

the voice of the  
american professional  
wound care association

WHAT'S INSIDE



Call for Abstracts!  
Provide your voice and  
research at this year's  
APWCA2010 conference.  
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Members In the News!  
Continued outreach by  
the members of our  
Association.  
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# SYNERGY



## APWCA2010

Philadelphia • April 8 - 11, 2010

**APWCA2010**

**National Clinical Conference**

**New Faculty, Content and Tracks**

**with over 30+ CE/CMEs**

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[www.apwca.org/apwca2010](http://www.apwca.org/apwca2010)

**Mark your calendar** for a spectacular meeting – the largest this Association has had to date. There are multiple levels of education for more and less experienced providers, varied topics, general sessions as well as break-out sessions, scientific lectures, oral and poster abstracts, and a session on the Business of Wound Care. All of which make this the comprehensive and thorough educational event to fit the needs of any provider in Wound Care!

The scientific program kicks off with pre-conference day of additional optional courses and includes a fantastic new panel session on developing and administering a truly integrated multi-disciplinary wound healing center. This session is directed by Harold Brem MD, FAPWCA from New York University and will include colleagues from his internationally reputed “in-house” wound center and other faculty from the “out-patient” facility at Temple University School of Podiatric Medicine. This will allow the presentation to provide perspectives from two different models with ample time for Q and A and discussion with panel members.



Other main events include a panel presentation describing the exciting release of the landmark APWCA paper which concludes a 5 year project for APWCA. The article was developed through a multi-disciplinary panel of leading Wound Care experts and is entitled SELECT: Evaluation and Implementation of Clinical Practice Guidelines -A Guidance Document from the American Professional Wound Care Association (APWCA). This article is the first of its kind and readers, as well as registrants from the APWCA conference attending this session, will better understand methods of, assessing, selecting and integrating clinical practice guidelines into practice and why this is important. Other main events include an international panel presentation on “Is This

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## LEADERSHIP UPDATE board votes in new president and vice president

The biggest administrative news is the October 1, 2010 installation of new officers to the Board of Directors. As you will see in the following articles, Robert Gunther, DPM, FAPWCA, after nearly 8 years of serving as President, has decided that it is now time for him to move on to spend more time with his practice, family and other activities of interest. As the Immediate Past President, Dr. Gunther retains his position on the Executive Board. Assuming the Presidency, and as elected by the Board of Directors, is David Brotman, MD, FAPWCA. Dr. Brotman is trained as a General Surgeon with a subspecialty in vascular surgery. He has served on the APWCA Board of Directors for about 7 years and for the last 3 years served as Vice President. New to the Board of Directors and now APWCA’s Vice President is Michael Fusaro, DPM, FAPWCA. Dr. Fusaro has been extremely instrumental in moving the

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**WINTER/SPRING 2010**

# ADMINISTRATIVE REPORT

## a message from the executive director

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Association forward by developing the Association's "grass roots" connection to its membership through forming our House of Delegates. The House was initiated 3 years ago and for that period of time Dr. Fusaro filled the position of Chair of the House. In that position he was actively involved in APWCA Board Meetings in a non-voting capacity. This policy allows the House to have direct input into major decision making of the Board. The House of Delegates consists of a minimum of two to a maximum of four delegates from each of the four APWCA Regional Districts. All of the delegates meet at least once each year when the House convenes during the APWCA National Clinical Conference. The 4 Regional Districts correlate geographically with the CMS-DME Insurance Carrier network throughout the United States. The newly appointed Chair to the House of Delegates is Randolph Fish, DPM, FAPWCA. Dr. Fish has served as first delegate to the APWCA Western Regional District. He has been the only delegate to retain a first position for the three years since the House was formed. He has organized regional conferences in the Seattle-Tacoma area as well as Anchorage, Alaska - all of which have been successful. One of his goals is to assist the other 3 Regional Districts to accomplish the same. For the Southeastern

Regional District, Princeton Baptist Medical Center organized and ran the "Advances in the Science of Wound Care & Hyperbaric Medicine Annual Regional Conference" in and near Birmingham, Alabama in the summers of 2008 and 2009. These conferences served as APWCA Regional Meetings for the Southeastern District. A big thank you is extended to Rodney Snow, MD, FAPWCA and to Donna Hammock, RN, BSN, DAPWCA for their extraordinary efforts.

Other important administrative news includes the addition of members with extensive experience for the APWCA Insurance Committee. This Committee has taken on the initiative of helping APWCA become an increasingly heard and increasingly effective voice to appropriate agencies and insurance companies on reimbursement, coding and related issues. The Committee is also dedicated to keeping our members more and more updated on regulations, guidelines for documentation and proper billing/coding that can assist all of us in enhancing the bottom line. The Committee is chaired by Sharon Baranoski, MSN, DAPWCA. Serving on the Committee with her is Kathleen Schaum, MS, AAPWCA, Thomas Serena, MD, FAPWCA; Elizabeth Ayello, RN, PhD, FAPWCA; Paul Kesselman, DPM, FAPWCA; Barbara Aung, DPM, FAPWCA and recently added to the Committee is the very knowledgeable Gerit

Mulder, DPM, FAPWCA. This Committee's membership represents a powerhouse of knowledge and experience which potentially places this Association as one, if not, the most effective provider advocacy organization on the playing field.

We recently sent a letter to President Obama and you can see in another article in this issue, including the unexpected reply. There are many other administrative features and additional news that you will find as you read through this issue of Synergy. In closing, and as a personal note, I am very much looking forward to the newly structured Board of Directors. That said, I'm sure many of you realize how closely Dr. Gunther and I have worked over the past 8 years. He is, in a word, a "Gentleman", bright, quick at assessing the situation on his feet and extremely knowledgeable about Wound Care after over 30 years of practice in this field. He has spent countless hours on behalf of this Association and all of us owe him a debt of gratitude for his dedication to the APWCA. I look forward to continuing to work with him and benefiting from his insight and perspective as he moves out of "the hot seat" and assumes the position of Immediate Past President - Steven R. Kravitz, DPM, FAPWCA, FACFAS



## Late Breaking News

### CPT codes finally included for the Application of below knee multi-layer venous wound compression system

Marcia Nusgart, RPh, APWCA member reports that the AMA recently released its CPT codes, and finally the code for "Application of multi-layer venous wound compression system, below the knee" was included. The code is 29581 and will be in effect January 1, 2010. **The 29581 CPT code was assigned to an APC group 0058 which has a reimbursement rate of \$71.03 for 2010.**

This is something which APWCA has worked on for the past several years along with the Alliance of Wound Care Stakeholders

for which Ms. Nusgart serves as executive director. We all thank and congratulate the Society of Vascular Surgeons (SVS) who submitted the application for their leadership and to all others involved.

APWCA believes our next challenge will be to ensure that the Medicare MACs are knowledgeable about this new code. If you are having problems with your regional MAC, contact APWCA. Also look for more detailed information in upcoming APWCA



eMail News updates as it becomes available or necessary.

This CPT report is abbreviated from our November "APWCA eMail News Update" with our new format that includes "Association News" and a section on "News

You Can Use". Stay on top of Association happenings and Wound Care news. Read these email monthly reports and if you are not receiving them, sign up today by calling the APWCA office at 215-364-4100.

