

SYNERGY

THE VOICE OF THE AMERICAN PROFESSIONAL WOUND CARE ASSOCIATION



WINTER 2008 IN THIS ISSUE

Administrative Report	1
Executive Director's Report	1
Editor's Note	3
Mission Statement	15
FEATURES:	
DIMES model of Wound Bed Preparation	1
Carpe Diem! - In Memory of Carol Paustian	6
Implications of the new CMS ruling in Acute Care	11
DEPARTMENTS:	
Members in the News	8
Book Review	10
APWCA Board of Directors	19
Medical Advisory Board	19
Sponsors	20
Contact Info	20

Editor in Chief

Larry Schuster
DPM, FAPWCA, FACFS

Managing Editor

Cynthia A. Fleck,
MBA, BSN, RN, ET/WOCN,
CWS, DNC,
DAPWCA, FACCWS

Photography

Randy Fish, DPM, FAPWCA

Administrative Report

From the Offices of the President, Robert Gunther, DPM, FAPWCA & Executive Director, Steven R. Kravitz, DPM, FAPWCA

2007 proved to be a very productive year for the Association. It is amazing with a relatively small but dedicated staff of five the number of projects that can be accomplished. Much of this progress is due to the tireless efforts of many members.

A summary of our upcoming APWCA2008 in Fort Worth Texas, March 6-9 is described herein by the program chair and promises to be a spectacular gathering to learn new clinically relevant skills for *continued on page 2*



Small but Dedicated Staff

Feature

DIMES model of Wound Bed Preparation

D. Chakravarthy, Ph.D, FAPWCA

Debridement, Infection/Inflammation control, Moisture Balance, Edge Closure: The DIMES model of Wound Bed Preparation, Rationalization of Therapies

In recent years, clinicians, biologists, biochemists, molecular biologists, and in fact, a whole multidisciplinary team of scientists spread across continents and working both in the clinic and the laboratory, have probed the nature of wounds, both acute and chronic. Several important insights have emerged, the most important of which is an understanding of the principles of Wound Bed Preparation (1-5), in the healing of chronic wounds. These principles, clinical researchers have

continued on page 5

Executive Director's Report

Steven R. Kravitz, DPM, FAPWCA, Program General Chair, Executive Director



Steven R. Kravitz,
Executive Director

APWCA2008 is Online - March 6 - 9, 2008 Ft. Worth, TX - Marriot Renaissance Worthington Hotel
Lecture Schedule is Complete and Registration is Open at www.apwca.org

30+ Faculty - all carefully selected for educational and clinical background and their ability to teach and communicate. A multidisciplinary list of speakers, many of which are world opinion leaders and new to APWCA faculty this year will provide a fresh perspective on the latest in

wound care and skills that you can take back to your practice and use the day you return! APWCA2008 will further solidify this association's reputation for providing an unbiased educational event by utilizing a diversified, expert and outreaching faculty that is simply unmatched at many similar venues.

APWCA2008 is the place to be in March



continued on page 4

Administrative Report *(continued from page 1)*

From the Offices of the President, Robert Gunther, DPM, FAPWCA & Executive Director, Steven R. Kravitz, DPM, FAPWCA

patient care, networking with colleagues and sharing experiences. Join us to also socialize in a relaxing atmosphere offering attendees and families a myriad of activities to fit various budgets, tastes and interests. Also note report from Gary Sibbald, MD, FAPWCA on the 2008 Congress of the WUWHS, June 4-8, Toronto, Canada.....mark your calendars for that international conference - lets show the world a large APWCA presence at this extraordinary event!!!!

Rather than provide a full administrative report here we have for this issue of Synergy, provided information through the committee chairs so that the membership becomes more familiar with some of these very dedicated members.

As the New Year opens we will keep you informed through this publication and monthly email news updates. We hope to see all of you at the APWCA2008 in March and then again in June at the WUWHS.

Headquarters Improvement Campaign



Federico Peguero, MD, FAPWCA
Headquarters Improvement Campaign: Chair and APWCA Treasurer

A substantial number of members continued to contribute to the Headquarters Improvement Campaign. All members can be assured that your association works on a very tight budget. I have been to the physical plant and there is additional space that could be utilized, but requires furnishings, telephone lines, computerization, etc. This is your association, there is not a more lean organization that I could think of and I have had the opportunity to work with many. I can assure you that 100% of your donations for this campaign goes directly to improvements needed. We ask that if not involved that you consider to do so..... all contributions of any size are appreciated.

Physician Certification Examination Committee, Robert Bartlett, MD, FAPWCA Chairman



Physician Wound Care Certification Exam is endorsed by the American Professional Wound Care Association (APWCA) and Recognized by the American College of Hyperbaric Medicine (ACHM) as the Physician Wound Care Certification

2

The committee is ongoing and at the time of this printing, questions required for our first examination have been completed. We expect to initiate field testing in January 2008 and additional field test during APWCA2008 in March in Fort Worth Texas. The first open examination is planned for Friday June 6 during the 2008 Congress for World Union Wound Healing Societies, held in Toronto, Canada June 4-8. We anticipate that this will be one of several pathways that will be available in the future to obtain the designation of Fellow with the APWCA.

The examination construction committee was established with members from the two professional societies, APWCA and ACHM. While APWCA has contributed to initiating and will endorse the examination, a separate testing organization will administer this certification process.

More information is found on our web site or you can contact the APWCA headquarters.

World Union of Wound Healing Societies

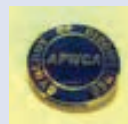
Gary Sibbald, MD, FAPWCA, Program Chair



Wearing a WUWHS Cap

APWCA is one of only two United States Societies to host the Toronto, June 4th-8th, International Congress for the World Union of Wound Healing Societies. The other American organization is the National Pressure Ulcer Advisory Panel. There are a total of five hosting societies, the other three are Canadian. APWCA is a primary organization involved in developing the Diabetic Foot Stream for the Congress. On behalf of the APWCA Board of Directors and all the participants of the WUWHS, we encourage all of our membership to join us in Toronto. Drs. Kravitz and Gunther add, "by way of background, this meeting occurs every four years, last held in 2004 in Paris and it may very well be that the 2012 Congress will be in China. Expecting 6,000 worldwide, mark you calendar. See you in Toronto." Go to the APWCA home page to click for full information on this Conference. Register early for course selection and hotel room lodging.

Lapel pins and lab coat patches are available for all membership, wear them proudly and contact headquarters or check the website for more information.



Editor's Note

by Larry Schuster,
DPM, FAPWCA, Editor-in-Chief



Cynthia and I wish all our readers a very happy and productive 2008 and thank all those who contributed to SYNERGY this past year. We look forward to an equally fruitful collaboration this year!

This year has been very special to me as a disease that has plagued my family and now the world has finally gotten world recognition.



First United Nations World Diabetes Day 11/14/07

A few weeks ago, my good friend, Dr. Kshitij Shankhdhar from Lucknow, India, sent me an email with a link to the recent activities in his town for World Diabetes Day. In December of 2006, the United Nations passed a landmark resolution recognizing diabetes as a chronic, debilitating and costly disease. The resolution designates World Diabetes Day as a United Nations Day to be observed every year starting in 2007. In the video Dr. Shankhdhar sent me was a group of activities organized by Dr. Lakshmi Kant Shankhdhar and Dr. Kshitij Shankhdhar, which were repeated worldwide including a walk of a symbolic 246 steps to symbolically recognize the 246 million people estimated to be living with diabetes worldwide. New York City hosted the key event close to the UN Headquarters. In addition to the 246 step walk, a large blue circle (the global symbol for diabetes) was formed on the UN Rose Garden lawn with blue umbrellas educational lectures were held and the Empire State Building was lit up in blue. Initiatives were taken to light up other world landmarks to also mark the day including the Sydney Opera House, the London Eye, Leaning Tower of Pisa, Tokyo Tower, Niagara Falls, the Burj Al Arab in Dubai, the Aleppo Citadel in Syria, the Obelisk in Buenos Aires, the Sears Tower in Chicago, Christ the Redeemer in Brazil, and the building currently considered the world's tallest: the Taipei 101 Tower in Taiwan.

