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Teamwork

A Periodical for Providers and Clients of Comp1One

Joint Replacement: A Personal Perspective



DR. RICHARD BURNSIDE
The Orthopaedic Center

Every day, several hundred total hip and knee joint replacements are performed in the United States. As a practicing orthopaedic surgeon with a large practice replacing hips, knees, and shoulders, May 17 was just like any other day with one exception: I was one of the several hundred, I was the patient. Since I am a firm believer that one is the physician or the patient but not both, I went to a hospital where I was not known and did not inform them that I was a physician. Now I would like to share that experience with you.

Cindy, called today. TV is a good distraction and the nurses are real nice.

May 17, 2004: Surgery is today and I am anxious. It felt funny riding down the hall looking at the ceiling instead of walking down the hall. I talked with the first assistant about hunting and this kept my mind off surgery. Everyone was very friendly on the way to the OR and the IV was started. I was transferred to the OR table and the next thing I knew I was in recovery. I needed pain medication and slept a lot the rest of the day. The night was very long, with the pain being a four on a scale of one to ten unless I caught my foot in the covers while turning.

May 16, 2004: I'm in the hospital now and anxiety is a lot less. I prayed and talked with friends and this helped a lot. I got a call from Jim last night, an old friend who had a hip replacement last year. Connie, my wife, is really great, and my daughter,

May 18, 2004: Morning is finally here. The resident took the drain out, a lot of tubes were removed, and I felt a lot better because I'm no longer tied to the bed. I was switched to pain medication by mouth and the pain is not too bad. I can walk on the leg now, if careful. I walked about twenty-five feet with physical therapy

Cont. on page 2

Case Management: What Is It Anyway?

According to the CMSA Standards of Practice for Case Management - Revised 2002, "case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

Effective case management reduces health care costs by identifying risk and preventing medical complications. It also removes the medical and psychosocial barriers to recovery and fosters consumer satisfaction and timely return to work. The case manager works with the patient across the care continuum on every element of treatment settings and payment sources. Throughout the process, the case manager identifies gaps in the efficiency and effectiveness

of treatment, and uses problem-solving skills to overcome them.

Many of the savings generated by case management stem from avoiding things like hospital readmissions and medical complications, or on less tangible benefits like improved patient compliance, employee retention and improved quality of life.

Case managers believe that cost containment is achieved when patients receive the best treatment in the most appropriate manner at the appropriate time and at the best available cost in a coordinated manner across the care continuum. More important, case management remains the one cost containment strategy that receives high approval ratings from both employees and employers.

Source: Case Management Society of America
www.cmsa.org

Comp1One

Comp1One is a comprehensive case management company located in Huntsville, Alabama with clients across the Southeast. Comp1One and sister company, North Alabama Managed Care, Inc. (NAMCI), are divisions of Premier Health Networks of Alabama, LLC featuring PPO network access for direct medical cost savings in group health and workers' compensation.

Comp1One features 24 hour case management services with Certified Nurse Case Managers and the backing of our Board Certified Occupational Health Medical Director. Our nurses and physician are available for pre-certification, utilization management, file reviews, case referrals, peer reviews, and catastrophic injury management.

Comp1One is certified by the state of Alabama Department of Industrial Relations, is licensed and insured, and has been recognized for Best Practices in Injury Management in the state of Alabama.

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Speakers: Dr. Richard Burnside and
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Legal Brief

Overtime Law Impacts Health Personnel: New Department of Labor amendments to overtime exemptions for "white collar" employees take effect today (August 23). A "professional exemption" includes many of the most common positions held by health care workers. To avoid vigorous enforcement of the new overtime pay rules, health care organizations should act preventively to develop solutions for compliance, including a comprehensive review of all pay practices in all job classifications. Immediate steps should be taken to correct any irregularities or vulnerabilities revealed by the review and to explain to employees the reasons for any needed corrections. The new regulations simplify criteria for determining when employees are exempt from overtime pay requirements under the Fair Labor Standards Act (FLSA). The FLSA requires that non-exempt employees receive time and one-half of their regular hourly rate for working more than 40 hours a week.