# A note from the President

David Brotman, MD, FAPWCA

It was 10 years ago, soon after I presented at one of his Diabetic Foot Care meetings, that Dr. Steven Kravitz asked me to join the Board of his fledgling Wound Care organization as a member-at-large. I couldn't imagine how such a position with such an "insignificant" association could involve much work, or could have much benefit or importance.

A lot has happened in ten years! I have marveled at the maturation of what is now a superb yearly national conference, witnessed first hand the mobilization of this organization on the insurance/government regulatory battlefield, and enjoyed interacting with students whose clinical and professional development have been aided by APWCA's linkage through student Wound Care organizations. I have enthusiastically assisted in the promotion of advanced physician credentialing to pave the way, someday, for recognition of Wound Care as an independent specialty, stood in awe as the top physicians, nurses, therapists and other health care workers walked into our conferences and meetings to join our ranks, and thrilled as the APWCA emerged as THE organization to promote and represent our Wound Care specialty and those of us who take care of the smelliest, ugliest, toughest wound problems day in and day out. In short, I have seen Dr. Kravitz's dream become the dominant multidisciplinary professional Wound Care organization in America!



It is, therefore, with great pride and pleasure that I accept the role of President of the APWCA and look forward to contributing even more to the further development and success of this great organization. Following in Dr. Robert Gunther's footsteps (no podiatric pun intended) won't be easy, for he was instrumental in guiding the APWCA to its current impressive stature.

Trained as a General Surgeon followed by a Vascular Surgery fellowship, my involvement in Wound Care grew out of a natural relationship with those specialties, coupled with the growing need for such care in the community. Participation in the APWCA (perhaps a bit reluctantly at first) opened my eyes

to the opportunities to improve both the care of patients (through education of health care workers, students, patients and their caretakers) and the environment in which we work. Collaboration with other organizations and Wound Care specialists, participation in discussions with

CMS and other regulatory agencies, and promotion of credentialing pathways demonstrate APWCA's commitment to healing both patients' wounds and those being inflicted on the practitioners of medicine today.

I look forward to working with Dr. Kravitz and the new/existing members of our Board in serving you and our organization, building upon its successful framework, and fostering pride in (and value of) the APWCA. Onward!

## the importance and benefits of membership

The APWCA mission is to enhance the care of all wounds including acute, chronic, post surgical, post radiation, reconstructive, and other problematic wounds. Our goal is to decrease the incidents of sequella, including major amputations and dysfunctions, while improving the quality of life suffering from these complex needs. This mission is accomplished through an interdisciplinary approach: clinical care, professional education and patient advocacy... We can accomplish a great deal working together!

APWCA serves as an educational resource to healthcare professionals, patients, care givers, health care systems and medical organizations.

Membership is encouraged for all physicians and other healthcare providers actively involved in Wound Care. This includes, but is not limited to, plastic surgeons, vascular surgeons, podiatrists, general surgeons, nurses, orthopedists, infectious disease specialists, internists, nutritionists and more.

Membership benefits include:

- Synergy Newsletter & Monthly eNews Updates
- Advances in Skin & Wound Care (MedLine Indexed Peer Review Journal)
- Fellow, Diplomate or Associate designation
- Consultation services
- Discounts to regional & national Association sponsored events, including APWCA2010
- Interaction with insurance companies to optimize the ability to provide services and reimbursement at appropriate levels
- Forum for networking
- Ability to demonstrate your interest in Wound Care to the healthcare companies and the public at large

*To find out more ways on how you can become a Member and support the APWCA please contact our office at **215.364.4100** or visit our website at **[www.apwca.org](http://www.apwca.org)***

### Help Us Help You...

- Contact the APWCA to coordinate a regional meeting with your hospital or wound center
- We continue to grow our Student Chapters. Let the Association know if you're interested in more information.

# A message from Dr. Robert Gunther

I am proud to have served the 3,000 members of the APWCA. I will remain on the Board of Directors as the immediate past president and look forward to working with the new President, Dr. David Brotman

I am proud to have served you, the membership as president of the American Professional Wound Care Association. We have come a long way since publishing the first issue of our newsletter Synergy on October 18th, 2001 on printers in the APWCA office. In the early years board members and staff sometimes stayed up all night printing, folding, attaching labels and mailing the newsletter. On December 29th, 2001, I appointed Dr. Larry Schuster as editor. Today under his direction, Synergy has become our professional newsletter. But Synergy is not simply the name of our newsletter, "synergy" has taken on a broader dimension for our Association. It represents the manner in which the different members of the Wound Care team work together to obtain optimal results. It also represents the manner in which our multidisciplinary Board of Directors, Executive Director/Founder and membership work together to make the APWCA the fastest growing multidisciplinary Wound Care association in the United States.

This synergy has allowed the evolution of our National meeting to be the model for others. Our National Conference, Wound Care and the Related Sciences is the only association-sponsored event (i.e., neither sponsored by a university nor publishing company) The APWCA offers World-Class Wound Care Education: covering all aspects of clinical practice. We have grown from a meeting room holding 60 attendees to one that holds as many as a 1,000. Now the attendees represent all corners of the United States and numerous other countries. The Scientific Committee does a tremendous job of creating multidisciplinary programming with interdisciplinary interaction. Every year the Committee, under the leadership of Dr. Steven Kravitz, plans a conference with new clinically relevant content that participants can apply in daily practice as soon as they return to their office/health care setting.

Education occurs day in and day out throughout the nation and world. The APWCA has extended its educational arm by reaching out to members and non-members alike through seminars in Anchorage, Los Angeles and Seattle. This year "The Essentials of Wound Care," a review course which also serves as certification exam preparation was introduced with lecturers who have been

APWCA faculty for many years and will be teaching at our National Meeting.

At the APWCA2009 such subjects as "New Life for Dying Cells," and "Critical Limb Ischemia", were covered. At APWCA 2010 such topics as "Regenerative Medicine: Molecules You Should Know About," "Skin Repair & Regeneration, Stem Cell Research and Implications" and the Annual Scientific Address "Can We Slow Skin Aging Process? How does that Effect Disease?" will be addressed by the eminent leaders in Wound Care. The APWCA is proud to have been one of five hosting societies worldwide for the third congress of the World Union of Wound Healing Societies (WUWHS) which was held in Toronto. As a hosting society, the APWCA aided the WUWHS to accomplish the primary goal of the third congress to present the Wound Care evidence base and transfer the knowledge, skills and attitudes for improved patient outcomes.

The APWCA could not have grown to its current stature in the world of Wound Care if it had not built relationships with other illustrious partners throughout the world including: the American College of Hyperbaric Medicine (ACHM), the Veith Symposium. iLex-Biba, and New Cardiovascular Horizons.

As an extension of this, I would be amiss if I didn't thank our corporate supporters who manufacture the innovative dressings, antibiotics, medications and myriad supplies that have provided our patients an excellent chance for these wounds to resolve. Their financial support helps fund your educational programs.