This year's World Diabetes Day aims the spotlight on children and adolescents suffering with Type 1 Diabetes, the most severe form of the disease in which the body's immune system mistakenly attacks and destroys the insulin-producing cells in the pancreas. As wound care specialists, we are uniquely aware of the devastating complications, such as kidney disease, nerve damage, blindness, amputation of extremities, heart disease and stroke. Diabetes is a disease that needs to be brought to the forefront; I am hopeful that soon there will be a cure as the world has shown unity in its fight to eradicate this worldwide epidemic.

I welcome your comments and reactions and input in response to this Newsletter. The intention is for our newsletter to be as interactive as possible and maintain a dialogue between members. **Please contribute!** This is your forum.

I hope you enjoy this edition of our newsletter and look forward to seeing you in Fort Worth and Toronto this coming year.

Larry Schuster, DPM, FAPWCA
Editor **SYNERGY**

Executive Director's Report

Steven R. Kravitz, DPM, FAPWCA, Executive Director



2008! Held this year in Fort Worth, Texas, with 25 city blocks of shopping, restaurants, entertainment to fit all types of budget – anything you or your family will want to do in the 4th safest community in the United States. You will not need a car, as these attractions are right out the front door of the award winning, 4-Diamond Marriott hotel. Museums, Cultural Center, Stock Yard and year-round Rodeo every Friday and Saturday night are also within a short drive.



Billy Bob's Texas

The World's largest Honky Tonk

Featuring Famous Country singers, Live Pro Bull Riding and a Texas size dance floor for everyone to enjoy.

APWCA2008 Highlights:

1. Register early for both course selection and hotel accommodations as both aspects of this conference have sold out previously!
2. Thursday's Pre-Courses offer a variety of scientific programming, including AM break out sessions, interesting lecture topics, plastic surgical course (now enhanced with a pig's foot wet lab and covering skin flaps, grafts, indications, complications and more), a new course on start-up and maintaining hyperbaric oxygen therapy centers. Thursday also marks the opening of the exhibit hall and the Annual Scientific Address with 6 research doctorates from the University of Iowa all with keen interest and background in wound repair and skin regeneration – and directed by Darlene McCord, PhD, FAPWCA. You will not want to miss this opening event! The Annual Scientific Address is followed by an excellent update on the nutritional aspects of wound care, and the pro's and con's of external fixation for the Charcot deformed foot. The day finishes with a dinner symposium that is open to all registrants but seating is limited so register early!

(continued from page 1)

These late Thursday courses are open to all pre course and (Fri, Sat) general course registrants, add 3 contact



Exhibit Hall 2007 APWCA Conference Philadelphia

hours at no additional fee! Great, exciting education and a terrific value.

3. Friday and Saturday are for the main general course, which includes a lecture on "skin structure, cellular metabolism and the effects of diabetes and aging on the skin. Can a better understanding in healthy skin decrease risk and improve ulcer healing?" A main event of the day is the keynote address provided by Andrew Boulton, MD, who from Manchester England may very well be the world's most well known opinion leader on education and research on the diabetic foot. Dr. Boulton will also be honored as a recipient of our first Outstanding Achievement Award, which will be presented Saturday. Saturday also includes a featured presentation on skin ulcers.



James Andrew Boulton, M.D.

4. Each topic, pressure, venous, arterial, diabetic and critical limb ischemia (CLI) will be fully discussed providing updated information and each topic using a 40 minute lecture followed by a 20 minute panel discussion with audience participation for Q&A. A terrific 5 hour interactive session – a highlight of APWCA2008! Many other topics to fit the interest of all involved in wound care, including a return from Edwin Ampadu, MD, FAPWCA from Ghana, Africa to discuss the latest information on Buruli Ulcer.
5. Sunday's Post-Course will focus on the business of wound care, with all aspects of practice management, coding, billing, and the essentials of maintaining a viable center and practice. Although it can be taken as a stand alone course for a modest fee, this Sunday lecture series is also open to all (Fri., Sat.) general course registrants, add 4 contact hours at no additional fee!!! More great exciting education and a terrific value.
- 6.



See the whole conference schedule and register for courses and hotel today at our web site www.apwca.org click "APWCA2008"

Feature



DIMES model of Wound Bed Preparation (continued from page 1)

D. Chakravarthy, Ph.D, FAPWCA

concluded, consist of the following sub-elements:

- **D**ebriement (removal of necrotic tissue) (6)
- **I**nfection Control (control of bioburden at the wound site) (7)
- **M**oisture balancing (optimization of the moisture level in the wound bed) (8)

Adherence to these principles can heal a significant majority of chronic wounds, and such progress is deemed satisfactory when a wound has closed by 30% at the end of week 4, suggesting complete closure by week 12 (9, 10). However, it is clear from clinical practice that despite the control of the above elements, some wounds still refuse to close at this desired rate or otherwise enter into a healing trajectory. The wound bed preparation concept then may require the process of

- **E**dge control/effect which consists of active measures taken to initiate closure of the wound from the edge. Frequently, such non closing wounds have been described to possess a “cliff like” or steep sided epidermal edge(9)

Note: Some chronic wounds will not heal, for example those with severely impaired vasculature and/or other coexisting illness, and the best the clinician can do is to adopt palliative measures.

- **S**upport with products, services and education

There are other products that complement DIMES but do not fit into one of these immediate categories. Therefore, always consider the “other” supportive products that complete the treatment. For instance, for a patient with fragile skin, you might choose an elastic net as a secondary dressing versus tape. The secondary dressing is also important to the care plan. Nutrition products are also part of treating the whole patient and not just the hole in the patient. Connecting the right product to the right application is critical. However, ongoing education is paramount to achieving the best possible outcome. Education is not just for clinicians so they know and use the latest evidence base in their practice, but is essential for patient's and their families. Making sure that patients and their families are taught the expected outcomes and

the plan to achieve them is vital for successful wound treatment. Support with products, services and education can make the right treatment plan even better.

Following the understanding of the above concepts, many clinicians have referred to the principles of Wound Bed Preparation by the acronym D.I.M.E.S.

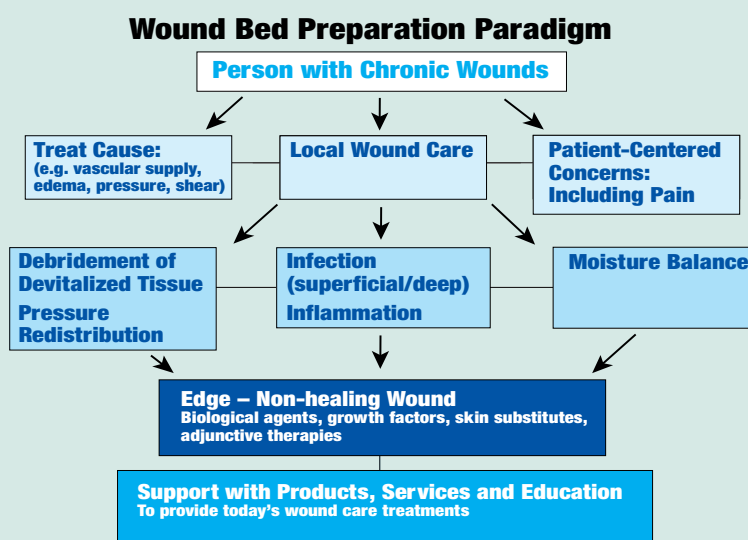


Figure 1. D.I.M.E.S. Model

© Sibbald, Woo and Ayello

The existence of scientifically rigorous model of DIMES (Figure 1) has made it possible to bring some order and understanding to the hundreds, if not thousands of individual wound care devices, dressings, and therapies that are legally marketed in the USA. The number of wound products and therapies that can be classified using the DIMES model is large, the following is an abbreviated list that captures broad classes of the commonly used products.



