Class of 2015 New Member Biographies continued

Karen M. Sutton, MD
Assistant Professor, Orthopaedic Surgery; Director of Women's Sports Medicine; Director of Yale Health Bone and Joint Center, Yale University School of Medicine; Chairman, AAO, Central Instructional Committee, 2014

Thomas Throckmorton, MD
Assistant Professor of Orthopaedics; Shoulder and Elbow Surgery Residency Program Director, University of Rochester-Campbell Clinic Department of Orthopaedic Surgery

Michael S. Shuler, MD
Head of Upper Extremity Orthopedics; Arthritis Orthopedic Clinic; Secretary AOC & Executive Committee, 2010-2013

Ernest L. Stuck, MD
Co-Director Center for Hip Preservation, Hospital for Special Surgery; Associate Professor, Cornell University, Weill Cornell Medical College

Channing Tanouye, MD
Associate Professor, Pediatric Orthopaedic Surgery, Medical College of Wisconsin; Clinical Vice President Surgical Services, Children’s Hospital of Wisconsin, Medical College of Wisconsin; Children’s Hospital of Wisconsin; Clinical Vice President Surgical Services, 2014-present

Jennifer Weiss, MD
Orthopaedic Surgeon, Southern California Permanente Medical Group; Board of Directors, AAO, 2014-2016

Vonda J. Wright, MD
Medical Director, UPAC; Levine Sports Complex; Assistant Professor, University of Pittsburgh

Kenneth F. Taylor, Jr., MD
Associate Professor, Chief, Division of Hand Surgery, Department of Orthopaedics and Rehabilitation, Penn State Milton S. Hershey Medical Center

Michael Terry, MD
Associate Professor of Orthopaedic Surgery, Northwestern University

Robert Z. Taubjian, MD
Associate Professor of Orthopaedics, University of Utah School of Medicine; Chief of Orthopaedics, Veterans Administration Medical Center, Salt Lake City, UT, 2009-present

Craigigh C. Tabb, MD
Vice Chairman, Department of Orthopaedics & Rehabilitation; Assistant Professor of Surgery, Uniformed Services University of the Health Sciences; Saw Amer Amid Medical College of Wisconsin, 2009-present

Catherine E. Stull, MD
Orthopaedic Consultant, U.S. Army Medical Command; Co-Chair, SPS/SSI Children’s Hospital of Wisconsin, 2014-present

Michael Terry, MD
Associate Professor of Orthopaedic Surgery, Northwestern University

“it would be superfluous for a second-term man who has the honor of presiding over your deliberations to attempt to recall the work you have done during the first quarter of the century. The highly efficient Editorial Committee has kept you fully posted on the advance in orthopedic [sic] surgery, and the presiding officers from year to year have done their share in bringing before you the achievements of the same.”

- Virgil P. Gibney, MD from Suggestions for the Second Quarter of the Century; The American Journal of Orthopaedic Surgery, Volume X, Number 1, August 1912.

Dr. Gibney was the AOA’s first and 26th President, and the only individual to have held that office twice.

Donate to the AOA in Gratitude to Those Who Have Given So Much
By David E. Atarian, MD, FACS

A s members of the American Orthopaedic Association, all of us understand and embrace the importance of leadership, education, research, mentorship, community service, excellence, and professionalism. Those who have come before us, and taught us, established extremely high standards and expectations; in fact, none of us would be members of this organization if it were not for the energy, time, and guidance that our mentors so selflessly committed to promote our professional development and success. Their only demands, some spoken, some implied, were to give back to the profession and community, and to impose upon what they taught and practiced during their careers.

Over my 53 years in orthopaedic surgery, I have been blessed to have four icons help and guide me along the way, all of whom served as President of the AOA. … and I wanted another way to thank each of them.

Dr. J. Leonard Goldner was my Chief of Orthopaedics during my training at Duke; he was the penultimate orthopaedic educator and diagnostician with an encyclopedic knowledge of our specialty. He pushed all of us to do our best every day for the benefit of our patients.