Jackson Lewis
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**Celebrate National
Case Management
Week
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For more information go to:
www.cmsa.org/cmweek

Company News

We are pleased to welcome Cindi Bradley as the new Comp1One Account Executive. Cindi, a graduate of David Lipscomb University in Nashville, has over 16 years of healthcare account service experience. Cindi is also a sought after speaker on motivational and self-help topics for various audiences nationwide.



CINDI A. BRADLEY

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Joint Replacement: A Personal Perspective (continued)

today and fifty feet with Connie, but I can't straight leg raise yet. The nurses really appreciate honest effort and are very supportive.

May 19, 2004: I have less pain today. It was a long night and I didn't sleep well. I did minimal activity during the day and had lots of naps. Physical therapy times two helped a lot as well as more use of the leg. The worse thing is waiting for things to happen, especially while lying in bed.

May 20, 2004: This night was pretty much the same. I had lots of naps yesterday so I didn't sleep too well. A sleeping pill did help though. I complained about blood being drawn at midnight. Apparently they have to do that since the insurance companies won't allow them to draw blood for the same test twice within a 24-hour period. I am moving a lot better and am able to be up in a chair and can ambulate without help. After breakfast, I will get physical therapy and then be discharged home.

May 21, 2004: I went home yesterday and it's good to be here. Pain is present, but is tolerable. Pain medication has helped and I learned a few tricks to help make me more comfortable. I worked on stretching and upper body strength. Now the depression and anxiety start since I feel I should be getting well faster. I need to relax and enjoy the time off and get caught up on paperwork.

May 22, 2004: The leg is really swollen this morning and pain is increased. It was hard to move it. I must have bled in the muscle last night. I need more pain medication today as well as rest, elevation, and ice packs. I must have over-done it yesterday. I am very grumpy now and hard to live with. Connie is a real saint.

May 23, 2004: The leg is still swollen and painful with lots of bruising. I took a shower today and that helped some. Maybe there is a little more motion in the leg today and I try to move it some every few minutes. I also can move around some better. I am reading a great book from a patient whose problems make mine pale by comparison.

May 24, 2004: I am doing better. I had an ultrasound today to look for clots because of swelling, and it was negative. I went to

the gym, but got tired quickly. The skin is very sensitive on the side of my calf, probably from the swelling.

May 25, 2004: I am more comfortable, but still have pain with a lot of swelling and tire easily. I remember this from the last operation. It just is going to be a slow uphill course.

May 26, 2004: Swelling has gradually decreased and pain is improved. Activity capabilities improved but I spent a lot of time exercising. Skin clips were taken out at ten days and then I was able to exercise in a swimming pool, which helped. Extension was very slow to come and some days are better than others are.

"...total knee and hip replacements are the most satisfying procedures that I do as far as patient happiness is concerned."

As I write this, it has been three months since surgery. At six weeks I was back to work. I worked hard with my physical therapy, doing as much as I could to return to normal activities. I walk better than I have in years and I do not have to look for a chair every time I enter a room. I know the knee doesn't feel normal and never will. I will always know it is there, but the pain is gone for the most part and I am looking forward to a great hunting season this year.

As I look back on this experience, three things seem to stand out:

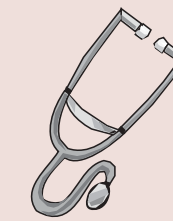
- 1. Pain:** I understand why this is the primary concern for most people. While pain is there, it is manageable and medications help a lot.
- 2. Physical Capabilities:** In the primary sense, you get out of it what you put into it. The possibilities are there and you need to try to make out of it what you can.
- 3. Mental Aspects:** It is really impossible to express the weight of the concern and anxiety associated with joint replacement. But, all things considered, total knee and hip replacements are the most satisfying procedures that I do as far as patient happiness is concerned. Most say they would have done it earlier had they "only known".

Does this experience make me a better physician? I would like to think so. But at least it lets me shout, "Hang in there. There is a light at the end of the tunnel. I know. I've been there."

