Improving Wound Outcomes with a Coordinated Cross Continuum Wound Service

Debra Healey, MSN, RN, CPHRM, NEA-BC

Objectives

1. Describe several examples of innovative business planning to provide quality integrated wound services across the continuum of care (inpatient, homecare and primary care)
2. Identify a care coordination model for integration across the continuum of care (inpatient, homecare and physician office practices)
3. Demonstrate the implementation of efficiencies gained using a coordinated care model using a Case Study
Who are we?

Middlesex Hospital Homecare and Collaborative Partners:

- Homecare services: Medical, Surgical, Rehab
- Hospice/Palliative Care and S7, Inpatient Hospice
- Center for Chronic Care Management
- The Middlesex Hospital Wound and Ostomy Center / Inpatient Wound Team

Middlesex Health System Service Area

22 Towns
Total Population @ 248,000
Total Square Miles @ 623
So - How do we demonstrate our value?

• Be creative
• Look for opportunities not just in your own house
• Look for places to create revenue elsewhere in a system
• Look for places where you can create savings
• Be identified as the solution
Proving Demonstrated Value

• Collect the data
• Report timely on the total value you bring to the table, remember it is not just revenue

Value = Delivery of Quality Care + Revenue Generated
       + Savings Gained

Wound Services Silo
Practice Model

• Staff in each practice setting, no cross-training
• New orders and supplies with each care transition
• Different staff at each care transition
• New orders and potentially new physician in each setting
Wound Services “Make-over”

Coordination of care at each transition:

- **Review** each wound patient is reviewed by a care transitions nurse or case manager
- **Build** complex wounds are evaluated by an APRN or wound certified nurse
- **Design** a custom care plan is designed for each patient based upon need.
- **Assign** Wound patients are stratified based on an established criterion and assigned to a homecare case manager or referred to the outpatient wound center
- **Outreach** Review of each patient at bi-weekly case conferences

Wound Services Redesign

- Staff cross train to work in all settings - Inpatient, Outpatient and Homecare
  - APRN’s
  - RNs
  - Medical Assistants/Aides
  - Clerical Support
Wound Care Formulary

- Wound supply re-design...
  - Wound supplies are standardized in all settings
  - Wound Vac supplier is standardized to go from inpatient to home with no interruption in service
  - Process developed for wound evaluation to decrease daily wounds within 7 days of homecare admission

Wound Reports

- Inpatient Wound referral/evaluation updated
- Wound report developed to update physicians on wound treatments
- “wound rounds” developed for Homecare nurses to get wound expert consultation
Wound Pictures

- Use of wound pictures to transfer information between providers and to physicians
- One example is an I-Phone app called “click-care”

Wound and Skin Team

A specialty Wound and Skin Team was developed that includes members from all practice settings:

- Inpatient
- Outpatient Wound and Ostomy Center
- Homecare
Wound and Skin Team Membership

The team meets monthly to review wounds across the care continuum and review case studies.

Membership:
- Inpatient RN's
- APRN’s
- Outpatient RN's

Results

One example of decrease in HAPUs in one year using wound team consults

HAPU, CCU 2012: 38
HAPU, CCU 2013: 17
Across the Continuum Integration

Building Referrals for Care Coordination

Hospital Rounds
- Multi-disciplinary (not just physicians)
- Multi-departmental collaboration
  - Hospitalists
  - Nursing
  - Therapy
  - Community
  - Chronic Care Managers
  - Homecare RN Liaisons
Right Provider in The Right Place

Wounds can be identified in any care setting:
  - Inpatient
  - Outpatient/Surgery
  - Direct referral to wound and ostomy center
  - Physician offices

Result:
Maximizes income and quality outcomes

Case Study “Makeover”

JS: a patient receiving Silo care

• Surgery 1-13-12, inpatient 3 days for colectomy. 8 nurses involved in care with no wound expert nurse

• JS is discharged home with Homecare services and sees one admission nurse and 2 RNs during a 6 week episode of care

• JS returns to her Physician for a 2 week follow up with instructions to the homecare nurse to order supplies and discharge patient
Continued – JS Case Study

• JS is discharged from Homecare but the insurance company does not approve the supplies that the hospital provided, patient goes to the wound and ostomy center for more teaching

• JS is seen twice at the Outpatient Wound and Ostomy Center by an APRN and an RN before she is discharged with the confidence to manage her colostomy and order supplies

• During the 6 week episode for JS from surgery to discharge from the Wound & Ostomy Center she sees over 10 nurses. She states on her satisfaction survey that the care lacked continuity

The Integrated Wound Care Model

• JH has surgery on 2-1-13 for a temporary colostomy and is cared for under the new integrated care model

• Mary the Wound and Ostomy Certified RN sees JH in the Wound & Ostomy Center for site marking

• Mary visits JH in the hospital after surgery, provides teaching, checks insurance to order supplies prior to discharge

• Mary sees the patient at home during his homecare episode & consults with the homecare primary care nurse on care plan & supplies
The Integrated Wound Care Model-cont..

• JH goes back to his Physician and receives a good report on the status of the healing and is discharged from homecare with a follow up appointment to the Wound and Ostomy Center

• Mary sees JH one more time in the Wound and Ostomy Center to reinforce teaching and finalize home supplies.

• JH sends his patient satisfaction survey with high scores for the consistency of the wound specialty nurse in all settings.

Results...  

• Improved patient satisfaction
• Decrease in amount of staff needed to provide care
• Improved efficiency for referrals across the continuum
• Successful discharge with wound healing
• Breaking down of silos to provide coordinated care
Case Study Time Line

- **02-1-2013**: Patient has surgery at Middlesex Hospital
- **02-4-2013-03-24-2013**: Post Acute referral to Middlesex Hospital Homecare – 6 week episode of care
- **03-18-2013**: Post OP surgeon visit
- **03-25-2013**: Visit of outpatient Wound and Ostomy Center for final follow up visit, teach and supply ordering
- **04-1-2013**: Patient is received telephone follow up call for wound care nurse to check on progress and provide telephone support
- **06-1-2013**: Patient satisfaction report is received that reports high scores for continuity and coordination of care

How did we integrate the team?

- Recruit team members with an interest in cross training.
  - 3 Wound and Ostomy Certified nurses are cross trained
  - Recruit APRN’s with an interest in practicing in a variety of settings
  - Build team interest in integrating care – to date 9 nurses, 1 aid and 2 clerical staff cross trained
Budget Savings

Decrease in FTEs
- All wound services now managed by one manager vs. 3
  Savings = 1 FTE
- RN staff increased in Wound Center resulting in ability to see more patients

Betting on the Future

- Expectation is to practice to the highest level of license and Certification
- Outcome driven care improves quality and lowers cost and improves patient’s quality of life (demonstrated by improved patient satisfaction reports and better outcome scores)
- The model of being an "adjunct " to other players in the system integrates disease management expertise in the day to day practice of Homecare
- Practicing coordinated care management and teaching individuals to better manage their wounds illness is our gold standard
- Each individual is accountable for health-care consumption in a responsible fashion
Our Continuing Goal:

Collaborate with our partners to provide:

The *right* care
At the *right* time
By the *right* provider

Coordinated Care = Happy patients