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How Aligned is your WoundCare Program?

WoundCentrics
INTEGRATED SOLUTIONS

In an insightful article in Becker Hospital Review, authors Lovrien, Peterson, and Salmon distinguish three types of provider alignment; namely Clinical Activity Alignment, Economic Alignment, and Alignment of Purpose, proposing that enduring success in a future healthcare market requires balanced emphasis on all three parameters of provider-hospital alignment.[1]

Woundcare is a critically important service line in the LTAC, with wounds representing a disproportionate share of discharge diagnoses, and a disproportionate share of CC and MCC diagnoses.

Forward thinking organizations have made development of Woundcare Departments a strategic focus. It's no secret that the most successful LTAC organizations reap the rewards of high-functioning woundcare programs, in season and out, largely on the basis of provider alignment.

But how do we measure the parameters of alignment that predict successful, profitable woundcare programs? The answer is critical if a hospital, or health system intends to optimize, and maximize its woundcare opportunity.

Kurt Salmon, the strategic advisory firm whose analysts wrote the aforementioned article, offers a tool to help facilities and systems perform this sort of analysis, but it is not specific to woundcare. Let's see if we can create some focused benchmarks using the framework, to help shed some light on alignment as it pertains to woundcare programs.[1]

[1] **Creating Stronger Physician-Hospital Alignment,** Kate Lovrien and Luke Peterson, Becker Hospital Review, January 2011

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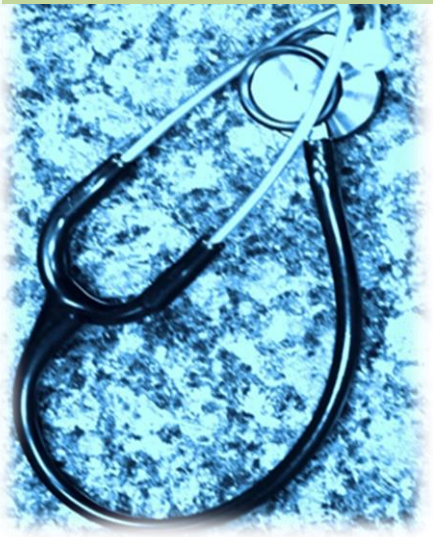

We will assess 5 components each, in the areas of Clinical Activity, Economics, and Purpose. Finally, we will compare three facilities using the assessment tool, using a 5 point scale to rate each parameter, for a maximum possible total of 75 points across the three areas.

These components have been chosen for strong correlation with sustainable success in terms of outcomes, cost containment, maximization of DRG revenue, and optimal referral levels.

Provider – Hospital Woundcare Alignment Diagnostic

Diagnostics

Clinical Activity

- Woundcare training and qualifications of providers
- Quality tracking systems in place (data collection)
- Quality assurance systems (pressure ulcer prevention, etc.)
- Outside auditing and oversight
- Continuity of care

Economic

- Percentage of practice devoted to facility and facility aligned programs
- Formalization of relationship with facility (i.e. employed, medical directorship, medical staff member, etc.)
- Mechanisms for tracking of care-associated costs (utilization of specialty beds, wound vac utilization)
- Provider is involved in efforts to optimize facility staffing costs for wound care
- Compliant incentive structures

Purpose

- Branding (is woundcare program branded as facility, or as provider)
- Marketing involvement by providers
- Cooperative educational initiatives pairing providers and facility personnel
- Provider leadership in program development, QA/QI
- Provider / Facility satisfaction are maximized

To illustrate the use of this diagnostic tool, we will look at three hypothetical LTAC woundcare programs, assessing these programs on the basis of our component matrix, arriving at an alignment point score.

Facility A is a 36 bed LTAC in a metropolitan suburb. The facility is well established, with referrals predominantly coming from two different STAC facilities, as well as a number of skilled nursing facilities. Woundcare is handled by a WOCN, who performs most wound evaluations. Formal consults are performed by a plastic surgeon.