VASAMED is pleased to sponsor a Dinner Symposium at APWCA 2008, Thursday evening, March 6th (6:45 p.m. – 8:30 p.m.) entitled, “Skin Perfusion Pressure: The Optimal Diagnostic Test for Assessing Wound Healing Potential?” Chaired by Robert Warriner, III, MD, ABPM/UHM, FAPWCA, FCCWS, this 1 CME/CE symposium has limited seating capacity, so reserve your seat now!

Feature



Carpe Diem! In Memory of Carol Paustian, RN, BSN, ET/WOCN, DAPWCA 1956 – 2007

Margaret Falconio-West, RN, BSN, APN/CNS, ET/WOCN, DAPWCA

Although Carol A. Paustian left this world too early, she imparted a lasting imprint for all of us to remember. She was an excellent nurse, friend, mentor, published author, well respected educator, speaker, not to mention a mother and grandmother – but most of all, she was an influence to those around her.

Carol lived her life in Omaha, Nebraska – but over the last seven years, became a world traveler and presented programs and educated in just about every state in the country. I remember when Carol was on the West coast – in California – she called to tell me that she dipped her toes into the Pacific Ocean! Carol left her mark on the beaches of southern California. She made a similar call when driving by the Texas home of President George W. Bush. Carol savored everything life had to offer, and then some. She seized each and every day.

Since we often were able to get together at various wound care conferences – we always took the opportunity to enjoy the time we had. For those of you that travel and have attended out-of-town conferences– you know they are a lot of work – but also can be a lot of fun! There was one trip in particular that I'll never forget, a trip to Las Vegas and a stay at Caesar's Palace, yes, the hotel with ALL those shops. Carol and I were walking back and forth to the conference – and every time I thought we were “lost”, I realized that Carol knew just where we were – the Roman Jewelry shop. She had a real eye for the “bling” – needless to say – she left the shop with a beautiful ring and her husband wondering why the credit card company called! Carpe Diem!



Carol Paustian, happy and healthy in 2004

After September 11, we attended yet another conference, The Clinical Symposium, in Orlando Florida. Despite the horrible tragedy that this nation was experiencing, Carol was able to sneak in a trip to Disney World – and the Buzz Lightyear ride. Carol, Janet Jones and I - there we were the three of us “adults” able to enjoy life as if we were

young and carefree again. Leaving her mark once again, Carol received the highest score, proving her precision and grace. With that aim, you can see why Carol was a great ET/WOC Nurse and able to start an I.V. or place an ostomy pouch or wound dressing on just about anyone!



Carol (second from left) and E.T. pals at the Oprah Winfrey Show

Carol loved and bragged about her family – what the girls were doing and achieving – but also about her vegetable garden. An avid gardener, Carol enjoyed plants of all kinds. I remember a discussion that we had about orchids, a beautiful flower that she adored. She was captured by their beauty, as she explained the complexity of the plant and the great detail in the flower itself. Any time I see an orchid, I will think of my dear friend Carol. Not only was she a lover of nature, she adored animals and frequently used them as “teasers” in her always amusing and interesting talks. One of my favorite pictures was the one of her dog Elvis, balancing a bone on his nose. She used it to describe the balance of moisture that a wound should have, very clever! Carpe Diem!

On a more serious note, Carol was the first to mention the word “bioburden” in our circle, many years ago. Carol told us that we must broaden our horizons – and “biofilm is where our industry is going”. During a yearly event and meeting for our clinical team, we work together for hours, yelling and screaming and then when it is time to break – we all hug and go to dinner together, similar to the way many brothers and sisters fight. Can you imagine, when Carol starts preaching about biofilm? We are all tired and ready to go – but, no, Carol has to

have her say and edify us about this new concept that is hitting the wound care world. Again, she was right – and I think that because of her – our wound care team has stayed above the curve when it comes to education. Thank you, Carol!

She was a stickler for clinical accuracy. She was known affectionately as the “Professor”. Anytime there was a source to be found – no matter which airport she was in – she was able to not only retrieve the reference that was needed, but to add her suggestions. Carol was never confined to a traditional schedule. I received many emails during the middle of the night, not knowing if she was having a bad day or a really great day. She could be productive and even creative at any hour!

Even after Carol was diagnosed with cancer, and throughout her fight – she would send emails or make a phone call to share something that she felt was important for me to know and follow up upon. Carol helped with poster abstract submissions for several of our

I have been honored to know and work with this caring professional nurse who gave so much to her colleagues and her patients. The documents she helped to create are helping caregivers all over the United States to deliver better, more consistent, evidence based care to patients everywhere.

Margaret Goldberg, MSN, RN, CWOCN;
Immediate Past President, WOCN Society

customers – always the mentor and consummate professional. Although Carol had many publications to her name and she loved to write, Carol really enjoyed the opportunity to help someone else publish or present a poster. Carpe Diem!

Carol received her Bachelors of Science in Nursing from Creighton University College of Nursing, in Omaha, Nebraska. She attended the University of Texas Medical Center, MD Anderson Cancer Center in Houston, TX where she completed her “Enterostomal Therapy” education in 1997. Carol’s career was a very busy one – covering all areas of the hospital including the emergency room, staff nursing in med-surg as well as the critical care areas. She was involved in the wound care focused areas, such as the skin care team, providing not only an ostomy care, but advocating for all her patients. She focused on pressure ulcer prevention, she was the prevalence studies point person, and a clinical preceptor for the New Mexico School of Enterostomal Therapy. In 1998, Carol received the Nebraska Nurses Association Positive Image of Nursing Award, a real characteristic of distinction.

Carol served on the WOCN’s Wound Guidelines Task Force that produced the Wound Ostomy and

Continence Nurses Society’s (WOCN) Clinical Practice Guideline Series. In addition, she was a co-recipient of the WOCN President’s award. What a great honor, but also sense of pride as Carol was able to walk with the group as they received the award, despite her health challenges. Carol was a co-author the WOCN’s Guideline for Management of Wounds in Patients with Lower-Extremity Venous Disease. Carpe Diem!

If Carol were here today – she would leave all of us a piece of advice. And, I think it would go something like this:

“As caregivers we often neglect ourselves...Take advantage of the medical advances and the technologies available today, whether it is your annual pap smear, mammogram or PSA, and delaying that colonoscopy after age fifty is not a good idea. Know what your cholesterol level is, but more importantly know how to lower it if needed. Get your teeth cleaned on a regular basis – see your dentist regularly.” She would also



Carol (third from left) and her E.T. team at Medline

recommend a good manicure and pedicure as those are simple things that will help the mind as well as the body. Take care of yourself, in Carol’s memory.

Carol’s legacy will be forever in the hearts and minds of her friends, family and colleagues. She leaves her husband, Dwayne two daughters and two grandsons. Carol also leaves many friends that are touched by her prints. Goodbye dear friend, you will be in our hearts and minds forever! And yes, you truly did seize the day! Carpe Diem!

