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EXECUTIVE SUMMARY

Ontario Wound Care Interest Group (OntWIG) is an interdisciplinary group of health professionals seeking to harmonize public policy with best-practice wound prevention and treatment in Ontario. In 2012, OntWIG developed the Ontario Wound Care Strategy Framework as a blueprint for meaningful dialogue and action.

On Friday, April 25, 2014, OntWIG hosted a professional symposium at the White Oaks Conference Resort & Spa in the province’s Niagara region to discuss approaches to making the Ontario Wound Care Strategy Framework a reality. The symposium brought together leaders in acute, community and long-term care who share an interest in bringing much-needed efficiencies to the management of wound care across the province.

The day-long event began with presentations on the impact of policy changes on wound care. A panel discussion allowed participants to ask thought-provoking questions about the state of wound care in Ontario today. During the afternoon, participants broke out into groups to discuss barriers to best practice and make recommendations to surmount these barriers. This report focuses on the discussions and recommendations that came out of the symposium.

Getting the OntWIG Framework message to Queen’s Park

Participants agreed that efforts to promote the Framework need to focus on solutions, and recommended a grassroots approach – including a public awareness campaign – to help increase exposure to the document.

Developing certification for wound care

Without exception, participants viewed certification in wound care as an important step toward enhancing standards of practice. They endorsed a cross-disciplinary certification program with both academic and experiential components and available to all health providers, with nurses playing a leading role.

Getting wound care on the Ontario health quality agenda

Participants agreed on the need to focus on innovation and economic efficiencies in communications with government. To strengthen the case, they recommended quantifying the societal burden of wound and comparing best practice to usual care in well-designed studies.

Standardizing data collection

Participants explored how inconsistent language and standards hamper data collection. They unanimously and strongly agreed on the need for a single shareable database across the circle of care. They recommended legislation to ensure collection of specific data sets and a pay-for-performance model to encourage compliance.
## Call to action

Ontario Wound Care Interest Group calls out to our government to partner with us in creating a provincial wound care strategy that incorporates public awareness, evidence-based care pathways, and data collection. It is our hope that a provincial strategy will not only help improve care for the hundreds of thousands of Ontarians affected by wounds, but propel the province to a position of national and international leadership in wound care.

### TOP RECOMMENDATION SUMMARY

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<th>Framework message to Queen’s Park</th>
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<td>Leverage RNAO’s Queen’s Park day</td>
<td>Set up a governance structure</td>
<td>Build on other provinces’ successes</td>
<td>Legislate must-have data</td>
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PRESIDENT’S MESSAGE

Ontario Woundcare Interest Group’s 2014 symposium built on the energy and ideas generated in the symposia from previous years. Both the speaker presentations and roundtable discussions at this year’s event focused on the challenge of implementing these ideas – and the tremendous opportunities for Ontarians and the Ontario health care system.

A diverse group of clinicians, health care leaders, researchers, industry decision makers, and government representatives, all committed to improving the health services for persons with wounds, contributed to the dialogue. Participants unanimously supported a province-wide strategic approach to wound prevention and management, with compelling health-economic rationales.

Our executive is eager to partner with the province’s Ministry of Health and Long Term Care (MOHLTC) to bring about these much-needed changes. We have the expertise to support the government with policy development and the ground-level experience to implement clinical change and knowledge transfer.

I encourage you to join OntWIG in continuing our mission to improve wound care delivery and access for all Ontarians. By joining forces, we can make it happen.

On behalf of the Executive: a heartfelt thanks to each person who attended, to our volunteers, and to our sponsors. Your participation and engagement made the 2014 symposium a success.

Karen Laforet
President
Ontario Woundcare Interest Group
CONTEXT

Between 30 and 50 percent of health care involves wounds.¹ If this statistic surprises you, you’re not alone: chronic wounds do not receive the same media attention as higher-profile conditions such as cancer and heart disease, leaving many people unaware of their enormous impact. With the increase in noncommunicable diseases and life expectancy, the prevalence and impact of chronic wounds are likely to increase still further.²

Personal impact

The loss of mobility caused by wounds such as pressure sores, venous ulcers and diabetic foot ulcers impairs people’s ability to participate in work and leisure activities.³ This makes them more vulnerable to social isolation, which in turn can trigger depression.⁴ The stress and anxiety experienced by people with wounds can also lower their pain threshold, leading to a vicious cycle of anxiety and pain.⁴ Research has linked pressure sores to infectious complications, prolonged and costly hospitalizations, and increased risk of death,⁵ while diabetic foot ulcers lead the list of causes of nontraumatic amputations. Wounds take a toll not only on affected individuals, but on the caregivers who give them physical assistance and emotional support.⁶

“A wound can control a life.”

