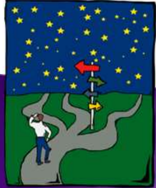
Procuring the Preferred Future for Skin and Wound Care



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Objectives

- Identify the preferred future for skin and wound care in your setting
- Discuss how to garner administrative support when articulating the need for resources for optimal pressure injury prevention and wound care
- Examine how an interdisciplinary team is ideal for implementing evidence-based practices

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What is the current culture of care?

- Depends on who you ask…
  - Provider driven by some patients
  - Payer driven by some providers
  - Patient driven by some nurses
- Or do we have a culture of “cure”?
  - And how much money are we going to spend on it?

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Extent of the Problem

- PrI = 2,500,000 [1]
- DFU = 1,600,000 [2]
- VLU = 4,600,000 [3]
- SSI = 157,000 [4]
- Burns = 40,000 [5]
- Prostate CA = 288,300 [6]
- Breast CA = 207,790
- Lung CA = 120,790
- Bowel CA = 81,860
- Melanoma – 58,120

How much of your facility's resources are being spent on cancer care compared to wound care?

Patients with Wounds | Patients with Cancer

1 AHRQ; 2 Armstrong, 2023; 3 Lorimer 2003;
4 NHSN, 2024; 5 American Burn Ass'n, 2023; 6 American Cancer Society

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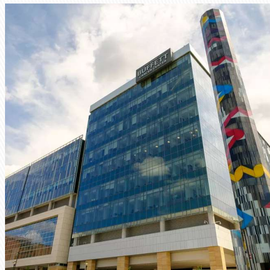
UNMC and Methodist Cancer Centers



Buffet Cancer Center

Estabrook Cancer Center

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The Nebraska Medicine Wound Clinic Entrance

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Can we make PI more important?

- Not without interdisciplinary engagement
- Who is on your wound team now?
  - If it is just nurses, then your system sees PI as a nursing problem… a nursing quality indicator
  - Is that why the MD notes say nothing about skin or say "no rashes, no lesions" when a PI is present?
- Can we engage hospitalists for weekend management?
  - If nurses can't stage, then what policy is implemented from 1700 Friday to 0700 Monday?
    - Most are based on wound stage not appearance

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Can we quit setting goals of zero?

- We will never have zero HAPIs
- We need to
  - use AI to determine risk accurately
  - get support surfaces that reduce pressure and shear when HOB is up over 45 degrees
  - determine in what patients PI are unavoidable
  - risk adjust patient situations
    - Remove skin failure from our lingo

Jackson, SS et al. Electronically available comorbidities should be used in surgical site infection risk adjustment. Clin Infect Dis. 2017, 65 (5) 803-810

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Can we change our practice?

- We must have enough WOC nurses to guide prevention in high risk patients
  - ICU, OR, NICU
  - Very high risk patients have 10 times the risk of developing HAPI that minimal risk patients
- Consider implementation of SPIPP (at npiap.com)
  - Note turn Q 3hrs, leg up position (see infographic)

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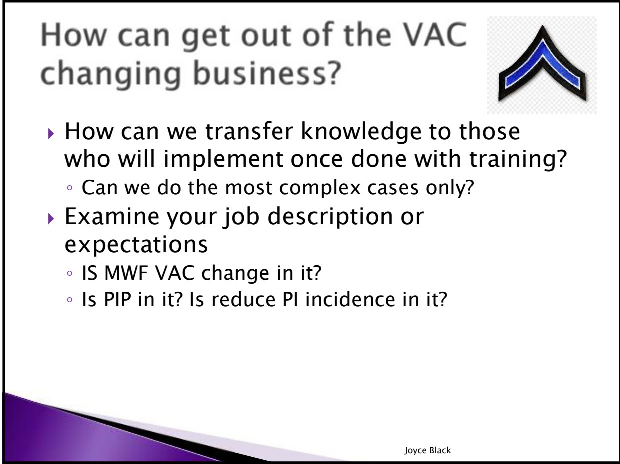

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It Starts with Leadership

- Leadership initiatives
  - Recommended WOC/bed ratio 3.8 WOCs/1000 beds
  - Adding one WOC nurse per 1000 hospital beds reduced the rate of HAPI by 17.7%
  - Annual programs to highlight competency and prevention efforts
    - Old NDNQI slides now on NPIAP site
  - Attendance at CE programs – many today by webinar
- Performance improvements
  - RCA must be done when PI found
    - And discoveries must be addressed at that time

Padula, WV, et al. Investing in Skilled Specialists to Grow Hospital Infrastructure for Quality Improvement. J Patient Saf 2021 17 (1), 51-55