About 30% of patients receive a formal wound consult. Of these, about 80% receive an excisional debridement. More than 20% of excisional debridements are done outside the facility, at considerable expense. The plastic surgeon is under contract as a facility Woundcare Medical Director. In that role, her MEC meeting. Attendance is infrequent, meeting only the mandatory minimum for medical staff participation. She reviews cases on prn basis with the WOCN, with the WOCN screening patients to “make sure they are complicated enough for the surgeon.”

The plastic surgeon operates at both nearby STAC facilities, and an outpatient surgi-center. She holds no formal wound care certifications, but is considered competent by colleagues in the area of woundcare. The surgeon does not participate in marketing the LTAC wound care program in the community, or to other physicians, preferring instead to promote her participation at the LTAC as merely one of her practice settings. While the facility Medical Director feels that the hospital “does a good job with wounds,” the only metric currently tracked at the facility is the incidence of iatrogenic wounds. Any data tracking must be performed manually, other than limited data derived from LTRAX.

No formal quality programs are in place, but the WOCN periodically gives in-service training to facility RNs PRN, “when we have an increase in pressure ulcers.” The WOCN has expressed that physician leadership would be helpful in promoting stewardship in this regard, but “the surgeon is just too busy.”

Discharged patients are often seen by the plastic surgeon in her office, but she surgeon does not round in area Skilled Nursing Facilities; a fact that has resulted in some long-stay outliers recently, as the surgeon was unwilling to forego the convenience of being able to see the patient in the LTAC, and unwilling to trust SNF facilities with which she has no affiliation to provide adequate post-acute care for her patients.

Facility B is a 40 bed LTAC in major metropolitan area. The woundcare team is led by a General Surgeon. The surgeon is frequently consulted for General Surgical problems by other LTAC physicians, and as such, is often seen in the facility making rounds. He does not make formal “Wound Rounds” however, preferring that the facility wound nurse – an LVN holding a WCC credential – consult him on an as-needed basis, particularly for wounds requiring operative debridement, or where there is suspicion of infection or significant treatment failure. Most debridements are handled by the WCC, and are non-excisional.

The facility does not actively promote its wound care program as such, considering it incidental to the LTAC as a whole. The surgeon does not participate in formal wound rounds, but when present in the facility, he will review care plans with the WCC nurse if requested. The WCC has privately expressed frustration to the DON over a lack of “leadership” in wound care. She feels that more participation would improve outcomes, and allow for optimization of important aspects of the wound care service, including rationalizing formulary decisions, improving specialty bed utilization, and reviewing treatment protocols.

The facility wound nurse tracks iatrogenic wounds, and wound infection rates, but no other metrics. In part, this is due to the completely manual system for data collection, which would require manual chart stripping to collect data on healing rates, wound types, and other quality metrics. The WCC has asked the chief administrator to consider implementing an EMR, but the idea was rejected, as no physicians were willing to champion the initiative.

The WCC nurse provides a semi-formal implementation of the PUPS (Pressure Ulcer Prevention Survey) process, but there are no other formal quality improvement programs within the wound care department.

The Wound Care Medical Director does not participate in marketing programs, and has expressed that “wound care is a nursing function,” rather than a distinct “practice” or “department” to be marketed. He sometimes expresses the opinion that wound care is a “necessary evil,” and has indicated that when his OR schedule gets busier, the facility will just “have to make do without him,” because he “loses money every time he comes here”

Patient’s discharged from the facility are followed by their primary physician, SNF wound nurse, or the surgeon (in cases where a surgical procedure was performed).

Facility C is a 34 bed LTAC in a suburb of a major metropolitan area. The facility has been in operation for 9 years, but was acquired one year previously by a company that operates LTAC facilities in 10 states. This company has a corporate level policy to promote wound care as a service line in all of its LTAC facilities, and has chosen to partner with a management service company that provides wound care programs focused on the needs of the LTAC.

Prior to being acquired by the new company, the LTAC wound care team was led by a local internist with an interest in wound care, but whose practice was 90% focused on providing hospitalist services with a local call group that provides such services to a nearby STAC, in addition to the LTAC. The physician had been very supportive of the wound care mission at the facility, expressing that he "wished he had time to help build up the department." A trusted physician among his hospitalists, as well as regional surgeons, he received one to two admission referrals per month at the LTAC from the STAC, with primary wound diagnoses. When the LTAC was purchased, the chief administrator expressed reticence about changing the wound care program, due to concerns that these referrals would "dry up."

