understand who those key employees are and to recognize and appreciate them.

Finally, the change must be led by an appropriate Department leader. This will not be the Chairman or CEO but cannot be a junior Department member either (no matter their technical expertise). That leader must truly engage and work to help the transition by problem solving, anticipating difficulties, and engaging all key stakeholders in and out of the Department/office. This leader must help with education at all levels and continue to engage the Department throughout the process. Their leadership role will not stop at the time of implementation and continued improvement is a vital part of a successful implementation.

Practical changes are required with an EMR change as well. Appropriate technical support must be available during the initial period of the new EMR with technical experts available. This support should be ‘at the shoulder’ for several weeks but support should continue for as long as necessary. Department employees will master the new EMR at different rates and support should continue as long as necessary for all to gain the necessary skills. Clinical volume will be affected and a temporary decrease in patient volume will ease the challenge of
are the number of revision cases, partly because of this increase in overall surgical volume and partly because patients are living longer and aging with these prostheses in place. Patients remain healthy and active enough that these problematic prostheses need to be addressed.

Unfortunately, rather than reporting to the institutions where initial surgeries were performed, the quality measures that report rates of infection and the rates of revision tracked in every country are reported to the institutions that provide these revision surgeries. To the public, who do not understand the subtleties of this statistic reporting, the same surgeons and institutions who were being referred complex cases by their community peers because of their expertise and advanced skills, appear as though their patients suffer a much higher rate of infection and complications than the patients of these community peers. While in most countries, physician reimbursement was not directly linked to the scores on these quality measures, public profiles and reputations were definitely hurt by this reporting process, particularly for patients considering primary joints. It was interesting to us what a universal issue this was becoming.

So as leaders, what can we do? We need to celebrate and reward the providers and institutions that take on these complex cases, not punish them in these public reporting systems. Most providers would agree this is an unintended consequence of quality measure reporting, but solutions using the current methods of tracking data for this issue are few. The answer is not simple. Exempting these institutions and cases from reporting allows these complications within the system to get lost and does not give us a real picture of problems associated with joint replacements. Clearly, a more complex reporting system that allows the tracking of the long-term results of an individual joint within an individual patient, regardless of where they receive their care would help with this issue, but we are likely several years away from that. In every country, even though electronic medical records have helped with tracking patients, the sharing of records tended to be restricted to regions within the larger health system rather than universally across the country. This issue reinforced to us the need for physicians to take a proactive role in these quality reporting initiatives and to demand a constant review of the information this data provides, with amendments to the processes as needed. Joint revisions represent only the beginning of this quality measures reporting issue within orthopaedics. We need to learn from this experience as this process expands to other subspecialties and procedures.

Critical Issue

Change Management and the EMR (cont.)

the first several weeks. While physicians may argue that they can handle their normal patient ‘load’ with the new EMR, the check-in desk, the nurses, the radiology technicians, etc. are unlikely to be as able or willing to spend the extra hours required for success without a volume adjustment. Many sites will decrease clinic volume for 2 weeks although for some, the decrease may be even longer. OR volume can often be maintained at near normal levels but attention to specific OR requirements including scheduling, pre-certifying, dictating, and communicating with patients will be necessary.
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