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SERENAGROUP NEWSLETTER

Building the Nations Leading Wound Care Team

WHAT COULD I HAVE MISSED?

THOMAS SERENA, MD, CEO

A 67-year-old diabetic gentleman with an infected full thickness foot ulcer presented to the wound clinic for evaluation and treatment. On examination, the ulcer clearly jeopardized the patient's foot. I prescribed hyperbaric oxygen therapy (HBOT) for his Wagner III DFU. I obtained an ABI, CXR and EKG. I carefully documented his 30 days of prior medical treatment. The ulcer was measured and photographed. I debrided the ulcer and placed the patient in a total contact cast. "We are ready to go with HBO," I yelled over to Mr. Mayhugh who was sitting in the HBOT suite. We started immediately. The patient's ulcer healed in less than 8 weeks with HBOT, good wound care, and the application of 2 CTPs.

Three months later we received a denial from Medicare. By this time in my career, I had treated thousands of diabetics with foot ulcers with HBOT.

What could I have missed?

In 2010 Atul Gawande, a Boston Surgeon, published a pioneering work: The Checklist Manifesto. In it, he describes the role of simple checklists in increasing patient safety in medicine. In truth, medicine is late to the checklist game: Pilots have been using them to improve airline safety since the 1930's. Checklists are ideally suited to complex situations in which a clinician must complete a series of steps. They play an integral role in the SerenaGroup® continuous quality improvement (CQI) program.

SerenaGroup® instituted a hyperbaric oxygen therapy (HBOT) checklist in 2020 that guides clinicians through the elements necessary for a patient with a Wagner III foot ulcer to qualify for HBOT. In addition, we review the checklist to ensure that all the medical necessity documentation is present. Physicians need not fear denials or aggressive auditors. In the case study above the patient had a successful clinical outcome avoiding the need for amputation; however, the unfortunate financial outcome dampened the celebration. A checklist would have prevented the denial.

If you are wondering what I missed, there was no nutritional assessment anywhere in the chart.

What is a Diabetic Foot Ulcer?

Tim Mayhugh, National Safety Director

A diabetic foot ulcer is an open sore or wound that occurs in approximately 15 percent of patients with diabetes and is commonly located on the bottom of the foot. Of those who develop a foot ulcer, 6 percent will be hospitalized due to infection or other ulcer-related complications.

Diabetes is the leading cause of non-traumatic lower extremity amputations in the United States, and approximately 14-24 percent of patients with diabetes who develop a foot ulcer will require an amputation. Foot ulceration precedes 85 percent of diabetes-related amputations; however, research has shown that development of a foot ulcer is preventable.

Causes:

Anyone who has diabetes can develop a foot ulcer. Native Americans, African Americans, Hispanics, and older men are more likely to develop ulcers. People who use insulin are at higher risk of developing a foot ulcer as are patients with diabetes-related kidney, eye, and heart disease. Being overweight and using alcohol and tobacco also play a role in the development of foot ulcers.

Ulcers form due to a combination of factors, such as lack of feeling in the foot, poor circulation, foot deformities, irritation (such as friction or pressure), and trauma, as well as diabetes. Patients who have diabetes for many years can develop neuropathy, a reduced or complete lack of ability to feel pain in the feet due to nerve damage caused by elevated blood glucose levels over time. The nerve damage often can occur without pain, and one may not be aware of the problem. Your podiatrist can test feet for neuropathy with a simple, painless tool called a monofilament.

Vascular disease can complicate a foot ulcer, reducing the body's ability to heal and increasing the risk for infection. Elevations in blood glucose can reduce the body's ability to fight off a potential infection and may also slow healing.

Prevention:

The best way to treat a diabetic foot ulcer is to prevent its development in the first place. Recommended guidelines include seeing a podiatrist on a regular basis. Your podiatrist can determine if you are at high risk for developing a foot ulcer and implement strategies for prevention. You are at high risk if you have or do the following:

- Neuropathy
- Poor circulation
- A foot deformity (e.g., bunion, hammer toe)
- Wear inappropriate shoes
- Uncontrolled blood sugar
- History of a previous foot ulceration

Reducing additional risk factors, such as smoking, drinking alcohol, high cholesterol, and elevated blood glucose, are important in prevention and treatment of a diabetic foot ulcer. Wearing the appropriate shoes and socks will go a long way in reducing risks. Your podiatrist can provide guidance in selecting the proper shoes.