John MacDonald
World Alliance for Wound and Lymphoedema Care

Economic impact

According to the 2010 report titled “Ideas and Opportunities for Bending the Health Care Cost Curve Report,” the cost of wound care in hospitals and long-term care facilities surpasses $1 billion per year in the province.⁶ Indirect costs such as loss of economic output and long-term disability costs raise the figure still further.

Meeting the challenge

While awareness of wound care gaps has grown in recent years, wound care in the province remains fragmented, with inadequate communication across disciplines. Inconsistent access to the right care at the right time leads many people with wounds to experience the “revolving door” of frequent readmissions within the healthcare system. We urgently need a province-wide wound care strategy to address these issues and provide efficient, effective care for Ontarians with wounds.

References

PRESENTATIONS

The meeting began with three presentations that focused on policy change within the long-term-care space and its potential impact on wound care:

1. Excellent Care for All: The Journey Thus Far
   Stephanie Soo, Senior Policy Advisor, Ministry of Health and Long Term Care
   Jillian Paul, Manager, Policy Development & Implementation, Health Quality Branch

2. High Intensity Needs Funding Changes: Impact of Policy Change
   Candice Chartier, CEO, Ontario Long Term Care Association

3. Outcomes Based Pathways: Home Care Policy Change
   Jacklyn Baljit, Client Services Specialist, Ontario Association of Community Care Access Centres
   Janet MacLeod, Program Manager, OBP Community Care Access Centre
   Susan Filax, Director, Clinical Practice, Spectrum Health Care

Question & Answer session
After the first presentation, meeting participants had the opportunity to ask questions.

Q: Are there plans to include non-pressure ulcer wounds in the quality indicator model?
Paul: Organizations have every opportunity to incorporate various types of wounds into the quality improvement plans (QIPs). I applaud OntWIG for your proactive stance on this topic and encourage you to speak to people developing the QIPs to bring this issue to light.

Q: Can OntWIG create a template for a wound care plan that hospitals could use?
Teague: The Ministry of Health needs to bring experts to the table to produce such a plan. Different health sectors should be represented, and the experts need to be paid for their efforts. We are ready and waiting for this type of initiative.

Q: Is data collection up to each individual hospital, or are the metrics standardized?
Paul: The Ministry promotes validated measurements and methodology. We can facilitate and collaborate to improve what is measured. For example, we can promote reporting of pressure ulcers as a priority metric in hospitalized patients, but not mandate it.

Q: Can you comment on the fact that Alternate Level of Care days are allocated to wound care patients?
Soo: The case needs to be made, at the CEO level and beyond, that pressure ulcers contribute to bigger problems. We’re trying to drill down to the real problem and develop initiatives to solve it. We need to show that proper care reduces readmissions and emergency room visits.
PANEL DISCUSSION

Following the presentations and a buffet lunch, a panel discussion gave symposium participants the opportunity to ask questions to three key presenters. Highlights of the discussion follow.

Panelists:
- Jacklyn Baljit, Client Services Specialist, Ontario Association of Community Care Access Centres
- Janet MacLeod, Program Manager, Outcomes Based Pathways, Mississauga Halton Community Care Access Centre
- Susan Filax, Director, Clinical Practice, Spectrum Health Care

Q: I’m happy that you recognize that the pathway for diabetic foot ulcers needs more work. I’m wondering how you plan to incorporate orthotics and chiropody into the pathway.

McLeod: In our CCAC, if someone has a diabetic foot ulcer, they get an automatic referral to a chiropodist within 7 days. In order for us to get chiropody into our care pathway, we had to negotiate with the CEO of our partner Local Health Integration Network (LHIN). That’s why we’re unique. If a prescription for an orthotic is appropriate, it comes back to the CCAC, who works with an affiliate service provider that supplies orthotics. It’s still early days, but the process will soon be automatic.

Q: It’s great that you plan to refer to chiropodists, but not all of them know how to care for the diabetic foot. So how do we impart expertise in this area?

MacLeod: Our region has the unique privilege of having a compression wound group where we refer people – but you are correct that this doesn’t happen across the board.

Audience comment: At the regional level, we have identified patients and physicians who need more education, and that information gets triggered back to the CCAC.

Q: I’m interested in what you may be doing to share information about outcomes-based pathways with family health teams.

Baljit: As part of our change management process, we’re looking at creating a readiness tool to help us ensure that OBPs are ready for implementation. We’re currently testing an OBP in this regard. The process involves primary care, clinics and hospitals and requires stakeholder engagement from the start. A related challenge for CCACs is that LHINs may have different priorities and not want to fund our initiatives.