CME Audits are ongoing and it is imperative that any member who was contacted to provide documentation demonstrating the CME requirement stay in touch with APWCA Headquarters. Members who fail to follow up will lose their active status March 31, 2008. There are many avenues available to meet the CME requirement, so do not ignore the audit, make sure you follow through with APWCA headquarters.

Members In The News



"Volunteering allowed me to help others in need, but also the locals helped me in a sense. They helped me realize the importance of life and to live every day to the fullest."
Fred Peguero, MD, FAPWCA, stated.

Dr. Peguero giving instruction to a child

Fred A Peguero, MD, FAPWCA and Treasurer of the APWCA recommends to anyone considering volunteering internationally to go while they have the opportunity, and to realize that they are fortunate to be able to volunteer any service to people in need.

For the last ten years, he has organized and participated in Mission trips to the Dominican Republic. Medical care and construction of churches, schools and houses was part of the work done in 10 different towns throughout the island. He provided medicines for parasites, hypertension, diabetes, respiratory infections, allergies, hygiene and dental education, dental paste and brushes, and of course, wound care. Different antibiotics were also administered to these patients. Multidisciplinary teams of doctors and nurses of different specialties participate in these clinics. Medicines for parasites are used in children over two years old and in adults, except during pregnancy.



Dr. Kravitz

Dr. Block

Dr. Gunther

Barry Block, DPM, FAPWCA

Congratulations to Podiatry Management Magazine and the Editor and Chief, Barry Block, DPM, FAPWCA for 25 years and to our friends at Lippincott Williams & Wilkins/Wolters, Kluwer Health for the 30th anniversary of the journal now known as Advances in Skin and Wound Care (formally Cutis).



Vickie Driver



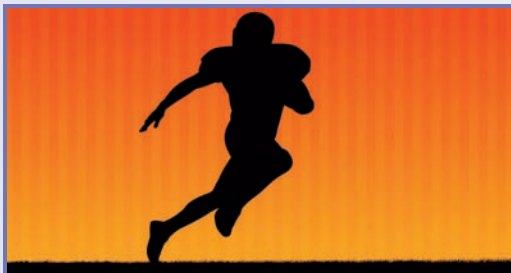
Elizabeth Ayello

Alliance of Wound Care Stakeholders' Meeting held on Friday September 28th 2:30PM , Washington DC

Vicki Driver, DPM, MS, FACFAS, FAPWCA represented APWCA today along with Dr. G. Sibbald. Vicki was wearing two hats as she also represented the Foot Council, ADA and there was no conflict with that. Additionally, Elizabeth Ayello, RN, PhD, FAPWCA represented us via phone in attendance. This demonstrates the excellent coverage by members of the APWCA members and we thank them for their efforts.

Dr. William M. Miller receives Football Award

As a member of the 1975 Hasbrouck Heights Football Team that were Group 1& 2 un-defeated State Champions in New Jersey, Dr. William M. Miller, a member of the APWCA, was inducted into the Hasbrouck Heights Hall of Fame for Football Excellence. Overall, three straight Hasbrouck Heights teams had won 27 games in a row, ending the winning streak with a tie. Dr. Miller practices in Bergenfield, NJ.



Feature

DIMES Wound Bed Preparation (continued from page 5)

Debridement (D)	Polyacrylate debridement Ultrasonic debridement Hydrosurgery® Sharp debridement (Operating room or bedside) Enzymatic debridement
Infection Control (I)	Silver ion containing dressings (alginates, foams, alginate/carboxymethylcellulose, pure carboxymethylcellulose, alginate powders, Microlattice® gels) Quat or PolyQuat containing dressings Sodium hypochlorite (Dakin's) solution Cadexomer iodine
Moisture Control (M)	Alginates and Hydrofiber® Foams Hydrocolloids Hydrogels
Edge Effect (E)	Collagen MicroScaffold®, Collagen/ORC Intestinal submucosa Growth factors Protease modulating dressings Skin equivalents Negative pressure wound therapy Hyperbaric oxygen therapy
Support (S)	Secondary dressing Nutrition products Product and application connection Education

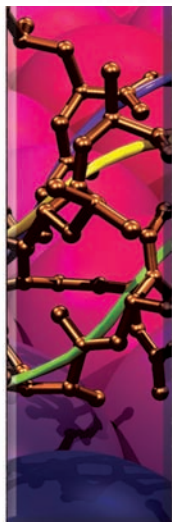
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Debashish Chakravarthy, PhD, FAPWCA is a biochemist, Fellow of the American Professional Wound Care Association, and Vice President, Technology for Medline Advanced Skin and Wound Care. Dr. Chakravarthy has worked in the field of research, development and licensing of advanced wound dressing development for the past 10 years. He has authored numerous papers and holds several patents.

COLLAGEN^{eration} PURACOL[®] PLUS



restore the chemical balance of chronic wounds
to help them heal!



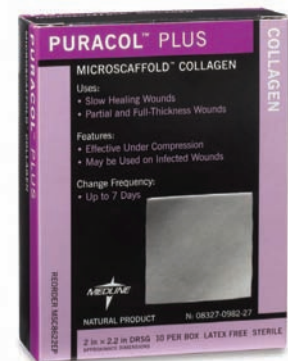
Puracol Plus is an advanced native collagen wound dressing based on state of the art biomaterial science and technology.

Puracol and Medline are registered trademarks of Medline Industries, Inc. MicroScaffold is a trademark of Medline Industries, Inc.

The MicroScaffold™ of **Puracol Plus** acts like a magnet by binding destructive enzymes, allowing the body's own collagen to heal the wound.

Introducing a native collagen dressing such as **Puracol Plus** that can bind and trap elastase and matrix metalloproteinases (MMPs) keeps the destructive enzymes occupied in the activity of breaking down the dressing material, instead of degrading the new collagen made by the wound fibroblasts.

For more information on Puracol Plus, call your sales representative or 1-800-MEDLINE.



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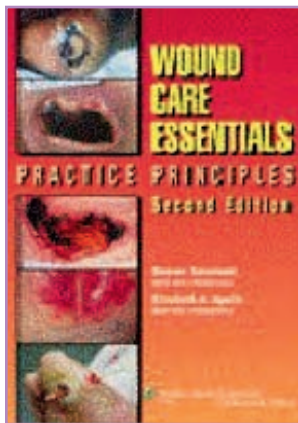
Book Review

Elizabeth O'Connell-Gifford,
RN, BSN, ET/CWOCN, MBA,
DAPWCA

Wound Care Essentials Practice Principles – Second Edition

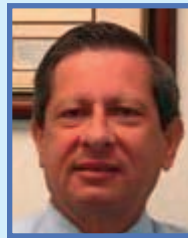
Sharon Baranoski MSN, RN, CWOCN, APN,
DAPWCA, FAAN
Elizabeth A. Ayello PhD, RN, APRN, BC, CWOCN,
FAPWCA, FAAN

Edited and written by two well-known wound care specialists and thought leaders, the second edition of this handbook is essential for all professionals involved in wound management, including nurses, physical therapists, physicians, podiatrists, and long-term care clinicians with each chapter written by an interdisciplinary team of experts. This text provides practical, comprehensive guidelines for assessment and management of both common and atypical wounds and related issues and covers many topics fully elucidated in other texts, such as sickle cell wounds, amputation, gene therapy, and the specific wound care needs of special populations. Features include more than 100 photographs and illustrations, recurring icons such as Evidence-Based Practice and Practice Points, case studies, and review questions. This is a must-have addition to every wound care practitioners' book shelf. You will find yourself reaching for it time and time again. It is also affordable priced and would make a great gift for a colleague, manager or co-worker! Thanks to APWCA board members, Sharon Baranoski and Elizabeth Ayello for pulling together another masterpiece!



