

CENTER OF EXCELLENCE

Ancillary Essentials to Get Wounds Healed and Keep Your Diabetic Patients Loyal

Here's a comprehensive guide to setting up and marketing a center of excellence for diabetics.

BY JONATHAN MOORE, DPM, MS, ANDREW SCHNEIDER, DPM, AND ANIMESH (ANDY) BHATIA, DPM, CWS

This article, written exclusively for PM, appears courtesy of the American Academy of Podiatric Practice Management. The AAPPM has a fifty year history of providing its member DPM's with practice management education and resources.

Consistent, Quality Comprehensive-ness Is the Key to Growth, Success and Improved Patient Satisfaction.

It's funny how the simplest things are the hardest to actually accomplish. Funny how so few practices and managing doctors actually take the time to look at new ideas and services to expand their practices and grow their patient base.

So you may be thinking, what does "comprehensiveness" have to do with diabetes and wound care? Diabetic patients (and all patients for that matter) want several things from their care provider that will ultimately determine whether that patient will either sing your praises or leave and never come back.

- 1) Quality Care
- 2) Quality Customer service
- 3) Quality Conveyance

Centers of Excellence

We often write and talk about creating "Centers of Excellence" (COE) within our practices. In fact, the authors often are involved in teaching

doctors how to create and grow a diabetes COE within their practice.

Among the concepts integral to any COE is the provision that patients should get everything they need (related to your specialty) where they see their doctor. Additionally, patients expect to see better technology and more specific services and products related to their condition. These are the fundamentals of creating a COE.

Here are several essential ancillary services that will be key to developing and growing your own diabetic foot and ankle center of excellence. It goes without saying that centers of excellence should be designed around your patient population with the primary goal of getting patients well. As a side-effect of doing this well, you will inevitably grow your practice financially.

At a diabetic center of excellence every effort must be made to provide the diabetic patient everything needed to achieve the best outcome possible; but additionally you want the patient to feel confident in making the right decision in choosing YOU.

Here Are the "Essentials" of a Successful COE

When it comes to diabetic care, the first thing that pops into our minds is "wound care."

While this is natural, don't forget that the largest portion of your diabetic

patients will not have ulcers, but instead will have neuropathy pain, imbalance, weakness, swelling, arthritis, and claudication, among a host of other conditions that will be equally important to address at a high level.

Remember, if you are writing prescriptions for everything you want for the patient and you are delegating others to provide services that you could do better, you are shooting yourself in the proverbial foot.

Diabetes-Related Durable Medical Equipment (DME)

In addition to performing regular wound debridements, along with working with appropriate physicians on glucose control, vascular testing, infection and nutrition management, your role can be vital in being your patient's comprehensive supplier of diabetes-related DME. This will include not only diabetic shoes, but also wound care products, offloading devices, pads, creams, and much more.

While much can be said about the compliance aspect of dispensing DME, it should go without saying that DME (if done right) can be an enormous financial shot in the arm for the podiatric practice. This becomes a critical aspect of completing the comprehensive cycle of care.

It is sad that so many practices

Continued on page 166

grossly under-dispense DME out of fear of an audit or fear of needing to hire additional staff. All the while, hundreds of thousands (potentially) of dollars are going out the window. Why inconvenience your patient while delegating services and products to people or organizations FAR less qualified than yourself?

Wound Care Products 101

Why should a podiatrist dispense wound care products from the office? The most important reason is that it will lead to better compliance and outcomes. This in turn leads to more referrals, and the rest you know.

When you write a prescription for your patients' wound dressings (or other supplies) and then shove those patients out of your door to a pharmacy, or arrange for a home delivery company to mail them the products, the likelihood of the patient following your instructions accurately is slim at best. Additionally, the care may not start immediately. When the patient receives a large intimidating box with a whole bunch of instructions, this obviously isn't a good thing for your patient or you. It isn't hard to imagine how much better it would be for the patient (and your bottom line) when you dispense and bill their insurance for the products, and you (or your staff) show the patient how and when to use those products.

- Wound dressings are a covered benefit under Medicare Part B if they are medically necessary, and if they are used in the treatment of a wound caused by or treated by a surgical procedure.