Dr. James R. Urbaniaik gave me my job on the Duke Orthopaedic faculty; he is without a doubt the most accomplished microvascular and upper extremity surgeon of his time, not to mention a beloved teacher and professional/personal role model for those of us lucky enough to train and work with him.

Dr. Paul DeRossa was a colleague at Duke, as well as a neighbor and friend in Durham, NC. In his role as the Executive Director of the AOB, he showed me how his incredible intellect and orthopaedic political power could transform board certification into a valid, fair, and modern process for the benefit of our profession and society.

And finally, I had the privilege to serve on the Board of Directors of OMeGa with Dr. Mac Evans; he epitomizes a life-long commitment to advancing our profession through the support of graduate orthopaedic education. He and the original Board members established a new merit based application process and platform for the matching of industry funds to worthy orthopaedic fellowship and residency programs throughout the country.

And so my donations to the AOA are to thank each of them as I can for what they have given.

I know many of us feel targeted by so many “asks” for support, from our various community programs, our alma maters, our religious organizations, political parties, countless charitable organizations, so many professional societies, and even family members… and the need is always greater than what we can realistically give. But we make choices on what we believe to be most important, and the best ways to make a positive difference.

And so, each of us can honor and remember the great orthopaedic leaders, educators, and researchers in our lives by providing the best possible health care to our patients, teaching others how to provide care, performing basic and/or clinical research to improve care; participating in our professional societies as leaders to advocate for our patients, or giving back of our earned wealth to support any or all of these worthy activities. These are personal decisions but we all have an obligation to leave things better off in whatever ways we can, and in consideration of our strengths and preferences.

Making a donation to support the AOA educational and leadership programs was a relatively easy and constructive way to pay my respects to all of my orthopaedic role models’ and teachers’ core values and legacies. And I believe the AOA is a reliable steward of any funds I donate to support its vision and mission.

And so in gratitude, I give back. The AOA would like to apologize for the exclusion of John R. Denton, MD’s tribute gift in the AOA Update. We greatly acknowledge his donation in memory of Frank E. Stinchfield, MD, a man who positively influenced and impacted many orthopaedic surgeons, including Dr. Denton.

OwN THE Bone
Lakeshore Bone & Joint Institute: A Group Practice-Based Fracture Liaison Service (FLS) Model of Care Using Own the Bone

By Natalie Eddy, DNP

Physician practices have taken an active role in implementing The American Orthopaedic Association’s Own the Bone® initiative, a program designed to ensure that individuals in their communities receive the best possible bone health care.

Lakeshore Bone & Joint Institute is an orthopaedic group practice which provides comprehensive orthopedic services to the Northwest Indiana area. It currently serves five counties employing 21 physicians and 13 non-physician providers at 12 different locations. In 2011, the institution hired a DNP to develop and pilot an osteoporosis program for fracture patients in the local community. In 2012, Lakeshore Bone & Joint Institute demonstrated their commitment to quality improvement by joining the Own the Bone program. The result is an open care model in which a program physician assists in referring fragility fracture

By Natalie Eddy, DNP

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Natalie Eddy, DNP

David E. Atarian, MD, FACS

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Lake Shore Bone & Joint Institute... continued

Key features of this model

• Group orthopedic practice is primary implementor with an NP in charge of treatment.

• Scheduler ensures spine fracture patients are seen and non-operative patients are seen by DNP for treatment and osteoporosis evaluation.

• Patients receive bone health consults with the DNP, who conducts BMD testing and bloodwork.

• DNP performs treatment and osteoporosis evaluation (labs and DXA scans) on patient, schedules follow-up in 2 weeks.

• Physicians and nurses refer patients not captured by EMR to DNP.

• At follow-up, DNP performs counseling/patient education, reviews DXA results and initiates pharmacotherapy, calcium and vitamin D.

