House Committee on Appropriations; Subcommittee on Labor, Health and Human Services, Education and Related Agencies
Public Witness Hearing -- Thursday, April 26, 2018

Testimony of Gregory Bohn MD, FACS, ABPM/UHM, CWSP, FACHM,
President, The Association for the Advancement of Wound Care

Chairman Cole, Ranking Member DeLauro, and members of the Subcommittee, thank you for the opportunity to submit testimony for the record on behalf of the Association for the Advancement of Wound Care (AAWC), with a membership of 2,400 members dedicated to inter-professional wound healing and tissue preservation. We would be remiss if we did not thank Chairman Cole for his public support of these issues through his participation in the September 6, 2017 colloquy with Representative Doug Collins of Georgia on Pressure Ulcers. The mission of the AAWC is to advance the care of people with and at risk for wounds and is recognized internationally as the leading, nonprofit membership organization in the United States (https://aawconline.memberclicks.net).

Much of the AAWC's work is based on the concepts outlined in the "The AAWC Conceptual Framework of Quality Systems for Wound Care." We strive to bring global leaders and researchers together to address the challenges of pressure ulcers. In February 2018, at the AAWC Global Pressure Ulcer Summit in Atlanta, Georgia, Representative Karen Handel of Georgia participated and spoke on pressure ulcers. The AAWC is committed to working with Congress to improve the identification and care of patients with pressure ulcers and to improve prevention strategies for those at risk for pressure ulcers. The following will provide more details on the scope, challenges, and potential opportunities to positively influence the much-needed national dialogue. The testimony will examine several specific areas of focus the Committee may want to

consider to move the effort forward.

The AAWC understands some reports on Pressure Ulcers (PUs) are that PUs annually affect nearly 2.5 million people and may cost up to as much as $25 billion in health care expenditures. In fact, the Agency for Health Care Quality and Research (AHRQ), in the mid-2000s, released data noting Hospital Acquired Pressure Ulcers (HAPUs) kill approximately 60,000 patients per year while negatively affecting over 2 million Americans at a financial cost between $9-$11 billion. We suspect the Committee would agree that addressing the prevalence of PUs or HAPUs is an effort of critical importance for our nation's interests in reducing human suffering and overall health care expenditures. The silver lining here is that HAPUs can be prevented or at least dramatic reduction are possible with an increased focus and acknowledgment of the problem.

Pressure Ulcer Prevention guidelines and tool kits address identified risk factors and have improved care, but they fall short in that they are not based on valid data and clinical understanding of pressure ulcer development. A better understanding of pressure ulcer development and pathophysiology is needed. There is new research that better defines how tissue is affected by pressure and how damage results. The current top down model proposed by other national panels does not embrace or include this new science and has brought about confusion and inconsistencies in PU assessment and care. A focus at our recent Pressure Ulcer Summit involved looking at this new research and examining it in terms of how it can help develop an "up to date" pathophysiology and improve conceptual understanding to help drive effective care. In addition, new HAPU protocols are being developed that may require the involvement of AHRQ or the Centers for Medicare and Medicaid Services (CMS) to test and modify reimbursement structures, as well as support hospital based education and training programs to implement new models.

On the research front, the AAWC notices a growing body of research examining tissue ischemia-reperfusion as a cause of pressure-related tissue damage. Further research is currently evaluating changes in subcutaneous tissue that may herald or predict pressure ulcer development. Unfortunately, the current "top-down" pathophysiology model as the sole basis for the revision does not reflect current science and evidence. This Committee could encourage the National Institutes of Health (NIH) to host a state of the science forum to evaluate and identify research opportunities into new models, like those using tissue ischemia-reperfusion in lieu of the current activity.

Another important aspect of PUs is determining the sequencing or staging of the PUs to assist with treatment and prevention. In our opinion, the current Pressure Ulcer Staging framework is inherently flawed. Tissue damage and loss does not start at the skin and progress down to deeper levels. We now know that tissue damage has already occurred once skin changes are seen and a pressure ulcer may well progress despite preventative strategies. A well-recognized criticism of the staging system is a lack of interrater reliability and validity. Plus, the inability to reliably identify the depth of tissue damage prevents reliable identification of the pressure ulcer stage. The weakness of the staging system in assisting providers with identifying causative factors and improving treatment planning is one of many reasons why AAWC is working to develop a new Pressure Ulcer Description Tool (PUDT) to more accurately describe tissue damage and categorization of these ulcers. We would encourage the AHRQ to partner with the AAWC on research on the Sub-epidermal moisture (SEM). The SEM scanner has been tested and demonstrated to be effective in identifying impending tissue damage. An opportunity exists to

validate and encourage the implementation of SEC or other methods that can improve sequencing of PUs in patients.

Accurate description is essential to data collection. Coding of pressure ulcers represents an opportunity to ensure policies and decisions are made that will dramatically improve accuracy and consistency across and within care settings. A simpler, more understandable description is needed. The AAWC Pressure Ulcer Description Tool (PUDT) recognizes this and is being constructed to cross walk to the coding descriptors to make coding consistent and accurate. The current staging system compounds the confusion for coders so that evaluating data from hospital admission data and coding does not accurately reflect the pressure ulcer in some cases. The Committee could encourage CMS to work with AAWC to develop an improved coding construct.

We understand that recent data, released in October 2017 from the CMS Office of Enterprise Data and Analytics, identified pressure ulcer discharges increased by 58.4% between the first quarter of 2016 and the first quarter Q1 2017. The Department of Health and Human Services (HHS) has authority to adjust provider payments through the domain formula to incentivize the reduction of HAPUs in the Hospital-Acquired Condition Reduction Program (HACRP) program. We need to work together to re-examine the tools available to HHS to best work with the health care system to improve on delivering better healthcare outcomes by reducing HAPUs and saving the government significant costs. The Committee could encourage CMS to re-balancing the domain formula in the HACRP to reverse the trend and reduce HAPUs.

Our testimony is an attempt to denote the scope of the challenge and a sample of actions we can

take in partnership with the federal government to dramatically move the needle to address the costs of human suffering surrounding HAPUs and PUs generally. The AAWC understands the critical role of this Committee as a catalyst to expand the public-private partnership and jointly address HAPUs and PUs in a positive manner. Currently, the AAWC is working on a Pressure Ulcer Description tool to simplify the evaluation of pressure ulcers and bring consistency and improved accuracy to bedside evaluation. Further, the AAWC is working with researchers who have HAPU protocols that are ready for final evaluation by AHRQ and CMS implementation. Our AAWC members are willing to serve on NIH, AHRQ, or CMS advisory panels to assist in identification of critically needed research to support the challenges outlined above. Finally, the AAWC has experts with field experience who can work with the appropriate federal officials to improve the coding challenges.

In closing, I want to leave a final thought. Partnership with organizations like AAWC and our partners with the federal government can provide for an more robust dialogue to change the nature of this critical problem. We look forward to working with you and your staffs to move the effort forward. Our goal is a for long-term relationship to ensure that our country takes positive steps to reduce the cost and more importantly the human suffering associated with Pressure Ulcers. Thank you for this opportunity to participate in this dialogue.