Let me conclude by restating that I am proud to have served the 3,000 members of the APWCA and I am remaining on the Board of Directors as the immediate past president. I look forward to working with the new President, Dr. David Brotman who has been involved with the APWCA since the early years. He will lead the Association through the challenging, but dynamic and exciting times facing health care. I want to acknowledge the commitment that Dr. Steven Kravitz has made to the Association as well as the APWCA's Board of Directors and Medical Advisory Board, who have been a force that has moved the APWCA forward in dealing with all aspects of Wound Care specifically and health care in general.

## THE ESSENTIALS: APWCA WOUND CARE REVIEW COURSE

**JANUARY 16-17 • LOS ANGELES, CA**

Covers Wound Care management and effects from systematic conditions that impact care.

Seating is Limited!

Register Today at [www.apwca.org](http://www.apwca.org)  
or call 215.364.4100

## SCALE Final Consensus

Following over a year and a half of effort, the SCALE Panel is pleased to announce the release of the Skin Changes At Life's End (SCALE) Final Consensus Statement. An international panel of 18 members developed the document that was then peer reviewed by 51 Distinguished Reviewers from around the world. The final document went through a modified Delphi process and has been submitted for publication to wound, geriatric and hospice journals.

The SCALE Final Consensus Statement and an Annotated Reference List can be downloaded free of charge from: [www.gaymar.com](http://www.gaymar.com) > Clinical Support and Education > SCALE Consensus Documents.

Please share this important document with colleagues and stakeholders.

# THE PHYSICIANS ROLE

## Ensuring Our Patients Receive Appropriate Durable Medical Equipment



Wound Care professionals have seen an increase in the number of surgical dressings and Negative Pressure Wound Therapy (NPWT) is quickly becoming the standard of care for many wounds. This has resulted in a significant increase in expenditures by all Third Party Administrators (TPA) for wound care related Durable Medical Equipment (DME) products.

Unfortunately this has also resulted in attracting unscrupulous DME suppliers who see this as an easy way to defraud Medicare and other TPA.

Some estimates that overall DME fraud averages 25% and is upwards of 50% for certain DME products. The Office of Inspector General (OIG) has targeted DME claims for review in order to reduce the fraud and abuse. Specifically, DME claims requiring modifiers (e.g. K.X.) are being targeted by O.I.G. and other agencies entrusted with claims review.

The honest DME supplier is caught in a catch 22. Our mutual patients believe that a physician's prescription will satisfy Medicare or their TPA requirements for DME. This however, is not true and the prescription to the DME supplier is insufficient proof of medical necessity for DME products and services. Communication from the DME supplier to the physician is also not considered documentation of medical necessity.

DME suppliers are now more than ever reliant on physicians properly documenting medical necessity and providing them with this information upon request.

Medicare requires that the prescribing (ordering) physician properly document medical necessity for all prescribed DME

devices. Any Certificates of Medical Necessity or order forms provided by the DME supplier must contain information consistent with your patient's chart.

The honest DME supplier will understand reimbursement regulations for DME products and should provide you with a brief summary prior to filling your prescription. The honest DME supplier will not tell you what to write or to change your documentation. Your chart should contain your rationale for the DME device. The prescription(s) should contain the patient's diagnoses (ICD9) and the number of days you expect them to require the device. One should be sure to document any co-morbidities which may impede the patient's ability to heal, their ability to use the device as well as any non compliance issues.

The DME supplier should provide you with a copy of their bill along with explanations of the product (HCPCS) codes and modifiers (e.g. KX), ICD9 and amount dispensed of each product. The KX modifier stipulates that the supplier has the medical documentation to prove medical necessity. This information is provided in the carrier's coverage policy, often referred to as a Local Carrier Decision (LCD).

DME orders containing inconsistencies with prescriptions and medical charts should be returned to the supplier unsigned noting your rationale for refusal to sign.

Suppliers may request copies of your patient's chart or letter of medical necessity. Medicare and most TPA require that you provide this at no charge to the patient or supplier. Your patient should also be informed of this potential request. Consent should be obtained from the patient prior to sending a

copy of their records to the DME supplier. One should remove any HIV or psychiatric history from the photocopy if the patient wishes this not be forwarded to the DME supplier. If the patient does wish to have this information forwarded, a special consent form authorizing release of this information is required.

Prescribers should work with reputable companies which have been in business for some time and have a physical plant. One may also inquire about their Surety Bond and other references confirming compliance with Medicare and other TPA regulations.

Be wary of companies enticing you or your staff with finder's fees, gifts, free vacations, or trips which are non-educational and primarily leisure in nature.

Do not refer to suppliers who are immediate family, relatives or to companies which you are an owner. This may be a violation of the Stark anti-kickback regulations and often will trigger an OIG investigation.

Never sign pre-filled orders sent to you by an unfamiliar DME supplier or for patient's or conditions you are unfamiliar with. Be especially leery of forms which have a diagnosis you cannot substantiate.

DME suppliers are our partners in health care. The benefits of surgical dressings, NPWT and other wound care DME have increased the success rates of our limb salvage procedures. Providing our DME suppliers with proper documentation ensures their ability to provide patients with medically necessary products. Responsible prescribing will keep the OIG and other governmental agencies out of your office.

## Job Posting: General Surgeon



The Department of Surgery at NYU Langone Medical Center is seeking to recruit a General Surgeon, for The Helen & Martin Kimmel Division of Wound Healing & Regenerative Medicine under the direction and leadership of Harold Brem, MD. The Division of Wound Healing is seeking a general surgeon with an exclusive practice for non-healing wounds for treatment of long term non-healing surgical wounds, specifically pressure ulcers, venous ulcers, diabetic foot ulcers. They will spend approximately three days a week in main OR and one to two days in wound center. Academic rank will be consistent with experience. The Helen & Martin Kimmel Division of Wound Healing & Regenerative Medicine is a highly academic practice and environment focusing on Regenerative Medicine. It is a highly collaborative group of general, plastic surgeons and vascular surgeons. Interested individuals should send their CV to the Helen and Martin Kimmel Program Manager Tracy Henry via email to [tracy.henry@nyumc.org](mailto:tracy.henry@nyumc.org).

“APWCA2010 promises to be the largest national meeting to date and will provide a comprehensive picture on a full scope of practice options.”

APWCA2010, continued from page 1

Wound Infected? What is best practice to assess and manage? Are new drugs for bugs any better?” It will be marked with quick moving lectures and an interactive panel discussion by Biba Medical, our European affiliated partner. The APWCA Annual Scientific Address as planned will have new animated video of cellular metabolism that will amaze you and provide a new perspective on the microbiological aspect of Wound Care and its relation to the health or lack thereof to all body soft tissue systems. Lectures on “Tissue Regenerative Medicine”, sessions on “New Technologies and their value or lack thereof for a Current Clinical Practice” are other examples of a vast variety of topics that can be carried to bedside. The ACHM will offer a separate session on new perspectives on hyperbaric oxygen therapy and the diabetic foot. Poster and oral abstract sessions, social activities with a relaxing poster reception, many meals provided, a great center city hotel with abundant amenities and more will highlight this major educational event.