Filax: For each therapeutic area, we may need a different process for stakeholder buy-in.

Q: I’m concerned that the current criteria overinflate the number of surgical wounds.

Baljit: We have specific inclusion and exclusion criteria for the surgical wound category. It’s true that the criteria may be too broad. I’ll look into the issue when reviewing the current pathways.
Q: Is it possible to collect more accurate data on hospital readmissions for wounds and link it to initial care and length of stay?

Filax: I don’t think we’re at the point where we can get granular enough to identify all readmissions for wounds, but we’re working toward that goal.

Baljit: We’re certainly looking at preventing readmissions, but aren’t tracing the causes accurately enough yet. We need to work on that.

Q: I wonder whether there will be some type of continuing care pathway for patients who come into acute care settings, so we’re not reinventing the wheel.

Baljit: Our best practice guidelines do not currently give advice on the flow from home to clinic to family doctor. We can definitely take this issue on board at our next guideline review.

Filax: We do try to send information with the patients, but often we don’t know when they’ll be moving to a different clinical setting, so it’s difficult to preplan.

MacLeod: One of the opportunities is around standardized patient education materials to go along with the pathways. Our hope is that this could empower the patient.

Q: How can we have an automatic flow for patient from hospital to CCAC to home if we have this kind of interruption [e.g., automatic referrals to chiropodists]?

Baljit: The OBPs are not prescriptive at all; they’re very high level. They draw on best practices to advise, for example, that “compression therapy must be initiated.” At a more granular level we depend on service providers to have the required point-of-care expertise.

MacLeod: The transition management piece is always a challenge. One thing the OBPs have done is bring people together who believe in providing a more seamless experience for the patient.

Notable comment: “I think it’s important to look at the “back door” when evaluating cost efficiencies. When patients are getting discharged quickly, length of stay goes down, but if readmission rates go up, there may not be any net savings. We’re just transferring accountability from one sector to another.”

Laura Teague, Past President, OntWIG
CONSENSUS TABLE DISCUSSIONS

Symposium participants broke out into teams in order to brainstorm ideas to address four salient challenges in wound care. Each team was assigned one of the following topics:

- Team one: Getting the OntWIG Framework message to Queen’s Park
- Team two: Developing certification for wound care
- Team three: Getting wound care on the Ontario health quality agenda
- Team four: Standardizing data collection

In each group, designated facilitators led the discussion and summarized key points on a flipchart. Key insights and recommendations generated from the process appear below.

TEAM ONE: GETTING THE MESSAGE TO QUEEN’S PARK
Facilitators: Valerie Winberg, Ann Marie McLaren

Specific issues to address:

- Given OTLCA’s success, how can we get the framework message to Queens Park?
- What is missing from our current initiative?
- What information should be presented at Queens Park, and how should it be presented?
- Whom do we approach and what should we be asking for?

Discussion

It appears that many key stakeholders remain unaware of the Framework document. The group recommended a grassroots approach to help increase exposure to the document. Noting the past challenges in establishing a dialogue with Queen’s Park, Winberg emphasized the importance of “presenting solutions, rather than simply raising issues.” The group agreed that efforts to promote the Framework need to be more targeted, consistent, and impactful. To this end, they suggested:

- Approach individual MPs, using a standardized letter that clearly states the return on investment (ROI) for government
- Request feedback on the Framework to ensure it has been read
- Use existing OntWIG and Registered Nurses Association of Ontario (RNAO) to set up personal meetings with key government decision makers
- Participate in the RNAO’s Queen’s Park Day or create a similar day for wound issues (possibly in partnership with other associations)
- Develop a public awareness campaign, using public figures and social media along with traditional media
- To stand out from the crowd, use a “theatrical” approach to dramatize wound care issues (e.g., wearing negative pressure units)
- Partner with a lobbyist
✓ Include a patient component (e.g., advocacy group, patient stories and photos) to draw the government’s attention to the gaps in wound care
✓ Invite patients to become OntWIG members
✓ Give the ministry a fair chance to respond to OntWIG’s requests within a set time frame
✓ As a last resort, consider approaching the opposition parties, who might become interested in incorporating the OntWIG agenda into their platforms

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<tr>
<th>Top three recommendations (by consensus)</th>
<th>Guiding insights</th>
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<tr>
<td>• Promote the framework from within</td>
<td>• OntWIG needs a face, not just a logo</td>
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<tr>
<td>• Form a patient advocacy group</td>
<td>• Use multiple touchpoints to approach the government</td>
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<tr>
<td>• Investigate Queen’s Park day</td>
<td>• Leverage RNAO’s resources</td>
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TEAM TWO: WOUND CARE CERTIFICATION
Facilitators: Deb Hanna-Bull, Lyndsay Orr

Specific issues to address:
• Wound care specialist is a term without clarity or qualification. What steps need to take place to move towards a province-wide or national certification process for woundology?
• The USA has done this well, with tiered certification based on formal education, wound education and experience. Is there anything we can learn from their model?