Richard C. Burnside, M.D.
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Clinical Comments

New Developments in Spine Surgery



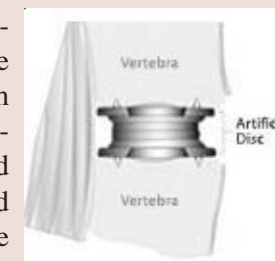
DR. CYRUS GHAVAM
SportsMED

There are two new developments in spine surgery that are of interest to providers of spine care as well as to patients undergoing back surgery. The first is artificial disc replacement, and the other is new technologies in performing spinal fusions.

Both developments pertain to treatment of painful, abnormal discs. The patient's primary complaint is low back pain, but leg pain and neurologic changes may be present. This condition can be a result of central disc herniation, disc surgery (discectomy), degenerative disc disease, internal disc derangement and annular tears. Despite a variety of non-surgical options, a percentage of patients will have persistent back pain and possibly nerve related leg pain. The current surgical treatment has been spinal fusion. In this procedure, the abnormal disc is removed, and the adjacent vertebral bones are fused to each other. This offers good improvement in pain level in about 70% of patients (depending on the specific diagnosis and other factors). The drawbacks to fusion include concerns about adjacent segments. Fusion of one level may lead to additional stress being applied to the discs above and below the fused level, and this may result in acceleration of disc degeneration. This is especially of concern in younger individuals because of higher activity levels and life expectancy. Also, many patients will have multiple degenerative discs. Generally, patients do not fare well with fusions of greater than two levels when the main complaint is back pain.

The option of treating a painful disc with artificial disc replacement has been available in Europe for several years. In the United States, investigational studies have recently been completed, and it is expected that within the next three to six months, the FDA will approve artificial disc replacement. The benefit of

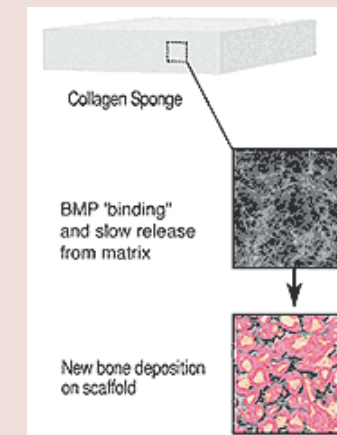
disc replacement surgery is that motion at the treated level is preserved. Thus, concerns about adjacent disc degeneration are lessened. In the investigational trials, disc replacement surgery patients were randomized with fusion patients. Both at early postoperative evaluations, as well as at two year follow-up, the patients with disc replacements reported less pain and generally were more satisfied with their decision to have had surgery, compared to fusion patients. Certainly, careful selection of patients is critical to obtaining good results, and not all patients will be candidates for disc replacement. Long term follow-up may also change these results.



Many patients will still require spinal fusions. Disc replacement will not be suitable for patients with spinal instability or spinal deformities, and may be of limited benefit to patients with significant arthritis extending to the small facet joints of the spine. Developments in fusion technology include minimally invasive techniques, which allow fusion to be performed through smaller incisions. Such techniques minimize blood loss and muscle dissection; this yields less post-operative pain and quicker convalescence. This technology is evolving, and improvements in these techniques are expected.

Fusions require bone graft, and obtaining bone from the patient's hip has long been the gold standard. The drawbacks of this autologous bone include residual pain at the donor site, as well as

risks of infection and bleeding from that area. Recombinant DNA technology has provided us with a protein (BMP) that stimulates bone growth and fusion, thus eliminating the need for harvesting bone from the patient. This material is only FDA approved (and successful) for fusions with cages, when the surgery is performed through an incision in the abdomen. In these cases, it heals as well as bone graft. Another product is a collagen sponge coated with a calcium layer, that is used as a bone graft substitute. Bone marrow (instead of bone graft) is aspirated with a needle and is added to this sponge. This technique is approved for fusions done with



incisions in the back, with results comparable to bone graft.

The above developments in biologic disc healing may provide benefit for back pain patients within the next decade or two.

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