The new wound care management company assuaged the administrator's fears by constructively engaging the internist to continue leading the wound care program at the facility. The new team retained the previous wound care nurse, an RN holding the WOCN credential, with the internist serving as a "Woundcare Medical Director." In addition, the management services provider brought a new wound-care-fellowship trained mid-level practitioner to the facility to provide Evaluation and Management, and procedural services related to wound care 5 days per week, under the medical direction of the internist.

Whereas previously the physician had been able to provide formal consultation and reevaluation to less than half of the patients admitted to the facility with a primary or secondary wound diagnosis, under the new system, all patients with an identified wound are now provided with a *formal wound care consultation*, and all patients with such diagnoses are re-evaluated at a case-appropriate frequency by the mid-level provider, with appropriate oversight provided by the Woundcare Medical Director on an as-needed basis.

The Woundcare Medical Director and mid-level provider in the facility are provided with ongoing , focused training in LTAC-specific: clinical documentation improvement, woundcare best practices, rubrics for optimal utilization of specialty beds, dressings, and negative pressure wound therapy (NPWT), and marketing strategies tailored to LTAC-based wound care programs. The Woundcare Medical Director has expressed to the chief administrator that he is "proud of his new team," and that he feels the quality of care has improved. Moreover, he is enjoying his new role as a wound care Team Leader and Medical Director, while finding that he has as more time left over to dedicate to his hospitalist practice.

90% of debridements are now done in-house, according to rigorous standards for utilization, safety, and patient satisfaction. This change alone yielded rapid savings on costs formerly associated with out-of-facility debridements. In addition, the application of rigorous wound care standards has resulted in an increase in case mix index, due to more effective Clinical Documentation Improvement, optimal debridement, and through referral of more complex cases as the visibility of the wound care program has increased. Specialty bed costs have fallen sharply, and NPWT use is at an all-time low, through use of evidence-based rubrics.

Since the inception of the new program, the facility has seen a strong improvement in metrics related

to wound care, including wound healing rates, infection rates, and iatrogenic wounds. However, no other statistics were previously tracked. Currently, an extensive suite of metrics are tracked, including utilization of specialty beds, NPWT (Wound Vac), healing rates by wound type, trends in wound diagnoses, and wound referral patterns.

The facility administrator now receives a monthly report showing these metrics, and trending patterns, and he has expressed that "they have a handle on their wound care program now." He has also begun to initiate focused marketing efforts, using facility marketing staff, with a data driven approach, making use of this newly available data; a program that has already generated positive feedback from important regional referral sources.

The mid-level provider attends IDT meetings, providing much needed continuity, and enhanced communication, resulting in clarification of wound diagnostic language, pressure ulcer staging, and comorbid diagnoses In fact, facility coders have complimented the new program for providing more consistently code-able diagnostic language. In addition, they have noticed more attention to identification of pertinent CC and MCC diagnoses, and a greater awareness of common co-morbidities affecting wound patients. As a result, the coding staff are now confident that they are coding more accurately, and capturing the true acuity of their wound patients. A formal PUPS (Pressure Ulcer Prevention Survey) process has also been implemented within the facility, to maintain low rates of iatrogenic wounds.

The wound team has engaged the surrounding community, providing focused wound care education sessions at Skilled Nursing Facilities in the area, These sessions are a joint effort partnering the facility wound nurse, and the mid-level practitioner; a program which has been very well received by the community, and which has raised the profile of the LTAC woundcare program. The chief administrator feels that this program will inevitably lead to more referrals, due to increased familiarity with the capabilities of his wound care team.

In tandem with these teaching events, the wound care management company is now providing clinical wound care services via the LTAC mid-level practitioner to Skilled Nursing Facilities (SNF) in the area, finding ready acceptance at most of the local facilities. This "umbrella program" is branded with the LTAC name, and it has been viewed very favorably, as it provides access to high-level clinical services within facilities where wound care was formerly provided only by SNF nursing staff.