APWCA2010 promises to be the largest national meeting to date and will provide a comprehensive picture on a full scope of practice options. It will also feature patient treatment and management concepts that will keep registrants current with the best practices. All of this plus...a Post Conference optional course at no additional fee on the Business of Wound Care, covering a host of topics including the art of coding and billing to maintain a healthy bottom line. Register early as pre-conference courses will have limited seating. Be sure to check out the wide selection of courses offered to cover the needs of the new provider of Wound Care as well as those with years of experience. This is the meeting that has something for everyone!

Learn more at [www.apwca.org/apwca2010](http://www.apwca.org/apwca2010)

## TIP & PEARLS

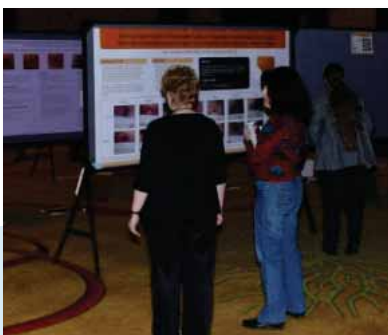
### To improve your bottom line

The following article expresses the recommendations of the author. This article has not been reviewed by the APWCA Board of Directors and therefore is not meant to represent the official opinion of the Association. That said, we believe this new monthly section of APWCA email news update will be a valuable asset to serve as a communications mechanism so members can share techniques or methods they use for diagnosis, management, billing/coding, documentation or other similar areas of daily practice.

Many LCDs working with Medicare (CMS) require that “necrotic tissue” be present for skin ulcer debridement to be a covered service. There are, however, instances where “necrotic tissue” may or may not be present as other circumstances regarding the wound make debridement not only justifiable but necessary to optimize the wound healing ability of the

patient. Wound margins with “rolled edges” or “undermining” are examples where debridement to clean viable wound margins is required and consistent with best practice guidelines. The provider in such instances should bill accordingly to size, etc., and clearly document the “rolled edges” or “undermining” (etc) using suggested terms as “non-reparative” or “non-viable” tissue. - Robert Bartlett, MD, FAPWCA

The APWCA recommends each member contact their LCD if further clarification is needed or there are any questions regarding billing policies regarding the above “tip and pearl” and their particular LCD. Furthermore, if an APWCA member is experiencing problems in working with their geographic LCD he or she should contact APWCA so we have an opportunity to assist and possibly intervene and/or provide advice.



## Call for Abstracts

**Oral and Poster Abstract applications now being accepted for APWCA2010**

Participate in the APWCA 2010 scientific program by presenting a Poster or Oral abstract. All material is now available online for Abstract Guidelines, Submission dates, and application.

For more information visit:  
<http://www.apwca.org/abstracts>

### APWCA2010 Event Update

The Honorable Scott A. Petri, Pennsylvania State Representative 178th District will speak on Medical malpractice reform and how it relates to rising healthcare costs during the annual meeting of the membership. The presentation and the membership meeting are open to all registrants.

# COUNCIL FOR MEDICAL EDUCATION & TESTING

## The physicians' choice for physician specific certification in Wound Care

Members continue to have inquiries concerning the difference between the CMET Certification and other certifications available. In short they ask “why should a Physician’s first choice for physician specific certification in Wound Care be the CMET exam? Is multidisciplinary certification of value?”

There are many reasons for a physician to select the CMET as “The certification of choice”. That is not to say that multidisciplinary certification is not also of value. However until CMET was formed the multidisciplinary exams were the only certification available for physicians, while nurses for many years have had two options, including the nurse-specific WOCN certification. With the advent of CMET, physicians are now for the FIRST TIME offered an additional certification that is physician specific, and by a physician specific organization. APWCA endorses that process in an attempt to help move “Wound Care” forward toward specialty recognition as explained below.

Here are some of the top reasons cited by those who have become “Physicians Certified in Wound Care-CMET:”

1. The CMET Exam - developed by physicians for physicians. This exam was created in response to credentialing committees that requested physician specific certification. CMET is the only physician specific organization in Wound Care. No other organization can make that claim.
2. The CMET Exam - the first certification to be physician specific. It is peer produced, peer proven. The examination has gone through multiple beta testing and critical analysis of questions by practicing physicians so that the exam is relevant to current standards of daily practice.
3. TRUE PHYSICIAN BOARD CERTIFICATION IN WOUND CARE is not yet available today. The CMET Exam is the first step - paving the way for specialty growth. CMET goal is specialty recognition in Wound Care which traditionally has been accomplished by physician specific organizations to date. That is the reason CMET was formed. See paragraph below for additional information.



4. The CMET Exam - the professional’s mark of achievement, the public seal of quality care, and foundation for specialty recognition.
5. There are no dues or membership fee for CMET as is found with other certifying organizations in Wound Care. Those certified by CMET do not have to worry about revoking certification status because dues are not being paid.
6. American Professional Wound Care Association (APWCA), which endorses the CMET exam, is approaching 3,000 active members and represents more physicians and podiatrists than any other US Wound Care Organization. [www.apwca.org](http://www.apwca.org)
7. American College of Hyperbaric Medicine (ACHM) recognizes the CMET exam as the physician certification in Wound Care.

Certification is becoming increasingly important as more hospitals and wound healing centers look for credentials. This observation, combined

with the facts above, we believe gives the CMET examination a bright and growing future. Additionally, keep in mind that Wound Care is not a physician recognized specialty in medicine today. Specialty recognition requires allopathic medicine through the American Board of Medical Specialties (ABMS) to approve Wound Care and with this the funding of residencies and fellowships in the subject area through Medicare. This is a CMET goal. Obtaining a critical mass of CMET certified physicians can be a critical

factor in demonstrating to the required agencies that there is an interest in this area of clinical practice. Being dedicated and arduous to the task we believe future specialty recognition can ultimately be obtained. The CMET is committed to moving the process forward and realizes that there will be many challenges, much work to do and likely considerable expense. That said APWCA and ACHM believe that CMET as a physician specific organization can be very helpful in achieving the goal of specialty recognition in Wound Care. Sitting for the CMET exam not only provides physician specific certification but also supports the CMET in achieving the goal of specialty recognition!!!

Should you have further questions or comments, do not hesitate to contact the CMET at the following [www.CouncilMET.org](http://www.CouncilMET.org) or contact 215-364-4100 or [Info@CouncilMET.org](mailto:Info@CouncilMET.org)

## APWCA continually seeking growth and new members

### APWCA, “Synergy of Disciplines in Wound Care”

**All types of wound care providers are vital to the goals, objectives and the principles on which this Association was founded.** The CMET is a totally different organization than the APWCA, separate Board of Directors with separate funding. That organization is physician specific for Wound Care certification just as WOCN is a nursing organization. **APWCA is the leader in promoting a synergistic quality that represents best practice and best outcomes for Wound Care patients.** So join with our Board of Directors and commit to bringing in one new member this year. There is not a more cost effective organization in Wound Care providing education, provider and patient advocacy.