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Telling the story

- Communication of true pressure ulcer problem
  - C Suite
    - Do they know your numbers?
  - Operating Room
    - Do they know what PIs started in OR?
  - Emergency Room/Department
    - Skin assessments on admission to ED
    - Placing patient into a bed when admission is delayed
    - Collecting data from EMS on position of patients found down in the field -to rule in DTI later
- Lack of root cause/common cause analysis

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C Suite: 3 Important First Steps

- Get Administration By-In
- Know Your Numbers and Costs
- Find your weakest areas by looking at cases and doing a root cause analysis
  - Don't rely on your NDNQI data to tell the whole story
    - Especially avoidable and unavoidable HAPI

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C-Suite Involvement

- Engages in bi-directional transparent communication.
- Appoint executive level liaison
- Identifies PIP clinical program facilitator and outlines reporting structure
- Supports IDT development
- Sets clear expectations for outcomes
- Removes barriers
- Ensures adequate staffing on unit level
- Support provision of EB product resources

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Budget Disparity…

- C-Suite may be unaware of the entire scope of the problem within the facility.
  - Data (physical harm to patient) + Cost to Treat+ Litigation= Investment of the Executive Administration
- Materials management operates under a budget directed by the goals and scope of the organization.
  - May state, "new dressings are not in the budget."
    - Don't spend more…switch from treatment to prevention

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Get your numbers/Compute Cost

- Present the current HAPI/FAPI rates to administration and their cost
  - Stage 1 = $893.00
  - Stage 2 = $3560.00
  - Stage 3 (uncomplicated) = $6550.00
  - Stage 4 (surgical care) $ $129,248.00
    - Data from Padula, 2019; Brem,2010
- Annualize the cost data for your unit/hospital
  - Current hospital rate is 2.5% (2% stage 1/2, 0.5% stage 3/4)
  - Annual acute admissions are 24,557
    - 491 stage 1 and 2 at 893/3560 = $1,081,210
    - 122 stage 3 and 4 x 6550/129,248 = $8,283,678
    - *Total cost if remains hospitalized is $9,364888*

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The Interdisciplinary Team

- Members
  - Where do PI start? –ED, ICU, OR, under devices
  - Where are PI cared for? General units, wound clinics
  - Who manages the staff?
  - Who monitors the staff? RCA teams, Quality, Risk managers
  - Who educates, trains?
  - Who diagnoses?
- The patient should also be a member of their hospital team
- Consider placing a member on the wound team

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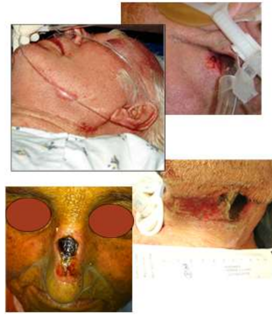
Oxygen Delivery Devices Have Highest Incidence of MDRPI

- Airway highest priority
- Difficult to place
- Facial contour varied
- Continuous securement to protect the airway
- MDRPI classified as nonserious problems



Wilson ME et al. Association of Home Noninvasive Positive Pressure Ventilation With Clinical Outcomes in Chronic Obstructive Pulmonary Disease: A Systematic Review and Meta-analysis. JAMA. 2020;323(5):455-465.

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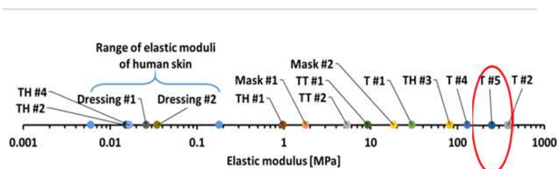
MRD PI is Primarily due to Stiffness of Tubing



Data from Gefen and Solmos, 2023

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Respiratory Therapists Must be Team Members

- Some Facial PI start before admission
  - Patient at home with CPAP on continuously
  - Lexie Carraway, RT presented how she detects early DTPI with thermography on admission at recent NPIAP
- Possible interventions
  - Place protective dressings in ED and on the RT carts
  - Then the dressing is available to be placed on the face and bridge of the nose for CPAP
- Alternate responsibility with RT for moving oxygen delivery devices that can be moved

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The Patient As A Member of The Team

- Patient Engagement is Being Recognized by Many
  - But being endorsed?
- 3 Basic Tenets
  - Education
  - Advocacy
  - Engagement
- Will still say patients are “noncompliant”
  - Can a demented patient be noncompliant?

