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Quality versus Saving: Outcomes and Indicators to Wound Care

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As the population ages, we are seeing increased incidence of chronic diseases. With this increase also rises the incidence and prevalence of wounds.

How can we SAVE MONEY while INCREASING THE QUALITY OF LIFE OF OUR PATIENTS?

“Chronic wounds are the hidden epidemic that affects millions of people around the world, having a high individual and economic impact, which makes this problem of enormous relevance to the scientific community” (OMS, 2008)

There is an absence of data in this field. The studies that HAVE been performed are not reliable because:

- Studies performed have been in isolated and distinct services
- Studies with wounds of specific etiologies are lacking
- Studies have been performed with different populations, methodologies and instruments

These factors lead to an absence of characterization of the phenomenon.

Martin,2001 & German National Healthservice, 2007 published the following progression:

1. Advanced age of the population
2. Weight gain
3. Comorbidities resulting -- Venous insufficiency, diabetes mellitus, immobility, decreased sensory perception
4. Increased number of chronic wounds

Additional issues with aging skin that can lead to wounds:

- The skin will lose barrier properties as well as elasticity and resistance.
- Fragile skin is more susceptible to mechanical and chemical trauma.
- Dehydrated skin causes serious problems in mature skin.

In the studies that have been performed:

70% of the patients with wounds are in the community. (Drew, et al. 2007)

Costs are divided between:

- Local treatment
- Treatment duration
- Wound dressing
- Treatment frequency

In the USA and Canada, of the over 3,500 therapeutical options, 2,400 are dressings. (Broussard, 2007)

In Spain, of 1,200 products, 50-60% are dressings. (Gago, 2010)

In the field of dressings, there are 8,400 different products available from 204 different suppliers. (DoH, 2005)

Does such a thing as a “perfect dressing” exist?

“lack of evidence and guidance on the management of types of wounds… results in confusion and sometimes disagreements between healthcare professionals as to which dressing should be used”

Extrinsic risks include:

- Continuous dressing change
- Wrong product application

- Aggressive cleansing
- Misuse of antiseptics

Costs of treatment aren't limited to the cost of the dressings – that is only a small part of the costs. The costs of hospitalization and health professionals' time need to be added in as well.

As such, we discover that buying the cheapest dressings doesn't mean a reduction in the total costs of care.

Quality vs. Saving

The effectiveness of the product is measured by the health gains, by the results obtained in decreasing the total costs of the treatment.

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IF:

- 20% dressings
- 30% health professionals
- 50% hospitalization surgeries

SO:

- Increase healing rates
- Reduce risk of infection
- Reduce associated complication (maceration/pain)
- Reduce frequency of wound dressing change

Costs are made up of a combination of:

- Local treatment
- Treatment duration
- Wound dressing
- Treatment frequency

Chronic wound locations break down to the following:

- 3.8% Head and neck
- 4.8% Trunk
- 3.5% Superior member

- 16.7% Pelvis
- 71.2% Inferior member

The rational utilization of the therapeutical options breaks down to COST REDUCTION and IMPROVEMENT IN QUALITY OF LIFE.

Outcome indicators

Final product of the assistance provided, satisfaction of standards and expectations. Changes in the health status of the user attributable to professional care.

There is a clear relationship between partial results, final results and prevention level.

While general objective we are looking for is wound healing, this can be broken down further into the issues of eliminating wound odor and eliminating excessive production of exudate.

Goals:

To eliminate odor in 80% of wounds (UP4) in 3 weeks.

To eliminate excessive exudate in 60% of wounds (UP4) in 4 weeks.

Things are often dressed up as "quality" but they're really to save money.

Where is the patient in these decisions?

The reality of reimbursement is hard to manage with the care we want to give the patients.

If you live in the city, you have great opportunities for medical care.

In Portugal, there is an advancing age of the population and this population is getting fatter and fatter (increased risk factors).

So, they did a national study to look at risk factors in hospital and community care – to see if there are difference between acute and chronic wounds using the same outcomes.

- They visited 340 units and 1.6 million patients.
- They tried to understand what kinds of wounds there were -- they were VERY different by region. (19 areas in 5 regions)
- In a trial of 5,274 patients with wounds, there was a huge difference between them -- huge difference between in-hospital and in-community.
- The majority of chronic wounds was related to advanced age and higher risk factors.
    - A leg ulcer had an average of 812 days of existence.
    - 70% of patients with wounds were IN THE COMMUNITY.
    - There were huge differences between the regions.

When we're talking about quality, the clinician is looking at quality of the dressing, NOT what the patient wants.

Implications to clinical practice give the following research recommendations:

- Incidence studies, in different contexts
- To develop prospective and controlled studies with specific populations
- Develop experimental studies with specific interventions
- Deepen the way some quality indicators influence results
- Develop a minimum instrument / summary of data for evaluation of the patient's skin
- To develop studies that allow the evaluation of wound impact on the quality of life of the patient and family
- Develop research to develop treatment materials that reduce treatment costs