- In general, for wound supplies to be a covered benefit if the wound is full thickness (this requires a wound grade and documentation of depth in your note)

- Documentation must indicate some type of debridement(s) having been done at some point in the course of treatment.

If you don't have a wound care product vendor that you purchase products from, it is acceptable (and quite common) to negotiate the best prices for these products. Many vendors will work hard to get your business and will often offer you faster de-

livery or free shipping.

Keeping an inventory of several key wound products (products that you know and use) will be essential as you will quickly find yourself running out if you do a lot of wound care. You can dispense up to 30 pieces of a collagen product for a patient with a full thickness wound per wound per month. The same is true for the Amerigel saturated gauze. For foams, up to 12 pieces can be dispensed per wound per month. Some wound care

products have reimbursements that are very favorable (two to three times the cost) while others have minimal financial benefit. Whatever the case, be careful about carrying products that actually cost more than what you get reimbursed (e.g., Aquacel AG, among others). Consider initially ordering one type of Alginate, one foam, the Amerigel saturated gauze, and one or two types of a collagen product.

You want to be able constantly to address the needs of the wound as the wound evolves. It should never be the practice of a wound care specialist to use only one type of dressing for all wounds. This would not be found to be the standard of care in a wound care practice as all wounds are different.

Remember that patients are not eligible for coverage for wound dressings if they are in a hospice or on a home health care plan (for any reason). Additionally, patients are not eligible for wound care products if they are in a Part A stay or in a skilled nursing facility (place of service 31).

Check DME HCSPCS Codes for surgical dressings and PDAC product listings for the most appropriate code for the product being dispensed (www.dmepdac.com). When billing for wound care products, submit claims to the appropriate DME MAC or private insurance with the appropriate diagnoses, the HCSPCS code for the product, the number of units dis-

pensed, and finally the modifier A*, where * is the total number of wounds being treated.

Once a system and protocols are established, the benefits will immediately become obvious. Training your staff to know how to handle and apply these products along with getting all of the compliance templates set up will be essential steps to ensure compliance. As for all wound care products (and all DME for that matter), you must have:

- 1) A prescription in the chart for

If you don't have a wound care product vendor that you purchase products from, it is acceptable (and quite common) to negotiate the best prices for these products.

the product—On the prescription, the number of dressings being dispensed must be recorded along with the length of anticipated need (typically one month).

- 2) Wound grade, depth and size (characteristics of the wound must be recorded; i.e. drainage, dryness etc).

- 3) Documentation of debridement and appropriate wound care in conjunction with use of the wound care products.

- 4) Signed pick-up form (proof of delivery).

Biologics

Technology and advancements in the world of biologics for wound care have been astounding over the last decade. Regranex, a growth factor gel, was among the first of this class. Since then, the choice has expanded to other biological dressings such as tissue-cultured skin substitutes Apligraf and Dermagraft. The above three are the only products to receive approval from the FDA for use on DFU's.

In the 2010 Consensus on Diabetic Foot Ulcers by Snyder, et al., there was a significant focus on bio-engineered tissue. After significant study, it has been noted that the best way to contain costs associated with wound healing is to get the wound closed as expeditiously as possible, thus perhaps requiring a change in the chronology of

Continued on page 167

when it is appropriate to use these products. Furthermore, prolonged healing times increase the risk of comorbidities such as infection, hospitalization, and amputation. Adjuvant therapies may result in increased wound healing rates and may lessen the frequency of dressing changes, clinical intervention, and hospitalization.

A conclusion of the Consensus Study was a determination that the appropriate healing expectation using conventional means—including wound offloading, debridement, and appropriate wound care—is at least a 50% decrease in the wound size in four weeks. If less than 50% healing is noted, staying with the same wound care regimen becomes detrimental for the patient. It is at this point that the use of biologically engineered dressings is appropriate.

Recognizing this, different products have been approved for different protocols after certain time intervals. Derma-

graft, a dermal skin substitute, for instance, is approved for weekly application to diabetic foot wounds. Apligraf, a bi-layered biological dressing, is approved for venous stasis wounds as well as diabetic foot ulcers. It is the duty of the podiatrist to assess the wounds and diversify the use of advanced biological dressings to the particular patient and situation that presents.