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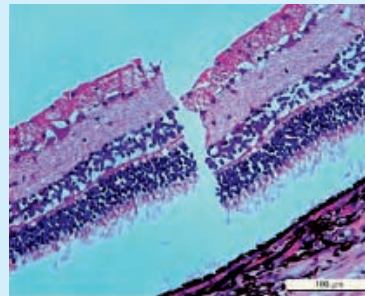
Visit www.LWW.com/nursing or call 1-800-638-3030 to order your copy today!



Finally A Magic Wand!

Larry Schuster, DPM FAPWCA

With the advent of MRSA VRSA, the explosion of wound care numbers and Medicare's concern over cost we need a magic wand that will separate dead from live tissue and kill bacteria without killing live healthy cells.



*Histologic section of a PEAQ™ cut
in a pig retina in vivo.*

No death of cells adjacent to the cut, the cells were just separated from each other. Sounds too good to be true! I hope it is true. Where did I hear about this? Physics today December 2007 issue arrived at my home today. I read this magazine so that I may

converse with my son, a physicist at Yale and MIT. Today there was an article I really understood and appreciated. "Cold Plasmas Enter the Biomedical Arena" by Jennifer Ouellette. Plasmas are the most common form of matter in the universe and in recent years, room temperature plasmas are being developed for biomedical applications. PEAQ Surgical's pulsed plasma and electrode insulation technologies were originally developed by Stanford University's Hansen Experimental Physics Laboratory and then licensed by PEAQ Surgical. PEAQ's PlasmaBlade tissue cutting tool can literally have cellular precision with less thermal and collateral damage than traditional electrosurgery technologies, as well as reduce bleeding. Science fiction? Not really. This actually has been used on human retinal tissue and pig skin. Results on the pig skin were improved wound healing with minimal scarring and inflammation.

The military application to decontaminate soldiers caused only a mild tingling in their skin but destroyed viruses and bacteria. Another handheld plasma pencil can generate a 5 centimeter plume that does not arc or overheat and can kill Escherichia coli without harming surrounding skin. Other groups have achieved similar results with viruses and other bacteria including salmonella. The plasma pencil appears to kill bacterial cells selectively perhaps because they are simpler in structure than mammalian cells. Stoffels-Adamowicz has developed a plasma needle for precise removal of cells and hopes to combine a scanning probe to detect irregularities in living tissue and only remove what is desired. Wow, a smart knife that knows how deep to cut! This will definitely become a crucial tool in wound care.

Feature

Policies, Procedures, Products and Patient Care: Implications of the new CMS ruling in Acute Care



The Centers for Medicare and Medicaid Services (CMS) recently unveiled their plans for reimbursement and non-payment for facility acquired pressure ulcers, among other issues, in acute care. Change is coming and this time, prevention and intervention underlie the CMS payment reform ruling including payment incentive for prevention and quality patient

care. Intense and comprehensive patient screenings at the onset of admission as well diligent prevention during their stay are the mainstays of this initiative. If you work in a hospital, guaranteed, you will play a major role!

Background check

Healthcare spending is on the rise, with dramatic increases just in the last five years. Where are the dollars being spent? \$570.8 billion is going to pay for care provided in hospitals alone. The government was on the prowl for burden that included either high cost and/or high volume healthcare issues. For example, in FY2006, there were 322,946 reported cases of Medicare patients who had a pressure ulcer as a secondary diagnosis (CMS Inpatient PPS Final Rule for FY 2008 available at: <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>.) Additional average charges for the hospital stay (per case) were \$40,381. An estimated 2.5 million patients are treated each year U.S. acute care facilities for pressure ulcers (Lyder CH. Pressure ulcer prevention and management. JAMA 389(2):223-226, January 8, 2003.). This nets out to a staggering \$12.9 billion. In addition, 60,000 patients die each year of pressure ulcer complications (Reddy M, et al. Preventing pressure ulcers: A systematic review. JAMA 296(6):974-984, August 2006.).

It all started with the Deficit Reduction and Reconciliation Act (DRA) of 2005 "Hospital-Acquired Conditions" which required that by 10-1-07 the Centers for Medicare and Medicaid Services (CMS) must identify at least two conditions that are:

- high cost or high volume or both
- result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
- could reasonably have been prevented through the application of evidence-based guidelines

By Cynthia A. Fleck, MBA, BSN, RN, ET/WOCN, CWS, DNC, DAPWCA, FACCWS

CMS released its final rule on hospital payments/reimbursement under the inpatient prospective payment system (PPS) for fiscal year 2008 on August 1, 2007. Based on the above politics, decisions made in this rule were based on laws passed years ago including non-payment for "never events" eliminating payment for marginal or poor care in acute care. They announced eight hospital acquired conditions that are deemed preventable (meaning there is evidence based information supporting the fact that these conditions could be prevented with proper care). CMS Inpatient PPS Final Rule for FY 2008, a 2,140 page document, is available for download in pdf format at:

<http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>

The section that specifically addresses Pressure Ulcers can be found on pages 311-317 .

What's the affect on the budget? The entire system is really budget neutral, which means that the base rate for all DRGs has been reduced to allow for some higher payments for more severe patient conditions. The purpose is to enhance matching of the payment to the severity of the patient. Included in the rule are provisions providing less payment for certain hospital-acquired conditions.

Change isn't always bad

Changes included in the Final Rule and the corresponding page number of the document:

- Surgical Site Infections (SSI)- pages 345-348
 - Mediastinitis after Coronary Artery Bypass Graft Surgery (CABG)
 - This final rule was recently changed to "Surgical Site Infection" without the qualifier of mediastinitis after coronary artery bypass graft surgery, and will not take effect until 2009
- Catheter-associated urinary tract infections – pages 303-311
- Objects left in the body post surgery – pages 317-321
- Pressure ulcers – pages 311-317
- Vascular catheter-associated infections – pages 323-330
- Hospital acquired injuries – pages 352-357
 - Falls, fractures, burns, etc.
 - This final rule was recently changed to Hospital Acquired Injuries – to only include "Falls" and will not take effect until 2009.
- Air embolism – pages 319-321
- Blood incompatibility – pages 321-323

As of October 2008, these preventable conditions will no longer be paid for by Medicare if they are acquired during

the hospital stay. The challenge will be to: Put the law into practice without destroying our healthcare system. Hospitals will need to align policies, procedures and personnel to prevent these nosocomial events and offer quality patient care. This can be accomplished by ramping up educational programs to prepare their facilities for change and by developing relationships with vendors to provide cost-effective products and programs to streamline care and save \$\$\$.

New terms to know and understand with regard to the changes are:

1. MS-DRG

- An acronym meaning Medicare severity-diagnostic related group
 - For example, in order to qualify for the higher-paying MS-DRG rate, the hospital will need to document a pressure ulcer within the first two days of admission

2. POA

- Another acronym meaning Present on Admission

Present on Admission (POA) Indicator

For discharges on or after 10/1/2007, hospitals must report whether pressure ulcers were detected upon hospital admission using ICD-9 diagnosis codes and POA indicators. The condition must be present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission. Data is now being captured from Oct 2007 through October 2008. The payment penalty will go into effect FY 2009 (October 2008). Hospitals must begin capturing data on hospital-acquired conditions in FY 2008 (starting October 2007).

