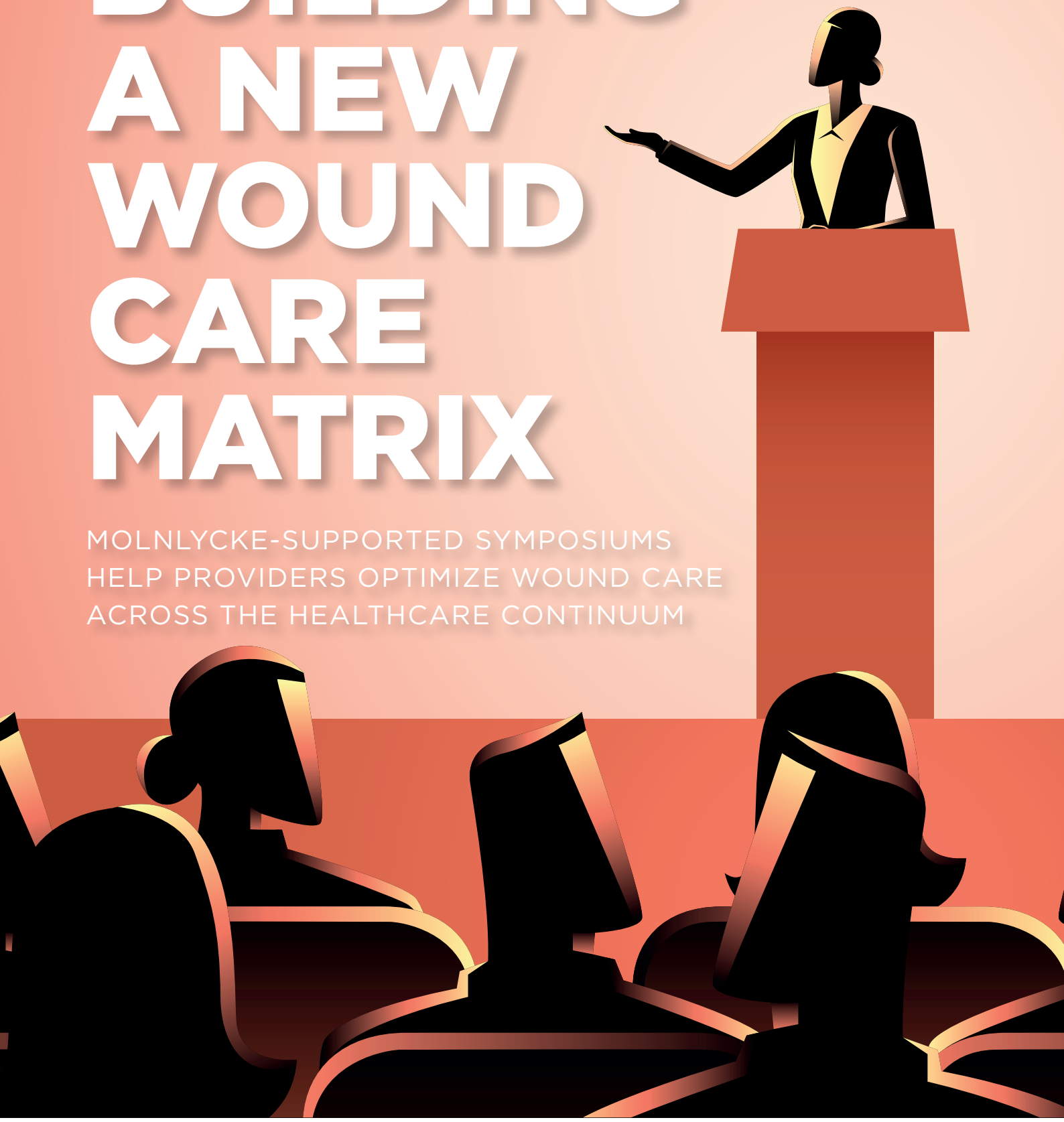
BUILDING A NEW WOUND CARE MATRIX

MOLNLYCKE-SUPPORTED SYMPOSIUMS HELP PROVIDERS OPTIMIZE WOUND CARE ACROSS THE HEALTHCARE CONTINUUM



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When wounds develop, how far they progress and whether they heal are factors of both preventative care at home and treatments given in a range of healthcare settings.

Improved communication and partnerships that span the continuum can help providers optimize wound care, avoid recurrences and promote quality of life for their patients.

There's never been a more urgent need to coordinate care.

"Education is critical in an environment increasingly focused on partnerships and outcomes-based payment models," said Jamie Bell, vice president of post-acute care at Molnlycke Healthcare. "We all share a responsibility to improve the breadth and depth of wound care knowledge, develop patient-centered strategies and ensure providers have the tools they need to promote healing regardless of where they work."