In a 2007 study, simulations performed by Waugh and Sherrat predicted wound closure within 9-10 weeks with eight weekly applications of Dermagraft. Application of a single piece of Dermagraft shows that healing can be induced, although the wound does not appear to heal for several weeks. A single piece of Apligraf was insufficient to induce wound healing in a diabetic wound.

Patients receiving one piece of Dermagraft weekly were 2.5 times more likely to achieve complete wound closure than patients receiving one piece

every 2 weeks. One application of Dermagraft weekly (up to eight applications) has proven to be the most effective dosing schedule. The pivotal registration trial, which gained FDA approval for Dermagraft, demonstrated a 64% increase over conventional therapy in the proportion of patients healed at 12 weeks.

Dr. Frykberg, in a Wounds 2010 supplement article, stated that, “There was a 43 percent improvement over control with Regranex; 47 percent with Apligraf; 51 percent with Graftjacket; and 64 percent with Dermagraft). In regard to the one FDA-approved BLA product and the two FDA-approved PMA modalities for diabetic foot ulcers, Dermagraft has the greatest efficacy of these three products. Direct comparisons between modalities, however, are difficult to make due to variability in study designs and analyses.”

Continued on page 168

Compliance

Documentation for Dermagraft must include a chronological progression of treating the DFU with the basic standards of care as described earlier before applying the first application. Current Medicare policy assigns it the code G0440 with a zero day global although some private carriers still use 15365. The product code is Q4106 dermal skin substitute, Dermagraft, per sq. cm. Suggested billing is 38 units.

When applying Dermagraft, it is important that your documentation highlight the criteria outlined by your Medicare Local Coverage Determinations (LCD).

Points to include in Subjective portion of note:

- Patient has Type I or Type II diabetes.
- Name of primary physician or endocrinologist managing diabetes and date of last visit.

Points to include in Objective portion of note:

- Size and depth of the wound
 - The wound must be at least 1.0 cm² and extend into subcutaneous tissue, but not beyond.
- There is no evidence of infection or necrotic tissue.
 - Be sure to establish that the majority of the wound is granular (clean).
- Document adequate circulation to support tissue growth.
 - This is accomplished by noting palpable pulses, referencing results of non-invasive vascular studies, or referencing vascular consultation that supports that the patient has adequate circulation to support tissue growth.
- There is no evidence of active Charcot arthropathy.
- Monofilament results should be documented in the medical record.
 - If not listed in the medical record, document in this note.

Points to include in assessment:

- Level of wound depth.
 - Full thickness ulcer extending into the subcutaneous tissue.
- Diagnosis of Type I or Type II diabetes mellitus.

Points to include in plan:

- Duration of wound under your

care.

- Wound must be under your care for at least six weeks before starting Dermagraft.
- List conventional treatment to date.
 - Debridement, offloading, dressings, etc.
 - Establish that improvement is not likely.
 - Indicate data that supports that conventional wound care has low healing outcomes.
 - If starting at the four week

very favorable reimbursement (as does the Bledsoe Conformer®).

Like any DME, documentation is key, and compliance with supplier standards is essential. If the patient has an ulcer with an underlying deformity, it is vital that you x-ray the deformity and describe its significance in your record.

For permanent off-loading for those with difficult-to-offload deformities, don't forget the many options that a custom AFO can offer. Gauntlet-style

For permanent off-loading for those with difficult-to-offload deformities, don't forget the many options that a custom AFO can offer.

point, indicate there is research that supports that wounds that fail to decrease in size by 50% at the four-week mark have a poor chance of healing.

- Indicate that Dermagraft will be applied weekly in a staged fashion.
- Indicate that therapy will be stopped if there is evidence that the wound is not improving with the product in two consecutive weeks.

Off-Loading

Having touched on dispensing wound care products and utilizing biologic dressings, what needs to be mentioned is something fundamental to the healing of any wound.