• Practice scheduler screens non-surgical spine and fracture patients referred to be scheduled with the DNP. Physicians and nurses ensure that fracture patients are referred to the DNP when necessary.

• The DNP automatically creates a consult with NP and needs to be intentionally disengaged. In the near future an automatic dashboard will be available for all fracture codes.

• Outpatient fracture fragility counseling occurs during the “teachable moment” post-fracture. The DNP counsels patients and provides supplemental take home patient education resources.

• The DNP usually prescribes vitamin D and calcium for the patient. Appropriate patients are also started on analgesic or antirefractive therapy once tests are completed.

• Ongoing educational meetings are held between the DNP and medical assistants, nurse practitioners, physician assistants, RN’s, and physicians regarding new osteoporosis treatment innovation and developments.

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patients to the DNP in an effort to reduce length of fracture care. Lakeshore Bone & Joint Institute is now a successful regional osteoporosis referral center.

The following information describes Lakeshore Bone & Joint Institute’s secondary fracture prevention, on-road program, through early-2015. The program operates with the goal that bone health referrals, evaluations, and follow-ups are incorporated into care pathways for fragility fracture patients:

• A DNP serves as the program champion in developing and implementing an osteoporosis program for fragility fracture patients. Patients are referred to the practice through the support of physicians, and nurses who see patients with back pain and spine fractures, as well as other low trauma fractures.

• Patients that are referred from the ER to the practice with back pain and spine fractures are screened by the practice medical secretory to schedule for emergent versus chronic concerns.

• Fragility fracture patients with other types of fractures are referred from other physicians and nurses within the practice.

• The DNP is scheduled to meet with the patient the same day (when practical) and treats patients for their spine fracture (most often bracing and pain medication). Osteoporosis evaluation including labs and DXA scan are ordered.

• Follow up for fracture care is done monthly and pending insurance approval, therapy is initiated. The DNP schedules the patient for a follow-up within two weeks after initial consultation. During follow-up, explanation of osteoporosis and future risk of fracture is discussed with the patients, labs and pharmacotherapy options are reviewed, calcium and vitamin D supplementation are initiated, and insurance forms are completed for osteoporosis medication.

• Fracture treatment options are also discussed such as anadiges, vertebrapathy/kyphoplasty, and/or pain management.

• The collaboration and process consist of:

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Silos and “T” Leadership

By Scott F. M. Duncan, MD, MPH, MBA

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omen times organizations realize that they are their own worst enemy. It is not the customer, it is not the market…it is the silo mentality, and all institutions have it to one degree or another. If you look at Sony and you get seven different components you will find that there are seven different shades of black, and the reasons for this is that they were so siloed they could never agree what the color of “black” should look like within their own company. Healthcare is full of silos and, honestly, a customer does not care how you are organized. The customer does not care if you are organized this way or that way. The question is whether the devil is really on the outside or is the devil really on the inside.

If you have the ability to serve patients in a cost effective and seamless way that aligns around the motivators of tomorrow and take away their frustrations, then where is the biggest problem? Is it silos or sandboxes and target customers and value propositions and understanding the motivators of tomorrow, or is it really our ability to run silos? So, in most organizations, silos are here to stay.

The other thing that can happen is an organization that starts to break down and they have these blurry boxes creating an extreme where you have silos and nobody talks to each other, or you have blurry boxes where everyone talks to everybody but nobody knows who does what and nothing gets done. You start seeing a dilemma where people do not even know who is responsible for completing what actions and what tasks. Ironically, we silo an organization that is supposed to be proactive but it ends up becoming highly reactive and it only shakes up when there is a crisis. Otherwise, it is kind of business as usual.

Silos are here to stay. You can try to break them down and you may try to do different things with them but, they are here to stay no matter how much you want to eliminate them and, in fact, you need them to get stuff done.

What we need is the capacity to bridge silos. This is what allows an organization to function maximally. Unfortunately, silo bridging is not a natural behavior.