The program now extends to 4 skilled nursing facilities, and 3 nursing homes. Quality of follow up care for patients discharged from the LTAC has been noticeably impacted, and the chief administrator believes that the umbrella program has become a key source of referrals. The LTAC marketing director accompanies the mid-level provider while she is making rounds on occasion, creating high-impact, informal marketing interactions. Also under consideration is a two-half-day per week outpatient wound clinic, to further enhance the profile of the facility wound care program, and to increase continuity of care for patients discharged to home.

Wound care metrics are tracked by the wound care management company, and compared with national standards of care on a monthly basis, and interventions are suggested when indicated. These metrics are tracked via a proprietary EMR system, provided to the facility by the management company at no additional charge. EMR data is collected by facility nursing staff and technicians at the point of care after a thorough training process.

The facility Medical Director is also engaged regularly by the management company, to assure optimal alignment with facility goals related to clinical quality, cost-containment, provider relations, and program marketing. The management company requires its Wound Care Medical Directors to participate in CME related to wound care and Clinical Documentation Improvement, and encourages (and pays for) its physicians to sit for a wound care certification exam, such as the CWS examination. Hour-for-hour payment for participating in these programs strongly incentivizes participation, and compliantly encourages alignment with company administrative policies, clinical standards, and cost-saving measures.

How do each of these programs stack up on our Wound Care Alignment Diagnostic? Let's Score them to find out!

Clinical Activity

Component	Facility A	Facility B	Facility C
Woundcare training and qualifications of providers	3	2	4
Quality tracking systems in place (data collection)	1	1	5
Quality assurance systems (pressure ulcer prevention, etc.)	1	3	5
Outside auditing and oversight	1	0	5
Continuity of care	3	1	5
Total Points	9	7	24

Economic

Component	Facility A	Facility B	Facility C
Percentage of practice devoted to facility and facility aligned programs	3	3	5
Formalization of relationship with facility (i.e. employed, medical directorship, medical staff member, etc.)	2	2	5
Mechanisms for tracking of care-associated costs (utilization of specialty beds, wound vac utilization)	1	2	5
Provider is involved in efforts to optimize facility staffing costs for wound care	0	0	5
Compliant incentive structures	3	2	5
Total Points	9	9	25

Purpose

Component	Facility A	Facility B	Facility C
Branding (is woundcare program branded as facility, or as provider)	1	0	5
Marketing involvement by providers	1	1	5
Cooperative educational initiatives pairing providers and facility personnel	0	0	5
Provider leadership in program development, QA/QI	2	1	5
Provider / Facility satisfaction are maximized	2	1	5
Total Points	6	3	25

	Facility A	Facility B	Facility C
Alignment Scores	24	19	74

This exercise illustrates the many modifiable factors that impact LTAC woundcare program alignment, and which by extension affect overall facility success. In addition, the exercise shows the impact which is attainable through a purpose-driven, managed specialty program that is system-based, and data driven.

Are programs like the one described under Facility C actually available in the "real world?" In fact, the program described at Facility C can be implemented in most any LTAC, today. WoundCentrics, LLC was founded on the principle that LTAC wound care is a tremendous opportunity, but one that must be carefully managed in order to achieve the enduring woundcare program success that LTAC administrators hope for but rarely achieve.

Alignment doesn't simply happen. It must be built, ideally from a standards-driven, best-practices template. In addition such programs must be data-driven to assure sustainable gains and year-on-year growth. Finally, such programs must embody *structural alignment principles*, with contracted program management, and providers who are trained and retained under contract.

We would suggest that you analyze your own LTAC according to these core metrics, and see how your own wound care program measures up. Is it aligned? Or, is it simply the result of circumstances and politics, yielding more frustration than promise?

WoundCentrics

7008 Indiana Ave, Suite B
Lubbock, TX 79413
800-796-4870
806-698-8588

Michael Nash, COO
michael.nash@woundcentrics.com

Find us on the Web:
www.woundcentrics.com

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If you would like help with optimization of your LTAC wound care program, we would like to be of service. WoundCentrics, LLC can provide a full spectrum of services, from initial program evaluation, to implementation of a full wound care program in your facility. To arrange for a no-cost evaluation, contact our team.