See Figure 1. for the five POA reporting options. Keep in mind that Reporting must rely solely on physicians' notes and diagnoses and cannot make use of notes from nurses and other practitioners.

Specifics

Stage I and Stage II pressure ulcers present on admission will not qualify for the higher MS-DRG payment. **Stage III or Stage IV** pressure ulcers present on admission will qualify for the higher MS-DRG payment (except elbows ulcers or those on "unspecified" locations). Pressure ulcers will be considered **POA** if they are documented by the end of the second hospital day (ex. If a patient is admitted on Wednesday with an existing pressure ulcer, the ulcer must be detected and documented by 11:59 p.m. on Thursday. CMS recognizes that often patients who get pressure ulcers are very ill and frequently have other comorbidities and difficult conditions that will qualify the patient for the higher paying MS-DRG. This fact should not preclude

physicians and hospitals from screening all patients for pressure ulcers on admission including those that enter through ER and OR for any surgery.

Bottom line

The eight targeted conditions (if acquired during the hospital stay) would be reassigned to lower paying MS-DRGs. In the past they would be recoded to a higher paying DRG. This proposal is expected to save the federal government 4.8% of the current payments to hospitals over a three-year period. If the hospital does not submit their outcomes data, they will receive a -2% adjustment to their payments.

5 POA Reporting Options*

Yes	Present at the time of inpatient admission
No	Not present at the time of inpatient admission
U	Documentation is insufficient to determine if condition is present on admission
W	Provider is unable to clinically determine whether condition was present on admission or not
Blank	Exempt from POA

* Reporting must rely solely on physicians' notes and diagnoses and cannot make use of notes from nurses and other practitioners.

Figure 1. Five POA Reporting Options

As it stands today and in the past, if something goes wrong and the patient gets sicker, the hospital need not worry because the "upcoding" in the DRG billing would pay for the additional costs. Here's a case study to illustrate:

Ms. D.Z. enters the hospital for a hip replacement and acquires a vascular catheter-associated infection or a BSI (blood stream infection). The patient will be given a DRG (diagnostic related group) code that has a higher severity rate and subsequently, a higher reimbursement rate.

Fast forward to next October 2008, a much different scenario emerges.

Mr. M.B. enters the hospital for pneumonia. His skin is in good condition, without breakdown. He develops a pressure ulcer on his coccyx on day three of his hospitalization. Under the final rule after October 2008, the hospital will not receive an increase payment or reimbursement and must care for Mr. MB' s ulcer without more funds from CMS.

“TSA” (Transportation Security Administration) for Hospitals? It’s really just a safety and finance deal between the hospital and the federal government. If the hospital has a patient that acquires a preventable condition, rather than pay for the problem, Medicare will only pay for the codes that were present on admission (POA). Hospitals will need to assess patients very critically. Physicians progress notes are key to reimbursement. They must reflect and record issues on admission. At a recent hearing, however coding experts acknowledged the need to review pressure documentation by varying professional health care disciplines. Originally, the position was to only review the physician’s note. Think of it like going through the security check point at the airport. They’re not looking for bombs, rather pressure ulcer and infections!

The Basics

What are some basic things that you will need to move your staff in the right direction? Education and implementation of prevention guidelines to start:

- NPUAP Pressure Ulcer Prevention Guidelines available at: <http://www.npuap.org/positn1.html>
- Pressure ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline Number 3 AHCPR Pub. No. 92-0047, May 1992 available at: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.4409>
- Ratliff C, Bryant D. (2003) Guideline for Prevention and Management of Pressure Ulcers. WOCN Practice Guideline Series No. 2 Wound, Ostomy and Continence Nurses Society. May be ordered from <http://www.wocn.org>.

Next, a thorough assessment on admission and at daily intervals for every patient. Prevention, training and education monitoring of documentation of key personnel, including nurses and physicians. And finally, the right products, programs and protocols to decrease these eight conditions.

Some simple strategies from industry thought leaders include (Ayello EA, Lyder CH. Protecting Patients from Harm: Preventing pressure ulcers. Nursing 2007, October:36-40.):

- Conduct a pressure ulcer admission assessment for all patients
- Reassess risk for all patients daily
- Systematically inspect skin daily
- Manage moisture
- Quality skin care
- Optimize nutrition and hydration
- Minimize pressure

The New Jersey Hospital Achievement Collaborative

achievement reports a 70% reduction in the incidence of pressure ulcers in two years from 18%, down to 5% using similar programs. Their focus on was on prevention, two-day sharing-and-learning sessions and observing and performing best practice wound prevention and management (Holmes A, Edelstein T. Envisioning a world without pressure ulcers. ECPN October 2007:24-29.).

Other possible solutions include:

- Two clinicians performing visual exams when patients are admitted
- Support surfaces that redistribute pressure on every exam and OR table, stretcher and bed in a facility
- Using bedside ultrasound and photographing skin area to document conditions
- Bedside high frequency ultrasound, which is due to be introduced to the market any day allows visualization of tissue beneath the wound, undermining, sinus tracts, edema, foreign bodies, permitting clinicians pick up problems early and document effectiveness of wound treatments. For an example, see Figure 2.
- More rigorous efforts to assure high-risk patients are repositioned every two hours or more often
- A push for more comprehensive documentation, with emphasis on the physicians
- Education for physicians and coders within the institution
- As expanded view around high-risk situations that could lead to pressure ulcers.
- Pressure ulcers can occur in only two hours, what about the surgical patient who may wait an hour or more in pre-op then lies immobile during surgery, plus more time in recovery?

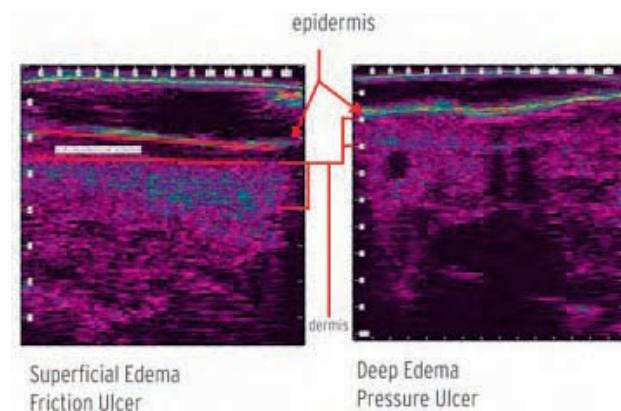


Figure 2. Example of bedside high frequency ultrasound image.

Overall Concepts

Prevention of pressure ulcers and other “avoidable” conditions is the responsibility of the accepting provider – included in episode cost. Products such as:

- high quality advanced skin care products that nourish the skin at the cellular level with amino acids, vitamins, minerals and soap and surfactant free cleansers,

- pressure redistribution mattresses and cushions,
- nutritional supplements and early intervention by a Registered Dietician, and
- super absorbent polymer (able to remain continuously dry against patient's skin while absorbing up to 1500 ml of fluid) underpads for incontinence, will assist facilities in prevention of all pressure ulcers. New tools such as digital planimetry photo documentation can dramatically improve efforts at measuring and documenting progress in wounds in the field by reducing the margin of error with hand measurement, which is about 30% down to less than 4% with digital planimetry (Wendelken ME, Alvarez OM, et al. Digital planimetry software provides accurate wound measurements that assist in the prediction of Wound Closure. Poster and oral presentation at the APWCA annual conference, April 2007.). An example of a wound measured with digital planimetry is below.