While it is now well known that off-loading devices like CAM walkers and other like "boots" are not covered by Medicare under the primary diagnosis of an open ulcer, what often is forgotten is that all of these devices are covered with the appropriate identification and documentation of the patient's underlying musculoskeletal deformity.

Among the author's preferred devices are the Bledsoe Conformer® Boot, the Active Offloader® and last, but not least, the new Zero-G® Offloader. While all of these devices have their pros and cons, the Zero-G is a new design in off-loading devices that introduces technology that nearly suspends the patient's foot while providing significant support and plantar bed shock absorption. Not only does the Zero G® work, it has

AFOs, like the Arizona AFO®, can afford one an excellent way to accommodate deformities, stabilize unstable or weak ankle joints, and reduce shear and pressure to the foot. Custom AFOs can be ordered with extended, plastizote-lined custom insoles (foot plates) along with deep accommodations for Charcot or a prominent styloid process. Fillers for amputations and tamarack joints can be easily added to the custom AFO as needed.

Vascular Testing

Vascular testing should be the heart of any diabetic COE. If you don't test for PAD in your office, you are missing out on a tremendous opportunity to provide the level of service and conveyance to your patients that is essential in any center of excellence. The authors all use the Biomedix PADnet® system that serves as the anchor of our respective diabetes centers. With this system, you get excellent reporting and even better integration with your electronic health record.

Indications for vascular testing include any type of claudication (thigh, leg, calf), non-healing wounds, rest pain, and any symptom that could be related to the vascular system. Symptoms must be documented well, as testing for screening purposes is not covered by most insurances. The authors highly recommend that testing

Continued on page 169

should be performed for any patient that is of need, regardless of insurance.

While a quality testing device may be expensive, what is far more expensive is not testing. It is not uncommon in some practices to appoint 10-20 tests a week. Considering an average conservative reimbursement of \$120 per test, you are looking at a very good return on your investment while saving limbs and lives. Utilizing staff and putting protocols in place to examine and ask patients the right questions regarding their vascular status are essential.

Keeping Your Diabetic Patients in Balance

One out of three adults age 65 and older falls each year and many will never rise again. In 2007, over 18,000 older adults died from unintentional fall injuries, while among those age 65 and older, falls are the leading cause of injury death.

Falls are also the most common

cause of nonfatal injuries and hospital admissions for trauma. In 2009, 2.2 million non-fatal fall injuries among older adults were treated in emergency departments, and more than 581,000 of these patients were hospitalized. Among the millions of seniors who fall every year, many are diabetic patients as a result of weakness, neuropathy, and poor vision.

A simple fall risk assessment can prevent a fall, but few do them. Implementing a fall prevention plan for your practice is easy and can start tomorrow if you have the right tools. Start by downloading and using a simple-to-use Podiatric Fall Assessment tool available on www.fallpreventionbrace.com along with articles, tools, and other resources.

Using an AFO for those at risk for falling has been shown in studies to dramatically improve postural control, enhance somatosensory feedback to the brain, and reduce the incidence of falls up to 30-60%.

Fall Prevention Plan

Putting in place a fall-prevention plan for your diabetic seniors can dramatically enhance your outcomes and place you squarely ahead of the game among your competition.

The Venous Ulceration

Most podiatric physicians know that venous swelling and ulceration can often be the most frustrating complication we see. While putting an Unna boot on someone is easy, keeping the patient ulcer-free and free from severe swelling can prove daunting.

While some in our profession are active in offering compression garments in their offices for those in need, many don't involve themselves at all, and this is a shame. Not only are 30-40mmHG compression garments covered by Medicare (not covered by Medicaid), they can be effective if the patient is educated as to how to use

Continued on page 170

and apply them. For coverage by Medicare (and other insurances), documentation of a venous stasis ulcer is mandatory. There is no specific size or depth that is indicated for coverage; however, there must be the diagnosis for coverage.

Most practitioners would contend that in the event of a venous ulceration or weeping of the legs, an Unna boot would be the primary treatment of choice to achieve healing or near healing, followed by implementation of a compression garment.