## Update from San Antonio

### Clinical Symposium on Advances in Skin and Wound Care

The 24th Annual Clinical Symposium on Advances in Skin and Wound Care held from October 22 through 25 in San Antonio, Texas gave APWCA its largest presence since we have affiliated with the conference both in number of affiliated courses as well as numbers of faculty. Unsolicited comments from over 1,000 attendees praised the quality of the lectures throughout the entire scientific program. APWCA presented two 3.5 hour tracks during pre-conference proceedings on off-loading and another on evidence based management of the diabetic foot. APWCA member faculty included Jeff Niezgoda, Robert Bartlett, Adrienne Smith, Kendrick Whitney, Lesly Robinson, Kathya Zinszer, Gary Sibbald, Elizabeth Ayello, Ira Herman, Kathleen Schaum, Kevin Woo, Steven Kravitz, the chair of this conference Sharon Baranoski and Tom Serena who was honored by giving a terrific last lecture that closed the scientific proceedings.

APWCA looks forward to an ongoing growing relationship with this conference which was started 24 years ago as the FIRST of its kind under the direction of Sharon Baranoski. It is recognized as the conference where organized Wound Care education started. APWCA Board Member, Sharon Baranoski is recognized as a leader in Wound Care education, as it was under her tutelage and through her foresight that conferences in this area of medicine began. Mark your calendars for The 25th Annual Clinical Symposium on Advances in Skin and Wound Care held from September 29 - October 3, 2010 in Gaylord Opryland Resort & Convention Center, Nashville, Tennessee.

## Represented in Thailand

### Meeting of the Royal College of Surgeons of Thailand

Recently, Gerit D. Mulder, DPM, MS, FAPWCA, FRCST and Daniel K. Lee, DPM, FACFAS, from UCSD School of Medicine, Dept of Surgery/Trauma and Orthopaedics participated in the 2009 Annual Scientific Meeting of the Royal College of Surgeons of Thailand as key invited speakers in advancing Wound Care. In 2008, Dr. Mulder was the first DPM to receive the honorary Fellowship into the Royal College of Surgeons of Thailand, and it was his fifth time speaking this conference as invited speaker.

During this annual meeting, Drs. Mulder and Lee also organized and directed the 2nd Annual Advanced Wound Care Course in Bangkok, Thailand at Siriraj Hospital of Mahidol University Medical School. Over 150 general, orthopaedic and vascular surgeons attended this course, from Thailand, Malaysia, Singapore, Laos, Hong Kong, India, Dubai and United Arab Emirates. This conference included lectures, hands-on workshops and cadaver surgery in wounds, surgery, Charcot reconstruction, and limb salvage. Southeast Asia is reported to have a limb amputation every 30 seconds. The conference lectures and course were extremely well received by the audience of physicians and surgeons dealing with vital limb salvage and complicated, difficult wound pathologies.

Drs. Lee and Mulder are both full time faculty at UCSD and are extensively involved in numerous international programs and projects involving all aspects of Wound Care, tissue repair as well as reconstructive surgery of the diabetic foot. They are both extensively involved in national and international research, education and lecturing.



## iLegx Seminar Munich, Germany

The iLegx seminar held by BIBA Medical, in collaboration with the APWCA, that was held October 13-14 in Munich, Germany was an overwhelming success! Physicians from all over Europe participated. We estimated about 250 attendees based on our prospective. There were several APWCA registrants and faculty members participating including Drs. Dieter Mayer and Michael Edmunds, who are both Fellows of the American Professional Wound Care Association and program directors. Dr. Steven Kravitz, Executive Director, also participated with a report on Skin Profusion Pressure.

Side trips of the APWCA registrants included trips to the Olympic site, BMW, DUCHAEL Concentration Camp, and the new and one of the largest synagogues in all of Europe. There were also tours through downtown Munich which was the location of the hotel and of course great opportunities for dining at the haubrau house. The scientific program was quick and firing with 10 minute presentations followed by questions and answers. The APWCA affiliated meeting in 2010 will be in London. This should be a great location. Look for future email updates for more information.

### Members in the News

#### World Diabetes Day Celebration at Temple University School of Podiatric Medicine



*Kathya Zinszer, DPM, FAPWCA,  
Philadelphia Mayor Michael Nutter  
and Mark Hinkes, DPM, FAPWCA*

Mark Hinkes, DPM, FAPWCA, holding his new book "Keep the Legs You Stand On," is seen with Kathya Zinszer, DPM, FAPWCA and Physician Certified in Wound Care-CMET. Dr. Zinszer is Chair, Department of Podiatric Medicine and Podiatric Orthopedics at Temple University School of Podiatric Medicine (TUSPM). Dr. Hinkes was visiting TUSPM during World Diabetes Day (WDD), held November 14. Dr. Zinszer has created, and now chairs, a major program at the school for WDD which attracts thousands from around the Philadelphia area and has become a City landmark event.

# THE BASIC PRINCIPLES

## of Hyperbaric Oxygen (HBO) in Wound Healing

### INTRODUCTION:

With the advent of the many therapies and medications available to the modern practitioner, this paper is meant to be a “primer” of sorts in the quest to demystify the use of HBO for wound healing. The selection of this modality as an adjunctive therapy is becoming increasingly popular in the treatment of wounds that are indolent and refractory to other forms of therapy.

HBO should be utilized in an appropriate setting with an understanding of its indications as well as its limitations. Experimental or “off-label” use may be considered in a particularly challenging case, with the understanding that it may not be reimbursed.

### DEFINITION:

The use of 100% oxygen breathed in at an increased atmospheric pressure. By definition this also implies that the patient be enclosed in some form of a pressure vessel and, for clinical benefit, subjected to a pressure that is at least 1.5 times the pressure at sea level or the ambient pressure at the location.

### HISTORY:

The history of the use of a form of HBO dates as far back as the 1600’s when an apparatus called a “Henshaw Domicilium” was utilized. It consisted of organ bellows and valves and was allegedly capable of producing a hypobaric as well as hyperbaric environment. Of course Henshaw had no concept of oxygen since it was discovered in 1773 by Carl William Scheele and the term Oxygen was coined by Antoine Lavoisier in 1777. Throughout the 1800’s and 1900’s there was some interest in HBO. Fontaine in France (1800’s) and Cunningham in Kansas (1920’s) treated asthma, bronchitis and generalized breathing maladies with forms of HBO. In the 1900’s Shaw and Behinke realized its efficacy in the treatment of “decompression sickness”.

### HYPOXIA and WOUND HEALING:

The rate at which a wound heals is oxygen

reliant. With an alteration of this oxygen component there exists the potential for pathologic consequences. The amount of oxygen at a given wound site is measured in millimeters of mercury (mm Hg) and the normal pressure in a wound environment is expected to be around 40 mm Hg. Peri-wound hypoxia alters the response to infection as well as the mechanisms of tissue repair. Kavian (Diabetic Care 1999;22(1): 147-151 describes established ranges of therapeutic values for PO<sub>2</sub> at a wound site. The threshold of 25 mm/hg is the minimum required for wound healing.