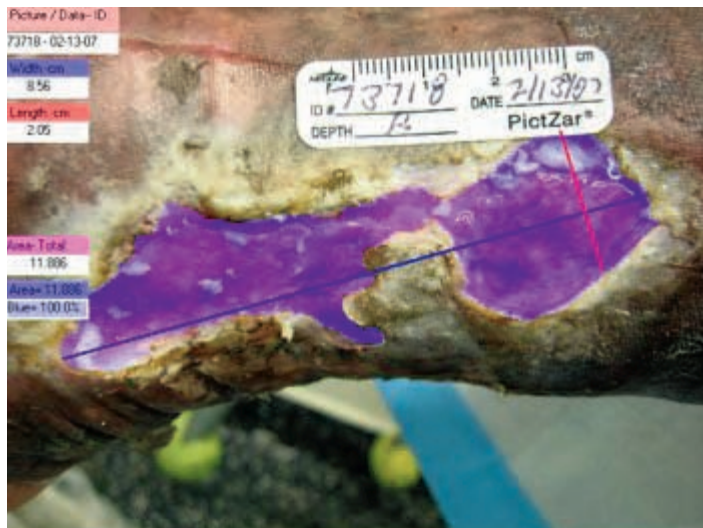


Figure 3. Example of a wound accurately measured with digital planimetry.

What's in store for the future in 2009?

One of CMS's goals is to eventually use the pressure ulcer codes as a quality reporting measure and to have the pressure ulcer data published on the "Hospital Report Card". In addition, The Centers for Disease Control (CDC) is considering a new code group for pressure ulcers. They held a hearing on this matter at the end of September 2007

One thing for certain is that cost containment, prevention of avoidable conditions and quality of care will remain paramount. CMS will target the following conditions moving forward:

- Ventilator Associated Pneumonia (VAP)
- Staphylococcus Aureus Septicemia
- Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE)
- Methicillin Resistant Staphylococcus Aureus (MSRA)

- Clostridium Difficile-Associated Disease (CDAD)
- Surgical Site Infection (SSI)
- Hospital -Acquired Injuries - Falls

Cynthia A. Fleck, RN, BSN, MBA, ET/WOCN, CWS, DNC, DAPWCA, FACCWS is a board certified wound specialist and dermatology advanced practice nurse, President and Chairman of the Board of the American Academy of Wound Management (AAWM), nurse board member of the Association for the Advancement of Wound Care (AAWC) and on the Medical Advisory Board for the American Professional Wound Care Association. In addition, Cynthia serves as Vice President, Clinical Marketing for Medline Industries, Inc. Advanced Skin and Wound Care division. She can be reached at cfleck@medline.com.

Bring a Friend



To APWCA 2008

As a member you are already aware of the superb benefits of membership in APWCA. You have experienced the quality of our conferences and have personally benefited from our organizations advocacy toward health care professionals and patients. By encouraging your friends to join APWCA, they become an active and supportive aspect of the process, gain many benefits and in that sense you do them a favor. Additionally, while APWCA is one of the largest wound care membership organizations in the US, there is still room for growth. The larger APWCA becomes the more effect we can have to accomplish our ever increasing objectives and a larger membership base helps maintain low membership fees. So bring a colleague to APWCA2008, member and non-members alike are welcome...(but by joining your colleague will gain membership registration discount.) It is the best way to learn about APWCA while attending a spectacular educational, networking and social event. Hope to see you and your friends in Fort Worth TX, March 6-9!!!

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Cynthia A. Fleck, RN, BSN, MBA, ET/WOCN, CWS, DNC, DAPWCA, FACCWS



Simple Solutions

If you are looking for unique ways to maneuver your facility through the mounting CMS changes, Medline has the answers! Innovative, novel 21st Century wound product educational packaging that decreases errors and provides a quick 2-minute inservice on each wrapper and wound care programs offered as value-added

services from product manufacturers and distributors can help your hospital “move with the cheese”. A picture may not only be worth a thousand words, there may be dollar signs as well! According to market research company Press Ganey, providing patient education is one of the four key measurements of patient satisfaction. An improved patient score of 1%, equals \$4980 increase per patient in revenue (E.C. Nelson, et al. “Do patient perceptions of quality relate to hospital financial performance?” Journal of Health Care Marketing 12 (1992); 6-13.).

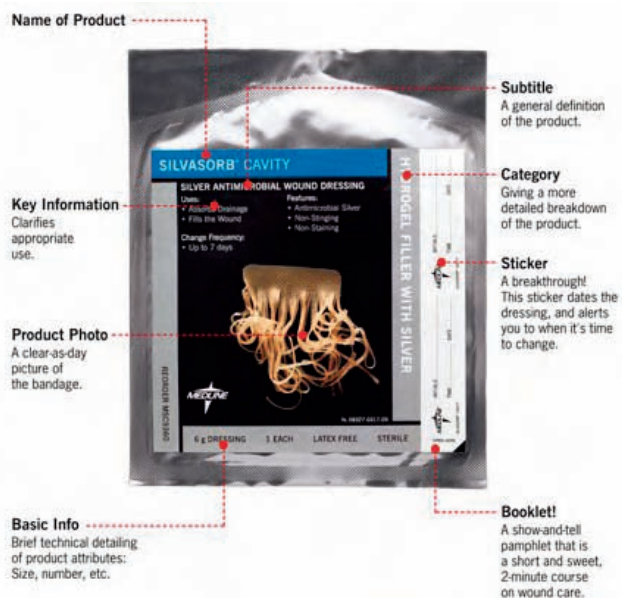


Figure 1. Example of new educational package with a quick user-friendly information pamphlet right on each wrapper!

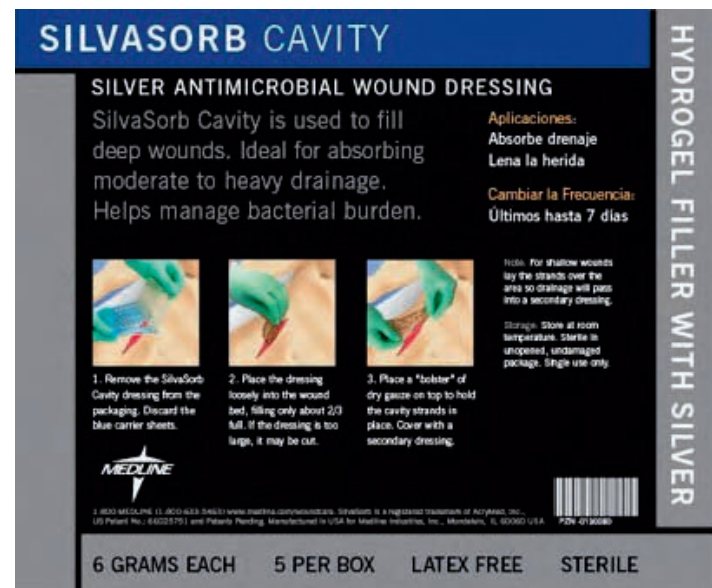


Figure 2. Example of an educational package box, complete with easy-to-follow instructions for use and clear information on the products generic category.

Justification of wound care supply usage will be scrutinized so the use of educational packaging can help decrease overall costs and waste. The use of key advanced wound care products to produce better outcomes – the “less is better” technique. Working with Medline Advanced Skin and Wound Care’s professional can help you and your team navigate the changes ahead. For more information, visit www.medline.com/ep or contact Medline at (800) MEDLINE.