Why do silos not want to bridge? Why are silos naturally resistant to bridging? Power. They want to preserve the power goals, different goals, and different expertise. In many cases, there are no incentives built in to bridge the silos. But bridges can be built.

What we need is the capacity to bridge silos. This is what allows an organization to function maximally. Unfortunately, silo bridging is not a natural behavior.

There are two kinds of bridges in an organization. The first is a coordination bridge. These people are talking to each other, creating task forces together, and forming work groups to find predetermined ways for people to come together and communicate whether it is co-locating specialties or finding some way to force interaction or to force cooperation.

The second type of bridge is the kind that is not forced, the spontaneous. This bridging emerges when you need it. This means that there are people with a willingness or desire to work with each other which is cooperation.

One is external and one is more internalized. You need coordination but you really need cooperation. And I would argue that cooperation is what you need most of all to bridge silos.

Coordination is secondary to cooperation. You try to allow the action and then align the interest. Why do you spend more time on coordination instead of cooperation? Why is coordination easier?

Coordination can be essentially forced and it can happen quickly whereas cooperation takes time. You may want to get people to do it but, in many ways, it has to come naturally. So if you are going to build the next generation health care delivery organization that is going to be delivering what patients of tomorrow seek, you have to ask yourself internally “what kind of bridges do we need to build?” At the same time bridges are built between people and that leads me to the next kind of question, what kind of leaders do you have in your organization?

The ideal leader you need in an organization are “T” bridging leaders, the T profile leader. The T profile leader knows how to manage vertically but also knows how to manage horizontally. The problem is that in most organizations, we develop vertical leaders but we do not develop horizontal leaders because vertical functions with authority and horizontal works with influence. Unfortunately, people who in general are good at vertical are not necessarily very good at horizontal. What kind of people do you want to develop? The old adage, “if you want people to do what you want, you have to ask them to have the bus?”

Visit the AAOS online store at www.aaos.org to view recorded leadership webinars and other materials.

Attend the Spring CORD Conference

Friday, March 4, 2016
7:00am-10:00am
Held in conjunction with the AAOS Annual Meeting in Orlando, FL
Registration is open: www.aaos.org
Changes for AOA Communications

Since its inaugural issue in October 1968, the AOA News has changed formats and contents, adapting to evolving member needs. Many members have expressed a strong preference for receiving this print newsletter, AOA News, in an electronic form and a desire for the AOA to “go green.” Starting with the spring 2016 issue, the AOA News will no longer arrive in your mailbox. Instead, the Executive Committee has chosen to develop the AOA News as a somewhat more condensed digital piece. This latest format change will be hosted on the AOA website and a link to download or print it will be e-mailed to members.

In place of the monthly Community of Leaders e-newsletter, if we have your e-mail address, we will send you a new electronic newsletter, AOA This Week, highlighting opportunities, dates and deadlines, recommended reading and viewing, and other AOA features. We hope this more succinct weekly communication will enable you to find all the important AOA going-ons and reminders all in one place as you plan for the week ahead.

We’d like to hear your ideas or suggestions about what you’d like to read about or learn. We’d also like to hear from you if you’d like to write an article for either the digital AOA News or AOA This Week. E-mail info@aoassn.org to let us know.

AOA Learning: Knowledge at your Fingertips

Finding time to increase and hone your leadership skills—or finding ways to help others do the same—can be tricky. The AOA now has a way for you to learn any time, anywhere. The on demand catalog includes the interactive Effective Mentoring in Orthopaedics course, recorded webinars on topics ranging from resident selection to career development for the young orthopaedic leader to a fracture liaison service in a multi-specialty practice. Find out more: visit the store at www.aoassn.org for details.

AOA Learning: Knowledge at your Fingertips

AOA webinars, courses, & more!

AOA Committee Restructuring... continued

Members-at-Large, and the CORD Chair will now sit on the Executive Committee as a non-voting member. Task Forces will assume the functions of CORD’s Education and Compliance Committee.