### MECHANISM OF ACTION:

Within the inflammatory phase of wound healing there exists the need for oxygen to facilitate oxidative cellular mechanisms. During normal wound healing fibroblasts are stimulated to make collagen which supports the development of a collagen matrix. This forms the scaffolding that supports angiogenesis. This neovascularization enables the delivery of oxygen and other wound healing elements which are essential for resolution of the wound. It must be reiterated that the probability for healing is increased if the tissue oxygen tension in a wound site is 40mm/hg or higher. Additionally, co-morbidities of each individual patient must be taken into consideration in any utilization of HBO therapy. As oxygen is introduced into the wound region (through arterioles and capillaries) it migrates from areas of higher concentration to areas of lower concentration. Wounds naturally have a central zone that is hypoxic. The improved migration of oxygen to this central hypoxic area facilitates angiogenesis. If a good oxygen gradient cannot be established to “encourage” diffusion into the wound, there is continuance of central zone hypoxia and lack of healing.

Oxygen is also an important component of cell mediated immunity. Neutrophils and polymorphonuclear cells lose their ability to fight infection as the PO<sub>2</sub> falls below

30mm Hg. The white cells’ bactericidal effect decreases geometrically as PO<sub>2</sub> falls below 40mm Hg. Diminished oxygen tension also inhibits production of vascular endothelial growth factor (VEGF), further compromising angiogenesis and revascularization. In addition, macrophage action is altered as well as the delivery of antibiotics to the wound site.

### PHYSIOLOGY AND BENEFITS OF HBO:

The hyperbaric pressure increases the amount of oxygen dissolved within the plasma. During Hyperbaric Oxygen Therapy the malperfused peri-wound tissue is hyperoxygenated under pressure so that an oxygen diffusion gradient is established to the central hypoxic wound area. Improved wound tissue oxygenation, augmented cellular bactericidal effects, and other mechanisms (nitric oxide and free radical scavenger pathways, growth factor modulation) result in improved wound healing (see: Bonanno, Davidson, Mustoe etal, Undersea Hyperbaric Medicine 1998: 25(4) 211-216).

### CAUTIONS and LIMITATIONS:

A full course of HBO therapy is costly, and Medicare (and other third-party payors) often restrict reimbursement to evidence-based therapy for a limited group of conditions, including Wagner Grade III or IV diabetic foot wounds, refractory osteomyelitis, and acute ischemia not correctible by revascularization alone. Complications include ear drum perforation, pneumothorax, rarely seizures, and temporary inability to optimally treat acute, serious other conditions (e.g. cardiac arrest).

### SUMMARY:

Hyperbaric oxygen therapy is a useful adjunct to treating difficult wounds in certain clinical situations, as long as risks and benefits are considered and therapy is provided in an appropriate facility, by experienced, appropriately-trained clinicians and staff.

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- Up to 14.75 CME/CNE Credits
- Multiple case studies on the business of Wound Care
- Billing and Coding strategies

# Association Resources

## Show Your Support!

### LAPEL PINS AND PATCHES

The lab coat patches are very attractive color embroidered patches for sleeve or front of lab coat with APWCA logo and the motto "Synergy of Disciplines in Wound Care". Wear these proudly on dress sport coats as well as lab coats. Our acronym, "APWCA" in center with the phrase "Synergy in Wound Care" or "Synergy in Disciplines" peripheral around pin border



### POWER POINT SLIDES FOR WOUND CARE LECTURES

PowerPoint CD with nearly 100 slides, "Fundamentals of Wound Care" is available. Nearly 100 word slides with many photographs. \$100.00 plus tax (\$106.00) for members and \$250.00 plus tax (\$265.00) for non-members. Allow 4 to 6 weeks for normal delivery. Expedited 10 day turn around out to mail, additional \$25.00.

### PATIENT BROCHURES

Brochures are now available to distribute to patients, place in waiting room, etc. They explain the benefits you as a provider offer patients through your membership. These can be purchased through the APWCA at a nominal fee of \$30.00 per 100 copies (includes \$25.00/100 plus \$5.00 for tax, shipping and handling). Charge card orders can only be processed by phone or fax. Until then, drop us a line and call us or fax your request.

For more information contact our office at 215-364-4100 or eMail [wounds@apwca.org](mailto:wounds@apwca.org)



# Conception of APWCAi

It was in the year 2005, that I presented my oral abstract at the American Diabetes Association meeting in San Diego, California. Right after my presentation, a well dressed gentleman came up to me and introduced himself as Steve Kravitz, Executive Director, APWCA. He invited me to be a faculty speaker at APWCA 2006 meeting at Philadelphia. This was indeed an honor for me. I accepted the invitation and made my presentation at APWCA 2006.

During this meeting, Steve asked for my opinion regarding how to take APWCA beyond America. In

other words, what shall we do to have delegates for APWCA Annual conference, coming from far off Asian and African countries. I suggested him to develop a separate division of APWCA which shall focus on APWCA activities beyond America. Since then, till now, I and Steve have been in touch and finally we are giving shape to this new body, which shall be called APWCAi. The small 'i' represents International.

APWCAi shall have colleagues working at different levels. Global head would be the Chairman, followed by Regional Heads (1 for each continent), followed by Country Heads and Representatives. A number of activities like medical conferences, camps, education programs and others shall be organized in different parts of the world, under the banner of APWCAi. This will be managed by the APWCAi heads and representative in that area in collaboration with local diabetes or Wound Care association. Through such events, on one hand, fruitful exchange of knowledge and experience will take place, and on the other, this will take APWCA to different corners of the world.

Such an effort is especially important for the developing countries. For example, the condition of diabetic foot care in the developing countries is of great concern. Every 30 seconds, a lower limb is lost as a consequence of diabetes. Today, diabetes mellitus is a global epidemic with a major impact on the developing countries. The World Health Organization (WHO) predicts that approximately 80 percent of all new cases of diabetes are expected to occur in the developing countries. Africa is likely to experience the highest increase in prevalence of diabetes in the world, estimated at 98% between 2003 and 2025 with a projected 26.9 million individuals with diabetes in Africa by 2025. With approximately 42 million people with diabetes, India heads the list of 10 most affected nations in the world. Current estimates indicate that India shall continue to hold the same position even in 2025.

The U.S. population is fortunate, when it comes to the availability of specialized medical services. Consider the following statistics. There are currently 24 million people in the United States who have diabetes whereas there are 42 million people in India who have the disease. Eight percent of the worldwide diabetes population live in the U.S. yet the U.S. spends more than 50 percent of all global expenditures for diabetes care. On the other hand, only 10 percent of the 1.3 billion population in India have medical insurance coverage and more than 80 million people in India go to bed hungry. In the U.S., there are currently ten schools of podiatric medicine and reportedly over 13,000 podiatrists offer foot care services. India has the maximum number of people with diabetes, but not even a single DPM Podiatrist. This situation is similar in a number of African and Middle East countries. In 1820, the average European worker earned about three times what the average African did. Now, the average European earns twenty times what the average African does.

APWCAi will take the expertise of Podiatry and Wound Care to different corners of the world. In years to come, this will help prevent amputations and improve the standards of Wound Care across the globe.