Discussion

The group envisioned a fellowship designation in wound care, valid across all medical disciplines. While they agreed that nurses form the backbone of wound care delivery, they felt a certification program should be open to all types of health providers, not just nurses. Participants agreed that several professional associations could participate in the creation of this certification, and that accountability to a regulatory body would raise the stature of the certification. The following features were deemed important by all:

✓ An academic component with defined expectations
✓ An experiential component, which need not take place in an academic setting
✓ The possibility for participating organizations to add a mentorship component
✓ Recertification requirements (e.g., after 5 years)
✓ A quality assurance program to certify instructors and ensure fair evaluations
✓ A gap analysis across disciplines and geographical regions
✓ A strategy for securing funding, including partnering with other professional associations
✓ Research into current wound care training courses that could be leveraged in the certification program
Committees for communication, quality standards, and competency exams

Over the longer term, an interdisciplinary governance structure to ensure ongoing quality and sustainability for the fellowship designation

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<tr>
<th>Top three recommendations (by consensus)</th>
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<tr>
<td>• Conduct a regional and interdisciplinary gap analysis</td>
<td>• Establish both short- and long-term goals</td>
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<tr>
<td>• Create subcommittees for communication, quality standards, and competency exams</td>
<td>• Nurses should be the backbone of specialized wound care delivery</td>
</tr>
<tr>
<td>• Create a governance structure that ensures ongoing quality and sustainability</td>
<td>• Leverage existing structures and programs</td>
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TEAM THREE: WOUND CARE ON THE HEALTH QUALITY AGENDA

Facilitators: Laura Teague, Ruth Thompson

Specific issues to address:
• How do we get wound care on the Ontario health quality agenda?
• Can we develop quality-based wound pathways for acute care?
• How can we link required organizational practices (ROPs) for pressure ulcers to beneficial outcomes for OACCAC?
• How do we move towards an inclusive wound agenda versus a focus on specific wounds?

Discussion

Participants expressed some frustration at previous efforts to engage the Ministry in meaningful dialogue and encouraged the government to send delegates to future OntWIG meetings. They agreed on the need to focus on innovation and economic efficiencies – key items in the government’s health quality agenda. To this end, they recommended highlighting successful outcomes and cost savings in all communications with government representatives and other stakeholders. Specific strategies proposed by participants include:

• Quantify the societal burden of wounds
• Compare best practice to usual care in longitudinal, adequately powered studies
• Calculate the costs of putting best practice in place and the subsequent savings and/or mine existing data on these issues
• Define quality-based pathways for acute and long-term care
• Include care transitions in all clinical pathways
• Build systems around a central electronic system that everyone can access
• Create a directory of provincial wound clinics
• Take a leadership role in knowledge exchange and evaluation of products and trials
• Learn from other provinces’ successes in reaching out to their governments and consider interprovincial collaborations
Top three recommendations (by consensus) | Guiding insights
--- | ---
• Compare best practice to usual care  
• Define quality-based pathways for acute and long-term care  
• Build on other provinces’ successes  | • More and more people will require wound care, so increasing efficiency is paramount  
• Aim for seamless care transitions  
• Focus on reducing regional silos

TEAM FOUR: STANDARDIZED DATA COLLECTION
Facilitators: Karen Laforet, Elaine Culvert

Specific issues to address:
• Public reporting depends on accurate and meaningful data. What steps can Ontario take to standardize data collection?  
• How can we ensure that all sectors use the same language and metrics?