WELL-HEALED CURRICULUM

Molnlycke is supporting a series of courses that explore the special challenges that come with caring for wounds during transitions. "Optimizing Wound Care Across the Continuum of Care" will provide potential solutions for clinical leaders and administrators who want to break out of their silos and partner with other providers to make care more efficient and effective.

The series launched Sept. 21 in Sacramento, CA, with additional dates through the fall and in 2020.

At the conclusion of each program,

"EXPERTISE ACROSS THE CONTINUUM" IS REQUIRED.

— DIANE KRASNER, PH.D., RN, FAAN

attendees will have a better understanding of:

- The prevalence of wounds and pressure injuries in post-acute, home health and hospice settings
- How care of those wounds and injuries might differ in acute care
- Transitions of care between settings
- The health economics of pressure injuries, catheter-associated urinary tract infections and central line-associated blood infections
- Telehealth and other strategies that provide ideal wound care and pressure injury prevention in home health and post-acute settings
- Research-based techniques for improving information exchange and developing cross-setting wound care teams

Pre-registered attendees can earn four CEU credits through the San Jose State University Valley Foundation School of Nursing.

Faculty for the complimentary, day-long seminars include experts who have demonstrated their ability to work upstream and downstream in pursuit of better wound care results. They include:

Diane Krasner, PhD, RN, FAAN, wants to get providers across the continuum speaking the same language. Because skilled nursing and assisted living facilities may have few staff with wound care expertise, assessment and management details can be lost in translation during a stepdown to post-acute care. Staff might take a different view on etiology, use different terminology to describe the same wounds, or even interpret the goals of treatment differently.

"The relationships between providers have become more and more challenging over the last decade, but even more so now because of the faster pace at which sicker patients are transitioned to post-acute care," said Krasner, a wound and skin care consultant and co-chair of the Why Wound Care? Nursing Student Advisory Board. "When we transition patients with wounds, we need to be as careful with the details of their treatment as we are with their medications."

Care partners need to ensure their wound care champions follow the same guidelines and staging procedures, document with similar methods and follow brand and ingredient-specific prescriptions.

Consistency matters, Krasner said, not just for patient outcomes but in the liability realm, too. Embracing training, facilitating care partnerships and making sure staff are fully equipped to handle the wounds they're asked to assess and treat are the best ways to promote healing and fend off potential lawsuits.

Michele Carr, DPM, RD, CD, FAPWCA, focuses on prevention as a trainer of clinicians in hospice and home care environments. "We focus too much on treatment and identifying wounds, but as an industry, we need to encourage prevention principles along the treatment path," she said.

Carr added that providers have too long been stymied by approaches that don't mesh naturally when a patient transitions to home care. Payment reform may be the difference maker, she believes.

Skilled nursing has the Patient-Driven Payment Model while home health has the new Patient-Driven Groupings Model. These two models will increase reimbursement for wound care, but only if providers can document they are using specific services

"WE SHARE THE SAME PATIENT ... WHY DON'T WE WORK ON THIS TOGETHER?"

—HOLLY KIRKLAND-KYHN, PH.D., FNP, GNP, CWCN, FAANP

that lead to good outcomes.

As hospitals and skilled nursing facilities partner with home health and hospice agencies, they'll need to commit to sharing communication through software, standardized forms or routine check-ins by phone.

"We are going to have to learn to speak to dollars," Carr said. "We are working within a business model. I want to give administrators and owners tools that empower them to make these kinds of changes."

Holly Kirkland-Kyhn, PhD, FNP, GNP, CWCN, FAANP, directs the wound care program at the University of California-Davis Medical Center. Her goal is to increase expertise among home health providers and family caregivers who often handle wound management tasks.

Increasingly, skilled nursing operators are branching out into the hospice and home health markets. But that doesn't mean employees of those secondary entities get the same kind of training given in more intensive settings. Often, too little information trickles down to create a solid home management plan.

Telemedicine is a largely untapped mine that Kirkland-Kyhn is working to promote. Sharing photos — and asking patients living in the community to photograph their own wounds for record keeping — is just a start. A study she led found 70% of hospital wound patients developed injuries at home. She said patients in the community, whether recently discharged from a SNF or coping with a lifelong condition that puts them at high risk, need support.

Her latest research project offers multi-visit ER patients home visits, during which tissue analysis and wound care teleconferencing can be conducted. The goal is to promote closure over 12 weeks and reduce the overall number of hospital visits. She hopes it produces a model other communities can emulate.

"We share the same patient. They have the same wound, sometimes for a long time," Kirkland-Kyhn said. "Why don't we work on this together?" ■

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