Dr. Kshitij Shankhdhar with Dr. Steven Kravitz  
June 2005, San Diego, California

# CLINICAL DOCUMENTATION UPDATE

## Why Clinical Documentation is so important for Pressure Ulcer Coding in Acute Care

by Elizabeth A. Ayello, PhD, RN, ACNS-BC, FAPWCA, FAAN

It has been over a year now since the financial implications of the Centers for Medicare and Medicaid Services (CMS) Present On Admission (POA) rulings for pressure ulcers went into effect for all but a few hospitals under the inpatient prospective payment system (IPPS) (See Table 1 on APWCA website). As most coders and clinicians know, as of October 1, 2008, CMS no longer pays the higher DRG for pressure ulcers acquired during a hospitalization. Also, only stage III and IV pressure ulcers that are present on admission and appropriately documented are eligible for the higher DRG payment. This change underscores the importance of adequate documentation of **both** the location and stage of a pressure ulcer by the CMS defined provider so the coder can extract both of these required descriptors for billing purposes. CMS defines provider as “MD or any qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis.”

Pressure ulcers are only one of the current 11 Present On Admission conditions (see Table 2 on APWCA website). **Present On Admission (POA)** is defined as “present at the time the order for inpatient admission occurs”. As indicated on the CMS website, “*conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA*”.

Coders must now submit **two codes** to completely describe a pressure ulcer. They are the **site** (codes 707.01-09) of the pressure ulcer and the **stage** (codes 707.20-.25) of the pressure ulcer. Therefore, the CMS provider must identify and document both the location and stage of any pressure ulcer POA in order for the coder to extract all this information from the medical record. Coders may query providers to clarify the site or stage of the pressure ulcer. Legible, clear, accurate clinical documentation is of the utmost importance.



In the past, coders have had ICD-9 CM codes for only pressure ulcer sites (see Table 2 on APWCA website). Six new ICD-9-CM codes for pressure ulcer stage were recently added (see Table 3 on APWCA website). CMS uses the term “unspecified” to mean that the provider has not documented the site or stage. CMS only pays for hospital acquired conditions (HACs) with the following reported options: “Y” (present at the time of inpatient admission) or “W” (the provider was unable to clinically determine whether the condition was present on admission or not). CMS does not pay for HACs coded with the “N” (not present at the time of inpatient admission) or “U” (documentation is insufficient to determine if the condition is present on admission). Check out more information about coding details on the CMS website at: [http://www.cms.hhs.gov/HospitalAcqCond/05\\_Coding.asp](http://www.cms.hhs.gov/HospitalAcqCond/05_Coding.asp).

As stated on the CMS website (<http://www.cms.hhs.gov/HospitalAcqCond/>), “for discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission, that is, the case will be paid as though the secondary diagnosis were not present.” CMS provides an example of the financial implications of incomplete clinical documentation. On one clinical record, a patient with an intracranial hemorrhage or cerebral infarction (stroke) with MCC- MS DRG 064 has a secondary diagnosis of stage III pressure ulcer (let’s say on the sacrum) POA which is recorded in the provider notes. The stage III pressure ulcer is an “MCC”, or Major Complication. Since both the site and stage (code 707.23) of this POA pressure ulcer are documented, the coder will indicate a “Y” and the hospital reimbursement is \$8,030.28. What happens if the stage III pressure ulcer is not documented as POA? Then the coder is directed to indicate an “N”, and this time the hospital is only reimbursed \$5,347.98. This lower DRG amount reflects a loss of \$2682.30! Therefore, clinicians need to do what they can to prevent pressure ulcers from occurring, as well as document the location (in this case sacrum) and stage (in this case stage III) of POA ulcers. Hospitals need to

review their guidelines for both pressure ulcer prevention protocols and documentation processes, and provide systems that facilitate clinician recording of this vital information.

Providers need education about, and documentation of their clinical competency regarding, differentiating pressure ulcers from other skin injuries and wounds, and the staging of pressure ulcers. There are a variety of educational materials available to assist clinicians including free staging diagrams on the National Pressure Ulcer Advisory Panel ([www.npuap.org](http://www.npuap.org)) website, and a module on pressure ulcer staging on the European Pressure Ulcer Advisory Panel ([www.epuap.org](http://www.epuap.org)) website. The National Database of Nursing Quality Indicators (NDNQI) has a four module training program available on their website (<https://www.nursingquality.org/NDNQIPressureUlcerTraining/Default.aspx>). Module I covers pressure ulcers and staging. Module II is about other wound types and skin injuries. Module III provides information on pressure ulcer survey guidelines. The last of the modules, number IV, differentiates between community versus hospital/unit acquired pressure ulcers. There are several options available with this training program including continuing education credits, no CEU’s or proof of completion with no CEU’s. Some hospitals have found it useful to have providers do this online program and bring in the completion certificate to verify their pressure ulcer staging knowledge. There are also several written and online pressure ulcer educational materials available from industry partners.

In this new era of accountability for pressure ulcers in hospitalized patients, clinicians are challenged to document any pressure ulcers that a patient may have upon admission to the hospital, as well as to prevent any ulcer from occurring during the course of the hospitalization. Providers are urged to consult the CMS website ([www.cms.hhs.gov/HospitalAcqCond](http://www.cms.hhs.gov/HospitalAcqCond)) as their primary reference on hospital acquired conditions for factual and complete information on this topic, as well as any updates. Remember, now more than ever, accurate, consistent and complete clinical documentation of pressure ulcers is essential.

*Dr. Elizabeth A. Ayello is a Faculty member at Excelsior College School of Nursing in Albany, New York and Senior Adviser, the John A Hartford Institute for Geriatric Nursing, New York, New York. Her current research focus is on assessment, education, and treatment of pressure ulcers.*

# Letter to President Obama

A response to a Presidential Town Hall statement regarding physician reimbursement for lower extremity amputations

Changes in the American healthcare system have become a major focus of the APWCA and the citizens of this country. In that regard it is important that when information is presented to the general public that it be correct. The



following quote is taken from a letter that was written to President Obama after the printing of the last Synergy. We expected at least an acknowledgement from the Obama administration. Instead we received a form letter thanking us for support but never mentioning anything about the specifics of our concern. An excerpt from the letter is printed below.

*During a Town Meeting, physician reimbursement for lower extremity amputations was inaccurately stated. Our understanding is that it was suggested that the cost is \$30,000 - \$40,000 "solely" for physician reimbursement. This is incorrect. \$30,000 - \$40,000 (or more) reflects the OVERALL estimated cost for leg amputation including hospitalization, operating room costs, anesthesia, pre-op and post-*

*op care, related imaging studies, as well as a small portion which represents the physician reimbursement. Surgeon reimbursement for major amputations is closer to \$500.00 - \$900.00, and that includes all "routine" postoperative care and visits for up to 90 days. When one considers the surgical operating room time, the time involved in all related routine post-operative care, and the overhead of the surgical practice including malpractice insurance costs, it would appear that the surgeon's reimbursement is extremely "reasonable" and in our opinion under-reimbursed. We suggest that reducing the overall costs involved in lower limb amputation can be best accomplished by adequately reimbursing clinicians for more frequent preventative care and early treatment intervention, and for use of clinically-proven advanced wound care therapies. This includes coverage for appropriate periodic evaluations by podiatrists, endocrinologists, vascular and orthopedic surgeons, family practice and other physicians who have expertise in lower extremity disease, wound risk reduction and wound management.*

*We hope the above information is helpful, and provides an informative perspective as you consider changes in the health care delivery system of the United States.*



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## MEMBERS IN THE NEWS

### 2009 Outstanding Nutrition Entrepreneur Award Winner Dr. Nancy Collins



Nancy Collins, PhD, RD, LD/N, FAPWCA of Weston, FL is the 2009 Outstanding Nutrition Entrepreneur of the Year. The Nutrition Entrepreneurs (NE) Dietetic Practice Group honored Dr. Collins at the annual American Dietetic Association Food & Nutrition Conference & Expo in Denver, Colorado on Saturday evening, October 17, 2009.