Discussion
Participants agreed that data collection is hampered by variation and lack of wound coding. “One of the biggest challenges is to get people to understand that measurement has to happen at the beginning,” said Laforet. They discussed different models for ensuring compliance with data collection and concluded that pay-for-performance would be a workable model. To ensure uniformly high standards of data collection, they recommended:

✓ A single database, ideally a shared electronic record  
✓ A common language to describe wounds  
✓ A quality improvement (QI) approach using specific interventions (e.g., “intervention X is able to reduce falls by 50%”)  
✓ Specifications for the type of data collected in both primary and long-term care (e.g., cause of wound, comorbidities, goals of treatment)  
✓ Legislation for data collection requirements  
✓ A pay-for-performance model to motivate compliance with data collection  
✓ Built-in capacities to evaluate the data collected

Top three recommendations (by consensus) | Guiding insights
--- | ---
• Create a single shareable database across the circle of care  
• Adopt a quality improvement approach with strategy for data evaluation  
• Legislate must-have data  | • We need a common lens through which to view wound care goals  
• Accountability is needed at a system level  
• Measurement must start at the beginning of the care cycle
CALL TO ACTION

Ontario Wound Care Interest Group recommends provincial action on wound care without delay. The province has standardized programs and strategies for several cancers, heart disease, mental health, and diabetes, among other therapeutic areas. These initiatives have demonstrated that a province-wide approach can improve outcomes while saving costs. The magnitude of the wound epidemic calls for a similar strategy for wound care.

We respectfully call out to our government to partner with us in creating a provincial wound care strategy that incorporates public awareness, evidence-based care pathways, and data collection. We are eager to harness our ground-level expertise toward this objective. We also invite all stakeholders in the healthcare community, from health providers to administrators to the general public, to help us make the vision a reality.

Wound care is an area of growing interest worldwide. It is our hope that a provincial strategy will not only help improve care for the hundreds of thousands of Ontarians affected by wounds, but propel the province to a position of national and international leadership in wound care.
APPENDIX 1: FRAMEWORK FOR AN ONTARIO WOUND CARE STRATEGY

In 2012, OntWIG created the Framework document titled “Fewer Wounds, Faster Healing” to foster a dialogue among health care providers, patients, policy-makers and the general public about the growing challenge wound care presents to the sustainability of the Ontario health system. The Framework is outlined below.

**Goals**

1. **Pan-provincial wound care strategy**
   
   Rationale: Wound care in Ontario costs an estimated $1.5Billion annually yet there is no provincial strategy providing direction on how best to coordinate the system so that it delivers improved patient outcomes and value-for-money. We are seeking a pan-provincial approach that synchronizes local efforts in order to develop a system-level strategy.

2. **Provincial wound care governing body**
   
   Rationale: Wound care in Ontario is under-managed from a policy perspective. There is no central body or organizing entity with the necessary resources that has taken a leadership role in advancing wound care in the province in a comprehensive way.

**Priorities**

1. **Access – People, Products, Processes**
   
   Rationale: Stakeholders identified uneven access to wound care expertise, advanced wound care equipment/supplies and standardized knowledge/tools as a major barrier for patients across Ontario.
2. Information – Collection, Evaluation, Dissemination

Rationale: There is general consensus that the lack of universal, standardized wound care service and cost data is hampering the development of system-improvements.

3. Awareness – Patients, Providers, Public

Rationale: There is little awareness of wound care as a major health issue despite consuming 30-50% of all health activity. More attention paid by the media and public may influence policy-makers when establishing priority areas for investment.

Guiding Principles

1. Integrated

The Framework must reflect an integrated system of care where prevention and curative services and acute, community and long-term care sectors function as a unified system across all of Ontario. Links between programs, sectors and regions serve to prevent duplication of service and emphasize optimum utilization of existing resources.

2. Evidence-based

The Excellent Care for All Act defines evidence-based care as “a treatment philosophy focused on using the very best current evidence to support decision-making about the care of individual patients. Evidence-Based Care also supports better use of health care resources by focusing resources on delivery of care that is known to be effective.” To ensure that all Ontarians receive a high quality wound care, the Framework promotes the use of practices supported by scientific evidence, or are considered best practice according to prevailing knowledge.

3. Patient-centred

The Picker Principles of Patient-Centred Care informs this guiding principle. They are: (i) respect for patients’ values, preferences and expressed needs; (ii) coordination and integration of care; (iii) information, communication and education; (iv) physical comfort; (iv) emotional support and alleviation of fear and anxiety; (v) involvement of family and friends; (vi) transition and continuity and (vii) respect for patients’ values, preferences and expressed needs.

4. Value-based

The Ontario Ministry of Health and Long-Term Care recommends a focus on producing value for patients and better care for the dollars invested. According to this approach, to achieve the highest value for patients, services should be organized around clinical conditions to ensure coordinated, specialized care delivered in a patient-centred, seamless manner.
Ontario Wound care Interest Group (OntWIG) is a group of interdisciplinary health care professionals representing all health care sectors that leads, promotes and influences wound prevention and treatment public policy for all Ontario citizens. All inquiries including membership requests may be directed through: http://ontwig.rnao.ca/contact