A new compression wrap now available on the market shows some promise for its ease of use and innovative design. The Circaid T3[®], compression garment is a Velcro-latch system that can offer those who can't don a regular compression sock an opportunity to be able to wear a 30-40mmHg compression garment. The good news is that the Circaids now have a HCPS code which affords decent reimbursement.

Getting the Word Out About Your Practice and Services

Not only are you the best-trained physician to treat and preserve the diabetic foot, you are also the best choice to heal a wound and keep it healed. This takes not only know-how, but the right tools available to you.

There are increasing challenges, however, to promoting yourself to the network of referring physicians, and existing patients within and outside of your practice. Conjuring strategies to educate those outside of your practice that are in need of your services about, you and your practice (or COE) can be very frustrating. It's not easy and can often mean spending unnecessary dollars.

The cornerstone of traditional marketing for medical practices used to be the *Yellow Pages*. While many still spend a significant amount of money to advertise in the *Yellow Pages*, the return on investment is diminishing at best, and disappearing at worst. The Internet and a comprehensive online marketing campaign has taken over as the go-to place for medical practices to market.

Unlike the telephone book, which provides you limited space and a static listing that you are committed to for a full year, online marketing provides

you the ability to add as much content as you would like. The anchor of your online marketing is your practice website. This is your online hub, where you have the opportunity to position yourself as the expert in your field. You must use your website to rise above the other practitioners in your area, but a flashy website is not how to do it. The best way to differentiate yourself to prospective patients and the search engines is to provide useful content...and lots of it.

should add a blog post at least once a week. Write articles 300-400 words in length on a topical issue that you have been seeing in the office. Be careful to only write about topics related to types of patients whom you want to see in your office. Also be sure to reference your geographic location so your posts can be properly catalogued by the search engines. In short order, you will find new patients attracted to the office seeking your help because you were the expert that they found online.

Education about necessary footwear and bracing starts long before the wound is healed.

Marketing on the Internet

On the Internet, content is king. Unless you are regularly adding pertinent content on your website, Google and the other search engines will assume that your site has been abandoned, and you will see your website ranking go progressively down. Adding new content to your site will show that your site is current. This can be accomplished in a number of ways.

The ideal way to update your site is to add articles to it. Depending on how your site content is managed, this can be very simple or very frustrating. If your website allows you to control and add your own content, then you have the tools. If, however, you need to request that content be added and constantly follow up with your website company, then it can be very frustrating. This is where a blog comes in.

Blogs

A blog is a section of your website, or a section of a free blog hosting website, that you have the ability to add content to. Ideally, the blog will be hosted on your website. Even if you don't have direct control of your other content, you should be able to have access to your blog. If you are unable to have a blog hosted on your site, consider using a third party, such as Blogger (www.blogger.com) or WordPress (www.wordpress.com).

Once you have the ability to blog, you now have to add content. You

Educate Your Patients

Your diabetic foot ulcer is finally healed. For some, getting a diabetic ulcer healed may have been a straightforward experience, but most have gone through an ordeal that spanned months or even years. As a podiatrist, getting the ulcer healed is only half the battle. Keeping the ulcer healed, and preventing new wounds from forming, will truly be the best service that you can provide for your patient.

Education about necessary footwear and bracing starts long before the wound is healed. In fact, your patient should have a good roadmap laid out by you from the first visit. Changes in footwear should not be new to your patient. After all, they likely were in a cast or fracture walker to offload the wound during treatment. It should only make sense that continuing to offload the wound would be necessary to keep the wound healed.

The most basic approach for a diabetic wound that is plantar to an area of pressure is an added-depth therapeutic shoe with a custom molded, total contact, multi-density insole. Wearing this shoe will redistribute pressures and offload the area that has previously broken down. Your challenge is to communicate to your patient why it is the only shoe to wear and explain the necessity of switching the insoles every four months. You also have the opportunity to offer your

Continued on page 172

patient additional pairs of appropriate therapeutic shoes with insoles to provide variety.

If you are among those who believe that “dealing with shoes” is below you or requires too much time and hassle, please reconsider—as all you are doing is facilitating your local pharmacy and DME supplier to start doing what you are best trained to do.

