Wound Care Centers Offer New Opportunities

BY JEFF EVANS
Senior Writer

BALTIMORE — The increasing need for wound care centers in the United States may present an opportunity for dermatologists to wed their interests in both medical and surgical dermatology, according to Dr. Robert S. Kirsner.

"Wound care is at the junction of surgical and medical dermatology. To somebody with broad interests, it may be attractive because there are certain wound problems that require the internist in you and some wound problems that require the surgeon in you," said Dr. Kirsner, director of the Wound CURE (Cutaneous Ulcer Rehabilitation and Education) Center at the University of Miami.

Dermatologists can offer their expertise in wound care by directing or even opening up their own wound care clinic or by practicing or consulting part-time with a center, he said.

Some wound centers have a dermatologist who works there a half or full day per week, but typically a dermatologist is a consultant to a wound center and sees patients with dermatologic conditions such as pyoderma gangrenosum, vasculitis, or immunobullous disease, Dr. Kirsner said in an interview.

Wound care centers that include a physician may be run from a solo or group practice or based in an ambulatory center or at a hospital. Hospital-based centers may be the more "economically savvy way of doing it," Dr. Robert D. Galiano said at the annual meeting of the American Society of Plastic Surgeons.

A center can be established independently by a physician, fully staffed by an outside company, set up by an outside company that the physician then runs, or formed by a mix of these approaches. Regardless of the type of wound care center, about 35% of all hospitals now have some sort of formal wound care center, "and I

think this number is only going to increase," said Dr. Galiano, who is in the process of establishing a wound care center at Northwestern Memorial Hospital in Chicago, where he is a plastic surgeon.

To determine the best course to take for Northwestern's wound care center, Dr. Galiano visited a wound care clinic at an academic medical center, a research-intensive podiatry-based center within an academic medical center, a small university-based center that was affiliated with a wound management company, and a wound care center at a large state academic medical center that also was affiliated with a management company.

During his visits, Dr. Galiano learned that most wound care centers "will be met with a high rate of skepticism. There's a feeling out there that wound centers are loss leaders and certainly not profitable." The success of centers at large academic institutions will depend on the costs of the facility, rent, and personnel; the types of wounds treated; and the role of research as an adjunct to revenue.

All of the centers that Dr. Galiano visited were well established and profitable. Such centers were also very labor intensive and left little time for other clinical activities.

Facility costs need to be shared with or underwritten by the hospital since the costs of running a center will probably not be covered by the revenues that the center itself brings in for ambulatory visits. "You have to incorporate downstream revenue," Dr. Galiano advised.

The costs of durable medical equipment and goods, such as the best dressings, need to be controlled in some way because most academic medical centers are nonprofit and will not allow physicians to bill for the best, most expensive dressings. Arrangements could be made with another provider not affiliated with the hospital to provide those materials on-site and then bill the patient directly for them, he suggested.

The most successful centers that Dr. Galiano visited had a large volume of inpatients with chronic wounds that consisted mostly of diabetic foot ulcers, which are associated with the highest-paying diagnosis-related groups.

Dr. David L. Steed, a vascular surgeon who is director of the wound healing/limb preservation clinic at the University of Pittsburgh, handles about 4,000 patient visits per year with his colleagues. The clinic cares for venous stasis ulcers (41%), diabetic neuropathy foot ulcers (27%), ischemic ulcers (13%), pressure ulcers (10%), and other types of chronic wounds (9%).

Dr. Steed's clinic, which is not hospital based, handles all charges itself, and must break even. The clinic employs a nurse practitioner, research nurse, patient care technician, diabetes educator, and podiatrist and has one student (medical or nursing) or resident (surgery or dermatology) present at a time. Plastic and orthopedic surgeons, as well as dermatologists and diabetologists, frequently consult on cases.

"We break even in the clinic, but all the things I send to the hospital make money," he said at the meeting.

At a wound care center, it is reasonable to expect about 40% of patients to be new to the hospital and that 15% on their first visit will require hospital admission, ambulatory surgery, or angiography, Dr. Steed said. Nearly all wound center patients use radiology and laboratory services.

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DR. KIRSNER

In another presentation, Dr. David Hurley said that he initially balked at the idea of opening a comprehensive wound care center at the hospital in which he worked as a general plastic surgeon and vice president. After the hospital opened a center without his support, he was later offered the opportunity to become its medical director.

He learned that his skepticism of wound care treatments, such as hyperbaric oxygen therapy, was unfounded. "They sent me off to a couple courses, and what I learned was that my understanding of comprehensive wound care had really stopped back with my residency training. It had not been a focus of my training," he said.

"One of the things driving the interest in the development of comprehensive wound care centers is the fact that we now have a much better understanding of the biochemistry and physiology of problem wounds," he said.

Dr. Hurley spent more and more time at the center and began looking at it as a possible exit strategy from his plastic surgery practice. Three years ago, he left his medical practice to become the chief medical officer of the management company that had helped to set up the center. That company, Diversified Clinical Services, Jacksonville, Fla., partners with hospitals to manage, operate, and develop comprehensive wound care centers. ■