Learning how to check your feet is crucial so that you can find a potential problem as early as possible. Inspect your feet every day—especially the sole and between the toes—for cuts, bruises, cracks, blisters, redness, ulcers, and any sign of abnormality. Each time you visit a health-care provider, remove your shoes and socks so your feet can be examined. Any problems that are discovered should be reported to your podiatrist as soon as possible, no matter how simple they may seem to you.

The key to successful wound healing is regular medical care to ensure the following "gold standard" of care:

- Lowering blood sugar
- Appropriate debridement of wounds
- Treating any infection
- Reducing friction and pressure
- Restoring adequate blood flow

Goals; Not Only in Sports!

Matt Schweyer, CPCO™, CHT-A, CHWS, UHMSDSA, CQO

February brings a lot of sports metaphors and Goal Setting. In the NCAA, both men and women, buffing up the record with a goal of getting to the Big Dance. The NBA and WNBA, starting the long and arduous task toward a championship. My beloved Dallas Stars finishing this season, hoisting the Stanley Cup. And Nick Duquette, Program Director @ Cleveland Clinic Akron General, hoping his Buffalo Bills have prevailed in the NFL. Likewise, it is time to start discussing the goals for advanced wound care patient(s) and our what and why of them.

Some Providers, Clinicians and Centers have been good at creating, implementing, and revising their goals. Others, not so much. For those who have been good at it, "JOB WELL DONE!" For others, here are some ideas for goal setting at the initial evaluation.

- Think about the what and why of your patients.
- Are you attempting to Heal the Patient? Or is this a Palliative patient?
- Think about the end point of treatment.
- Think about what socioeconomic impediments your patient might have.
- What Laboratory test are you ordering?

Those are all great jumping off points to create clear manageable goals in wound care. But why do you as a clinician and provider need to think about these things? There is the obvious: The evidence shows it's importance as it relates to off-loading, compression, nutrition, vascular Intervention, and other benchmarks; However, there is also the issue of Accountability.

Once goals are created, have they been conveyed to the patient? Does your patient understand the goals and timelines established for their care? And finally, the accountability of the goals. This is the tool that the Patient, the Wound Center, and others use to hold one another accountable?

If the patient is being treated for a venous leg ulcer and the goal is, reduction of edema and wound volume by X% over Y period and that is not happening, is that goal reassessed? Is the patient accountable for not keeping their feet elevated and cutting off the outer layer of their multi-layered compression dressing (MLC)? Or has the Provider not placed the patient in MLC on visit one after checking the patients ABI? Is the provider/center being held accountable by the patient and family members?

Goals are so important. They are spelled out in the CMS guidelines, the National Carrier Decisions (NCD) and Local Carrier Decisions (LCD) and Medical Policies by insurance agencies. Goals are now expected to be established and revisited in the medical record. So, when do we typically find out we are failing at establishing and revisiting and reassessing goals? Soon, it will be via the internal audit performed by our Compliance Department and a phone call from the Compliance Officer. The other, less pleasant time is when your hospital is made aware of an audit and the Medicare Administrative Contractor (MAC) or Insurer sends you additional document requests (ADR) for the encounters. This is not the time to realize goals have not been created for wound care, hyperbaric oxygen, and other advanced modalities we do at the drop of a hat.

In the Compliance world we have been made aware of one of a few reasons hospitals and providers FAIL the AUDIT: not reassessing the goals!

SerenaGroup Education

SerenaGroup recognizes that the key to continued success with positive clinical outcomes is education. Education is provided through different platforms to ensure the tools are available to our centers. Topics for January Education included (but not limited to):

- Journal Club: Lower Extremity Amputation (LEA)
- HBO Safety: Chamber Maintenance
- Monthly Education: Clinical Emergencies
- Roundtable Compliance

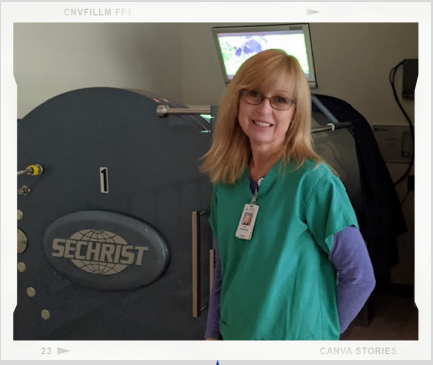
Education is one of many key benefits to partnering with SerenaGroup. We are Building the Nation's Leading Wound Care Team.

The Advanced Wound Care Conference

SAVE THE DATE

May 7, 2021 | New Orleans, LA
for more information visit:
www.serenagroupinc.com

SerenaGroup Blue Star Winner



Nancy Trafelet
Program Director

Nancy is a team player and strives every day to produce the best possible care, data and quality on a daily basis.

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