AFOs

For patients who have a biome-

Falls in seniors are one of the top priorities of the National Institute of Health due to their devastating effects. Identifying these patients will aid in providing them greater stability and reducing their overall fall risk. A custom-designed AFO can provide these benefits.

The Moore Balance Brace is an AFO that is a modification of a traditional gauntlet design. The casting for this AFO is the same as a traditional Arizona brace. The device itself is lightweight with Velcro closures that

Your diabetic patient is more than the ulcer you are striving to heal.

chanical breakdown of their foot like Charcot arthropathy or severe posterior tibial tendon dysfunction, a therapeutic shoe alone won't work. In these cases, it is important to remember to consider a custom ankle-foot orthotic in conjunction with the shoe as discussed above.

To achieve these goals, it is important to properly cast for the AFO. The gauntlet AFO must be cast semi-weight-bearing over foam, with the knee and ankle in perpendicular position. Be careful to mark all bony prominences and areas of ulceration to ensure the lab is able to identify them and do their part to offload them. The resulting AFO will serve the dual purpose to mechanically stabilize the foot and ankle while preventing the ulcer from reforming.

There is an often unidentified group who fall between the two previously described. There are those who have a resolved ulcer, don't have a major foot deformity requiring an AFO to properly offload, but for whom a therapeutic shoe alone is insufficient. Because of diabetic peripheral neuropathy, many diabetics will be unstable on their feet and are at risk for falls. In these cases, a different approach is warranted.

Every diabetic patient, especially those with a sensory neuropathy, should undergo a fall risk analysis. This is a simple evaluation to classify your patient as to overall risk for falling.

are easy for a senior to manage with any mobility level. The AFO is designed to provide stability which aids in balance, thus reducing the risk of falls. It also will redistribute the plantar pressures to offload the healed area to prevent another ulcer from forming.

Your diabetic patient is more than the ulcer you are striving to heal. In fact, healing the ulcer is only the tip of the iceberg. If you focus on all of your patient's needs, you will be providing the best service you possibly can. It's the right thing to do, but will pay off from a practice management perspective as well.

Educating your referring providers about the wound care services you provide will get you great returns. Whether through a lunch-and-learn with the doctors and their staffs or a series of newsletters or special reports directed to your referrers, you will find a significant return on your investment of time and resources. To reach out to diabetic patients directly, offer to speak to diabetes support groups, at AARP meetings and seniors groups to educate attendees about diabetic foot health and treatment of ulcers.

Don't assume that the diabetic population will come simply because you are there with the answers. It is vital to reach out to your referring doctors, patients, and potential patients who would benefit from your services. They need only to be informed and educated as to the extent of those services.

Conclusion

Don't forget that failing to make the time for innovation in your practice will result in your joining the masses on the gerbil wheel of futility. Take one aspect of your practice (diabetes, fall prevention, heel pain) and work diligently to create your own center of excellence. Invest in yourself and in your services, be courteous and service-friendly, and they will come. Employ smart tools to let the public know how good you are, and you'll need a bigger building. Where should you start? Try attending an AAPPm meeting and surround yourself with people who want to share and make you successful. **PM**



Dr. Moore is board certified with the American Board of Podiatric Orthopedics and Primary Podiatric Medicine and Fellowship-trained in diabetic foot salvage at the University of Texas Health Science Center. He serves on the Board of Trustees of the American Academy of Podiatric Practice Management and is Editor of AAPPm News. Dr. Moore is a lecturer and author on diabetes and practice management topics and is in private practice in Somerset, KY.



Dr. Andrew Schneider is in private practice in Houston, TX. He is a Fellow and member of the Board of Trustees of the American Academy of Podiatric Practice Management (AAPPm), a Fellow of the ACAOM



and APWCA, and a member of the Top Practices mastermind group. He can be reached at aschneider@aappm.org

Dr. Bhatia serves as the Assistant Medical Director of the Wound Clinic at Fairfield Medical Center in Lancaster, OH. He has been in private practice in Columbus, OH for the last 12 years, focusing largely on chronic wound care. He is a board certified wound specialist, a Fellow of the American Professional Wound Care Association, and a Fellow and regular speaker for the American Academy of Podiatric Practice Management.