A solid skin care program utilizing a four-pronged approach of cleansing (with a soap and surfactant-free cleansers), moisturizing, protecting (with high-quality silicone and zinc oxide containing barriers) and nourishing each and every skin cell with the necessary amino acids, vitamin co-factors and antioxidants to prevent all nosocomial skin conditions including pressure ulcers. Products such as the REMEDY™ skin care line, formulated with Olivamine™, can accomplish just this, while reducing painful and preventable skin issues. In addition, high-capacity polymer underpads can dramatically reduce moisture associated dermatitis (MAD), denudation as well as potential ulcers. Ultrasorb™ premium disposable underpads provide for optimal skin dryness, keeping both the patient and the bed dry. One Ultrasorb pad does the work of three or more pads. It is super strong, reducing tearing and resulting linen changes. The ultra absorbent polymer wicks moisture away from the skin and locks fluid away to provide better skin care while allowing the therapy of even low air-loss beds to continue, unencumbered.

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**An Overview for Clinical
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Just a few of the featured topics for 2008:

A Comprehensive Look at Skin Ulcers and Their Treatment

- Pressure Ulcers (DTI) • Venous Stasis Ulcers
- Diabetic Foot Ulcers • Arterial Ulcers (CLI) • Atypical Ulcers

2008 State-of-The-Art Approach to Wound Bed Prep

Hyperbaric Oxygen Guidelines: Where & When? Efficacious?

New Arterial Perfusion Assessment Predicts Risk & Healing

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Pain Diagnosis and Management • Deep Tissue Injury •

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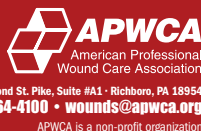
Your registration includes meals!

4 light breakfasts, 3 lunches, Dinner Symposium and exhibit refreshment breaks

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APWCA's invited faculty Includes these wound-care luminaries – and more:

David Allie, MD, FAPWCA • Edwin Ampadu, MD, FAPWCA • Elizabeth Ayello, RN, PhD, FAPWCA • Mona Baharestani, PhD, FAPWCA • Sharon Baranoski, RN, MSN, DAPWCA • Robert Bartlett, MD, FAPWCA • Andrew Boulton, MD • David Brotman, MD, FAPWCA • Nancy Collins, RD, PhD, FAPWCA • Erika Ernst, Pharm.D, FAPWCA • Cynthia Fleck, RN, MBA, DAPWCA • Robert Frykberg, DPM, FAPWCA • Prabhakar Goswami, PhD, FAPWCA • Allen Jacobs, DPM, FAPWCA • Laura Jacobs, MD, PhD, FAPWCA • Paul Kinberg, DPM • Steven Kravitz, DPM, FAPWCA • Darlene McCord, PhD, FAPWCA • James McGuire, DPM, FAPWCA • Daryl Murry, Pharm.D, FAPWCA • Jeffery Niezgoda, MD, FAPWCA • Richard Salcido, MD • Ehab Sarsour, PhD, FAPWCA • Gary Sibbald, MD, FAPWCA • Adrienne Smith, MD, FAPWCA • James Stavosky, DPM, FAPWCA • John Steinberg, DPM • Loretta Vileikyte, MD, PhD • Dot Weir, RN, DAPWCA • Thomas Zgonis, DPM, FAPWCA ...and more!



APWCA'S Advocacy Policy

By Dr. Thomas A. Kwyer, MD FAPWCA



During the past five years, APWCA has endeavored to provide fair-minded commentary on issues that have been supportive of providers while assisting the insurance industry with the issues of reimbursement and allowable covered services. We have made a conscientious effort to place the APWCA as a valued source for a balanced perspective regarding these and other key topics important to our members. We believe this position ultimately benefits our members but it does require difficult decisions in complex situations.

Several years ago, APWCA elected to not initiate a Seal of Approval or a similar endorsement program. This activity is promulgated by many other organizations and can produce significant non-dues income. However, it can be perceived as inducing a prejudice when dealing with reimbursement and similar issues related to an endorsement, even if the product analysis was done in a manner to minimize biased opinion or commentary. The old saying that "perception is reality" has motivated APWCA to take the position to not provide an endorsement program so that we may maximize our effectiveness and impact when we have the opportunity to provide our opinion or commentary to health insurance companies and/or governmental bodies involved in healthcare oversight.

We have been called on to provide background and perspective on complex issues important to the membership, particularly the need for the reasonable reimbursement. We recognize that there is much more that needs to be done in this arena and these challenges are never ending. Many of the APWCA activities regarding issues can be reported to our membership, but there have been a number of others that must remain confidential. That said, the association will continue to follow through with the insurance industry and government bodies through which health care services are provided. We believe that it is important for you to know that this has been, and will continue to be, a major commitment of the APWCA.

Membership online directory is just about to be initiated all membership have three options. Look to our web site or upcoming email news updates as the program goes on line. Members will be able to enter their own data and will have three options as follows for their contact information:

1. Available to the general public as well as members
2. Available to members only
3. Opt out and not participate with the directory.





Physician Certification Exam

First Open Certification Examination

Friday, June 6, 2008 During WUWHS in Toronto, Canada

Registration Information to be posted by March 15, 2008. For further information contact APWCA or call 215-364-4100.

Physician Wound Care Certification Examination Opens New Era for Certification in Wound Care. It is Endorsed by the American Professional Wound Care Association and Recognized by the American College of Hyperbaric Medicine as the Physician Wound Care Certification.

“This new examination will change the dynamics of this field and advances wound care to a new level. It brings us one step closer to the goal of specialty recognition. The next challenge will be the initiation of residencies and fellowships which are commensurate with the evolution of knowledge and practice. This examination will be available to all prescribing physicians, (MD, DO, DPM)” Robert Bartlett, MD, FAPWCA, Professional Examination Chair.

History, Background and Rationale:

The American Professional Wound Care Association (APWCA) was contacted about two years ago by members of the American College of Hyperbaric Medicine (ACHM) who expressed their opinion that there was a need for a certification process in wound care available to their members that was physician oriented. After reviewing options, they concluded that the APWCA was the most appropriate organization for them to work with and collaborate. An ad hoc committee was established with key members of both organizations which investigated the concept further and found that there is a growing need for some formal process to distinguish those who are skilled in the art and science of wound care. Dr. Bartlett explains “Hospital administrators, managed care organizations, physicians and podiatrists alike noted there is a growing need for some method to specifically recognize physicians working in this area. The field of wound care is no longer a simple affair of wet to dry dressings. Twenty-first century wound care has entered the molecular age of medicine with the advent of advanced therapies that require skill and discernment to achieve cost effective outcomes.” Based on these observations, an examination construction committee was established with members from the two professional societies. This gave a tremendous jump start to the creation of a physician certifying exam. While the APWCA has supported this initiative at many levels and will endorse the examination, a separate testing organization will administer the certification process. The exam will first be offered Friday, June 6, during the 2008 Congress of the World Union of Wound Healing Societies (WUWHS), June 4-8, in Toronto Canada.

The development of this physician exam is a first step toward the long term goal of achieving specialty recognition of wound care by the American Board of Medical Specialties, American Osteopathic Association and the Council of Podiatric Medical Education. The evolution of specialty recognition may not occur for quite some time. In the interim this exam will provide formal recognition to those practitioners who have substantial expertise in wound management. The committee is chaired by Robert Bartlett, MD, FAPWCA and co-chaired by Jeffrey Niezgoda, MD, FAPWCA.

Open enrollment for membership in the APWCA is still available to become a Fellow or Associate. With the launch of this exam, that opportunity will be discontinued and alternate pathways will be offered to become a Fellow in the organization. For further information go to the APWCA web site www.apwca.org or you can contact APWCA at Wounds@apwca.org or by telephone at 215-364-4100.

THE APWCA MISSION

*T*HE 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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853 Second Street Pike, Suite # A1, Richboro, Pa 18954
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