Dr. Collins has exemplified the spirit of a true entrepreneur in her twenty year career. She has two distinct loves, both of which are off the traditional path of registered dietitians. Dr. Collins' first love is Wound Care while her second love is technology.

Dr. Collins is nationally known for her work in the Wound Care arena. She has extensively studied the nutritional needs of patients with wounds and the effects of unintended weight loss on healing. She is passionate about educating other health care professionals on these topics and has delivered more than 350 professional lectures on these topics. Dr. Collins is also a prolific author and has numerous publications to her credit. Dr. Collins is an editorial advisor to the journal *Advances in Skin and Wound Care*, a contributing editor to *Ostomy-Wound Management*, and an editorial advisor for *Today's Diet and Nutrition*. She is also member of medical advisory boards including the American Professional Wound Care Association.

## APWCA Member Directory

APWCA Membership Directory is operational, and waiting for YOU! Before we open for access to allow members to search for each other, we need to make sure that the data for each member is correct and that members have the ability to participate or opt-out and not be listed. In that regard, you recently received an email regarding this topic. It contained contact information that we automatically entered based on your existing membership profile. All members will have the ability to modify and/or correct as appropriate and select how their information will be used:



1. Participate with Access to Public at Large & Membership
2. Participate with Access to Membership Only
3. Opt-Out and not participate with the directory (This is the Default)

To Add Your Practice(s) to the Directory,  
visit <http://www.apwca.org/member>

Share your "in the news" success stories with us!  
eMail [wounds@apwca.org](mailto:wounds@apwca.org)

## Incoming Vice President, Dr. Michael Fusaro

In recent years Michael Fusaro, DPM, FAPWCA, helped form and chair the Association's grass roots "House of Delegates" and will continue being instrumental within the organization as Vice President

It was about 10 years ago that I began attending the APWCA Conferences. Although the Conference was a small one at that time, after attending the first several Conferences, it became apparent to me that the APWCA provides much needed and useful day-to-day information for practitioners like me. An alumnus of the New York College of Podiatric Medicine, I trained at St. Barnabas Hospital in NYC. It was there that I developed my interest in Wound Care, treating a vast population of patients suffering from Diabetes.

Also evident at the Conferences was the personal aspect of the group meetings that I liked very much. The discussions allowed for interaction among the members and I always came away having learned something or at the very least, having some "food for thought" to consider. As time passed and as I began receiving the very informative newsletters, I started thinking that this was an Association that I would feel proud to be a part of, not only as a member but as a contributor as well. After speaking with Steve Kravitz at length about the vision and goals of the Association, I was asked to join the Northeast Delegation as its' first chair. I enthusiastically agreed but I couldn't help asking myself if I understood the scope of what I was becoming involved with. I say this because I knew then, as I know now, that the growth of the APWCA is limitless given its unique commitment to dealing with the issues of today effecting patients and health care professionals in Wound Care. Soon after joining the Northeast Delegation, I began traveling with Steve, Bob Gunther and

other APWCA Officers and witnessed how well received the Association is by the Wound Care community and the important role it can play now and in the future.

A few years later I was asked to chair the House of Delegates and I didn't hesitate. I saw the vision becoming a reality and I was ecstatic to become even more involved. We were embarking on the creation of a physician certification examination, and had received the attention of many prominent professionals in the field of Wound Care and especially in the area of Medical Insurance issues.

In addition to my association with the APWCA, I have been a Key Opinion Leader for Foxhollow Technologies and a member of the Physicians Speaking panel for National Healing Corporation. I am in private practice in Paterson, NJ and affiliated with St. Joseph's Regional Medical Center and Kindred Hospitals.

Now, it is with great pleasure that I accept the office of Vice President of the APWCA. I hope to continue to be a part of the success and growth of the APWCA and to assist you, our membership, in any way that I can.

Best Regards,  
Mike Fusaro



# Member Spotlight: Darlene McCord, PhD, FAPWCA

Four years ago Dr. Darlene McCord unknowingly began a journey that would change her life as well as the lives of people around the world. At the annual APWCA conference, Dr. McCord heard Dr. Edwin Ampadu, of Ghana, speak about the plight of children in his country and their struggles with the Buruli Ulcer, a skin disease that primarily affects children in tropical and subtropical climates.

Dr. McCord was so touched by Dr. Ampadu's words that she spent an entire year developing a Wound Care product that could treat the skin disease. Additionally, through the McCord Research Foundation, Dr. McCord and her husband, James, began funding scientists at Michigan State University, Millersville University and the University of Tennessee to support continued research.

Over the past four years, Dr. McCord has become an advocate for Buruli Ulcer treatment and research. She and James continue to work hard to raise awareness for the cause, taking their efforts to the highest levels of government. The couple met with senators, congressmen and heads of state in Washington, D.C. in November, and in December they received the 2009 Humanitarian of the Year award from the United Nations-affiliated non-profit organization, Airline Ambassadors, for their philanthropy and research in Africa.

In addition to her work with the Buruli Ulcer, Dr. McCord is constantly forging new paths on her way to changing the world. Her well-known

Olivamine is now in supplement form through her recently founded company Pinnaclife. She also published *Living Well at One Hundred*, a book that combines her personal and professional perspectives on good health and healthy aging. Her philanthropic efforts also include the APWCA as an Emerald Supporter.

Dr. McCord will be featured at a book signing during the 2010 APWCA Conference. Her book is available to purchase at [LivingWellatOneHundred.com](http://LivingWellatOneHundred.com), [Amazon.com](http://Amazon.com) or [BarnesandNoble.com](http://BarnesandNoble.com). All proceeds from book sales and a majority of proceeds from the supplement line will go to the Buruli Ulcer Foundation.

Of course, Dr. McCord's journey continues with even bigger plans for the future. She said the goal for 2010 is to raise "hundreds of thousands of dollars for the Buruli Ulcer Foundation so that the children suffering from the disease will no longer be forgotten."



“She said the goal for 2010 is to raise hundreds of thousands of dollars for the Buruli Ulcer Foundation”



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# The APWCA Mission

The mission of the American Professional Wound Care Association (APWCA) is to enhance the education involved in the care of all wounds including acute, chronic, post-surgical, post-radiation, reconstructive and other problematic wounds. Our purpose is to decrease the incidence of sequelae, including major amputations and dysfunction, while improving the quality of life for those patients suffering from these complex lesions. This mission is accomplished through an interdisciplinary approach to clinical care, professional education and patient advocacy.

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