The activities of the Academic Leadership Committee will move under CORD, Critical Issues and Educational Programming, and Leadership.

The Critical Issues Committee (CIC) will expand to become the Critical Issues and Educational Programming Committee. It will remain the think tank for all critical issues impacting orthopaedics and includes oversight of all Annual Meeting programs and activities, with the exception of the direct planning activities for CORD Conferences. This will include symposia, Department Leadership Forums, roundtables, and other educational programming. The Publications Chair will continue to sit on this committee, but will no longer serve on the Executive Committee.

The Development Committee will be renamed the Development/Donor Support Committee to reflect additional engagement with individual AOA donors. The Chair will continue to serve as a non-voting member of the Executive Committee.

The Leadership Development Committee has become the Leadership Committee. It will oversee all leadership offerings outside of the Annual Meeting, including Resident Leadership activities, Emerging Leaders Program, AOA Awards, and Traveling Fellowships. Their responsibilities will also include new regional educational offerings. The Leadership Chair will continue to sit on the Executive Committee as a non-voting member. As of June 2016, the Fellowships Chair will no longer sit on the Executive Committee but, instead, will serve on the Leadership Committee as a dotted position. The Fellowships Task Forces will work with the Leadership Committee to create more opportunities for engagement at the grassroots level.

The Own the Bone program is politically charged and has significant outreach beyond the AOA membership, positively impacting the AOA’s reputation on a national level across a broad spectrum of constituencies. Given the magnitude of the program, the Own the Bone Committee has become a standing committee. The Chair now directly serves on the Executive Committee as a non-voting member, instead of the previous dotted line.

The Finance and Investment Committees will be combined in order to reduce redundancy and promote a broader perspective for even more effective stewardship of the AOA’s finances. The Treasurer, who serves as chair of the Finance Committee, will chair the new combined committee, with the current Investment Chair becoming Vice-Chair. The Chair will sit on the Executive Committee in a voting capacity; the Vice-Chair will not serve on Executive Committee.

Impact on the Executive Committee

Each standing committee would have a non-voting or voting member (Standing Committee Chair) serving on the Executive Committee for a term(s) that runs concurrent with the term of their appointment; the proposed changes do not modify the current structure of voting members of the Executive Committee.

Task Forces

Standing Committees will have the ability to set up and oversee short-term (12-18 months) task forces to help accomplish their Committee’s work. Each standing committee can propose up to four task force activities annually, which will require the approval of the Executive Committee. At the time of the proposal, the committee will submit a suggested task force lead/chair, who will, along with an appointee from the standing committee, identify members of the task force. The committee will also need to define the project, scope of work, timeline, and provide an estimation of required resources. If approved, the activity goes back to the standing committee and is established by the standing committee chair, working in conjunction with the task force lead/chair and standing committee appointee.

Annually, AOA staff shall solicit AOA member, Emerging Leaders, and CORD affiliate interest in potentially serving on select subject work groups and shall provide this resource to task force leads for selection. Members will have an opportunity to self-identify as interested in certain topics and willing to serve on task forces in annual member solicitations.

Lakeshore Bone & Joint Institute... continued

Since beginning in 2012, the program has received approximately 500 fragility fracture patients a year, who otherwise, would statistically have only a 20 percent chance of being evaluated for any underlying bone health problems which resulted in their fracture. By implementing the Own the Bone program at their institutions, Lakeshore Bone & Joint Institute remains committed to ensuring that the highest quality of care is available to all fragility fracture patients.

The FLS model implemented helps fracture patients receive the time and effort needed for a proper bone health diagnosis and treatment. The efforts of the DNP and the rest of the staff through this program ensures that fracture patients are being identified in the system and referred properly to receive appropriate care, counseling, and treatment. Visit ownthebone.org for more information about how you can join the over 180 institutions in 48 states that have gotten started with secondary fracture prevention using the AOA’s Own the Bone QI program.