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We Must Have a Lot of Noncompliant Patients …Or So I Hear

- This term is used a lot and meant to describe the patient who *does not follow* the prescriptions for care
- What assumptions are we making when using this term?
  - Has the capacity to comprehend but just won’t do what is told
  - Speaks, hears and understands English
  - Fully understands all the big medical words we use
  - Can read and fully understand our written materials
  - Is not too anxious to understand what we are saying
  - Doesn’t appreciate all the expertise we are bringing to him/her for care
  - Thinks what is being asked is ridiculous
  - Has plenty of money/insurance to buy meds and supplies
  - Can stay home-- has enough sick leave and family support
  - Has no family obligations that would take priority

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How Can We Turn This Around?

- Get to know the patient
  - “If you weren’t here with me today, what would you be doing?”
- Understand the disease from their perspective
- Understand their social situation which might constrain their capacity
- Serve as an advocate for the patient and family
  - Communicate with the healthcare team
  - Protect the patient’s safety
  - Remove barriers to care
  - Let the patient tell us about their preferred treatment plan
  - If a chronic illness, ask about support group interaction

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How Can Patients Be Engaged?

- Organizational Level
  - Patient care surveys
  - Patients used as advisors to the hospital
  - Patients co-lead safety and quality improvement committees
- Federal Level
  - Focus groups with patients with similar diseases
  - Patient recommendations about research priorities
  - Representation on agency committees

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The future includes outcome measurement

- Because the pay for service model was expensive and outcomes were not great
  - US per capita health care cost = $7598
  - UK per capita health care cost = $3311
- Federal payments will be tied to quality of care metrics and population level outcomes
- Private insurers following suit with value based purchasing models

Flattau, Thompson, Meara, OWM, 2013

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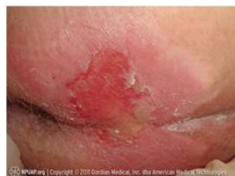
Goals for all patients with wounds

- Return to form and function
  - Seen best in acute wound healing
  - Scar prevents form and function in large wounds and chronic wounds
  - Wound closure in patients at end of life or end stage disease is not the priority for care
- Patient engagement
  - Management of condition
  - Management of wound



This buttocks ulcer will likely heal due to its shallow tissue loss, but only if the incontinence is controlled and the skin is protected

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Outcome measures for chronic wounds

- Expected outcome measures
  - Healing rates in 12 weeks of care
  - Health related quality of life
- Recent CMS questions addressed when a wound has deteriorated…
  - Is the presence of slough a sign of deterioration?
  - Is the presence of eschar a sign of deterioration?
  - Is the evolution of DTI a sign of deterioration?
  - Is a larger wound a sign of deterioration?
- Why is CMS looking at these outcomes?
  - Because it is the most common things measured in wounds! We have led them to believe that is the outcome of interest!

Cho, SK et al. Development of a model to predict healing of chronic wounds within 12 weeks. Adv Wound Care, 2020 9 (9), 516-524.

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Benchmarks for Healing

- Diabetic Foot Ulcers
  - 90% healing with TCC in 12 weeks
  - 65% healing in walker boot in 12 weeks
- Pressure Ulcers
  - 57-61% Stage II healed in 12 weeks
    36% full thickness healed in 12 weeks
  - So be certain the initial stage is recorded
- VLU
  - 53% healed in 12 weeks

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Wound outcomes and goals

- One goal is a healed wound
  - However, Complex wounds that require a team and several months and several modalities to heal
- Some wounds will never heal
  - *Could we accept a nonhealed wound as a satisfactory outcome?*

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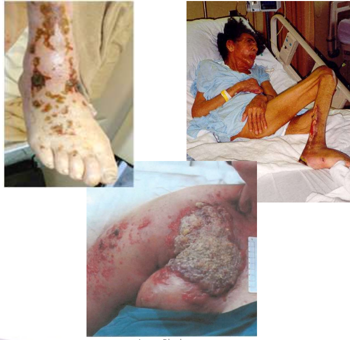
Wounds that will never Heal

- Inability to control underlying disease
  - Diabetes
  - Malnutrition
  - Venous hypertension
  - Arterial inflow
  - Pressure loading
  - Infection
  - Cancer
  - Paralysis



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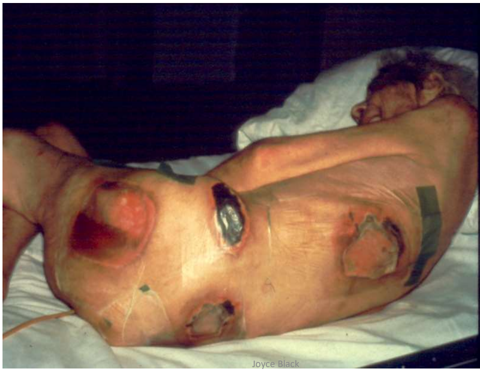
Huge issue: When to Stop?



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