Patient Centered Interdisciplinary Woundology: Optimizing Wound Care through Proactive Adaptation of Current and Future Standards

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Be it multidisciplinary, trans-disciplinary or interdisciplinary wound care, the concept and positive benefits of this kind of care are widely written about and accepted by the majority of wound care specialists (woundologists) around the world.[1]

One of the major issues about the team approach that has been elucidated is the lack of uniformity and conformity in the implementation of these teams. More specifically, like the Tower of Babel, there are misunderstandings and/or lack of knowledge of the definitions and the differences among the numerous types of teams that have been put forward. In a large integrative review of 84 articles on this subject, none of the articles provided a definition for the terms multidisciplinary, interdisciplinary, or transdisciplinary in the context of Wound care.[2]

Despite the absence of a clear definition, the World Health Organization (WHO) argues that interprofessional collaboration in education and practice are the keys to providing the best patient care, enhancing clinical and health related outcomes and strengthening the health system. In light of this, a position document on managing wounds as a team was jointly issued by four organizations: the Journal of Wound Care (JWC), the Association for the Advancement of Wound Care-USA (AAWC), the Australian Wound Management Association (AWMA) and the European Wound Management Association (EWMA). The overall objective of this document was to "provide recommendations for implementing a team approach to Wound Care within all of clinical settings and through this to develop a model for advocating this approach to decision makers in the upper national government levels."[3]

In my review of the literature on interdisciplinary approaches to wound care, several issues were mentioned as being important to the core beliefs and to the success of these teams. These may appear basic, and it might be assumed they are already in place, but this is not the case. Each deserves to be considered in greater detail.

THE CONCEPT OF THE PHYICIAN LEADER AND PHYSICIAN CHAMPION: This is not new, but may not be considered as important as it should be. Melissa Johnson, PT, DPT, CWS states that identifying a physician champion to serve as a medical director and to lead the multi-disciplinary team for her wound care clinics was extremely important to the process, but was, and continues to be, a very difficult task.[4] One obvious question is why is this so?

Beginning In the early 2000's, there was a proliferation of wound and/or hyperbaric Centers which continues to the present time. Currently there are about 2000 wound care centers open - some hospital owned and managed and some owned and managed by larger corporations such as Healogics, the Serena Group and others. Finding enough well-qualified, well-trained, knowledgeable and caring physicians to staff these clinics has and continues to be a challenge. Currently, most clinics are staffed by a variety of different medical specialists including, but not limited to: General surgeons, vascular surgeons, podiatrists, primary care physicians, emergency trained physicians, infectious disease specialists and orthopedists. These physicians work on an average of one-half to one and a half days per week. In Atlanta, most of the physicians work and/or own practices of different sizes to which they give appropriately of their time and energy.

So, while the advantages of the multidisciplinary team are clearly evident, the current reality is that due to the part-time employment in the wound clinics, there is an increased probability of lack of continuity of care because of time constraints. And because of this, the physicians may only focus on the physical and not the psychic wounds. Therefore, it is my contention that as we move forward all physicians should be full time, especially the medical director/physician champion.

Consistency of care leads to increased quality of care which leads to increasing compensation and reimbursement, especially in the near future when reimbursement will be based more on quality rather than quantity. This concept can be traced to the development of Engel's 1977 bio psychosocial model of health.[5] This model incorporates social, psychological and behavioral dimensions of illness and seeks to address inadequacies of the traditional biomedical model of care in which disease and not the total patient predominates.

My concerns regarding part-time physicians are that they will only be able to focus on the wounds (the disease) and not the psychosocial issues, which are of equal importance. Wound care patients are a very high risk group of patients, most with serious comorbidities. Healing them requires attention to the physical wounds as well as to the psychosocial wounds: Will the diabetic with a serious wound be able to take off work to offload properly? Can he pay his bills if he does not work? Does he have a primary provider to help him manage his blood sugars? Can he even find a provider who will accept his insurance? Remember, we try to treat the whole patient and not just the hole in the patient. A fully engaged full time physician can do this better.

One solution to this problem is the increasing use of mid-level providers, such as nurse practitioners who are certified in wound care and who can see patients on their own and when the physician is absent. The ability to get compensated and reimbursed is dependent on several issues, including state and federal (CMS/Medicare) regulations. This paradigm is common in many other medical specialties and well-accepted by most patients.

THE PATIENT AS THE FOCUS/ CENTER OF ALL ENDEAVORS IN CONJUNCTION WITH WOUND CARE NAVIGATORS

Although when asked, most clinicians will say safety and care of the patient are their first

priorities, this may not always be true. Of the articles used to come up with the previously discussed position paper, almost all of them include definitions of healthcare teams that reflect a provider-centric perspective. Of the 17 articles, only one includes a definition that refers to the participation of patients. In the attempt to define and diagram the different models of care, it is difficult trying to figure out the exact location of the patient: is he on top? On the bottom? In the middle of a wheel and equal to all the providers? I believe almost all providers put the patient first - as it should be - but occasionally this idea needs to be revisited and reinforced. Along with the patient being the focus of all our efforts, providing a wound care navigator could be critical to the success of all our endeavors.[6] Ideally this navigator would be both an administrative coordinator and an ombudsman to the patient and be a direct line to someone who knows him and who can be reached easily and regularly.

IN SUMMARY

Just as we know that the music from a single cellist is beautiful, we also know that putting many musicians together to create a symphony is better. Many people coming together to heal the whole patient in one of many possible arrangements is priceless.

References:

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