

NEW JERSEY HOSPITAL ASSOCIATION PRESSURE ULCER COLLABORATIVE

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**Spring Joint Provider/Surveyor Training
Michigan Department of Community Health
Bureau of Health Systems**

March 27, 2008

**Can the number
of pressure ulcers
be reduced?**

Source: New Jersey Hospital Association
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Lessons Learned #1

The past is prologue

**What lessons can
be learned
from the past?**

Historical Perspective

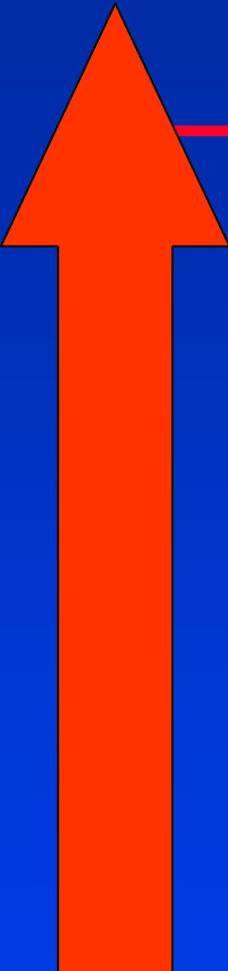
Preventing pressure ulcers is not new!

If a patient is cold...
if a patient is feverish...
if a patient is faint...
if he is sick after taking food...
if he has a **bedsore**...
it is generally the fault not of the disease but of the **nursing**."

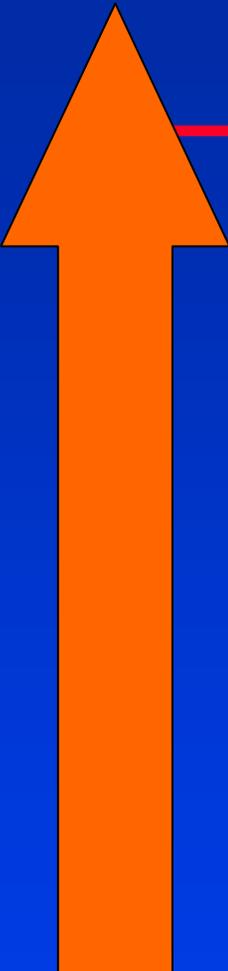


Nightingale, F. (1859). Notes on Nursing: What it is and what it is not.

HCUP- Hospitalizations related to Pressure Ulcers -2003

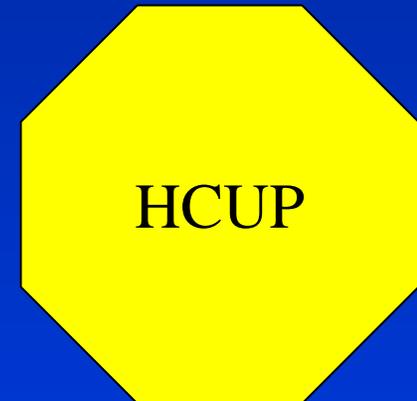
- 
- 455,000 hospital stays with PU
 - 63% increase from 11 years ago
 - COST = \$37,800
 - 90% had the following conditions:
 - Septicemia
 - Aspiration pneumonitis
 - Pneumonia
 - UTI
 - Congestive heart failure

HCUP- Hospitalizations related to Pressure Ulcers -2003

- 
- Mean LOS for PU = 13 days
 - Varied by age groups
 - Longest for patients 18-44 years (14 days)
 - Shortest for patients 85 years and older (10 days)
 - Average charge = \$37,800

Concomitant conditions for hospital stays principally for pressure ulcers:

- **Diabetes (29.4%)**
- **Paralysis (27.4%)**
- **Senility (22.7%)**
- **Malnutrition (17.8%)**
- **Spinal cord injury (9.2%)**
- **Substance abuse disorders (8.1%)**



CMS Manual Guidance to LTC Surveyors - Tag F-314

- 3 year project
- 40 page document
- Regulation unchanged
- Interpretation of guideline enhanced
 - Definitions
 - Prevention
 - Treatment

Issued 11/12/04
Effective 11/12/04

CMS Manual System	
Pub. 100-07 State Operations Provider Certification	Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)
Transmittal #	Date: NOVEMBER 12, 2004

SUBJECT: Guidance to Surveyors for Long Term Care Facilities

I. SUMMARY OF CHANGES: Appendix FF, Tag F314, current Guidance to Surveyors, is entirely replaced by the revision which is to be inserted in the Appendix, immediately after the regulatory text for F314. To complement the revision of F314, new language is being added to Tag F309 to include certain definitions of non-prostate related values. Hyperlink links are added for all Web sites listed in the Overview, www.ahrq.gov, www.ahrq.org, www.cms.gov, www.medicare.gov, and www.hhs.gov. Hyperlink link is added in the Facilities section to link to a CMS site (www.cms.hhs.gov/medicaid-access-soft-landing.asp) for further information.

NEW/REVISED MATERIAL - EFFECTIVE DATE: November 12, 2004
IMPLEMENTATION DATE: November 12, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red indicated material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated)
(R = REVISED, N = NEW, D = DELETED) - (Only One Per Item)

ROW#	CHAPTER/SECTION/SECTION/TITLE
R	Appendix FF-43.23 Quality of Care Tag F 309
R	Appendix FF-43.23(c) Prostate Sites Tag F314

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

Business Requirements	
X Manual Instruction	
Confidential Requirements	
One-Time Notification	
Recurring Update Notification	

*Unless otherwise specified, the effective date is the date of service.

http://new.cms.hhs.gov/manuals/downloads/som107ap_pp_guidelines_ltc.pdf

Avoidable or Unavoidable?

The Resident developed a pressure ulcer

Facility did not do one or more of the following:

- Evaluate clinical condition & risk factors
- Define/implement interventions consistent with resident goals/standards of practice
- Monitor/evaluate impact of interventions
- Revise interventions

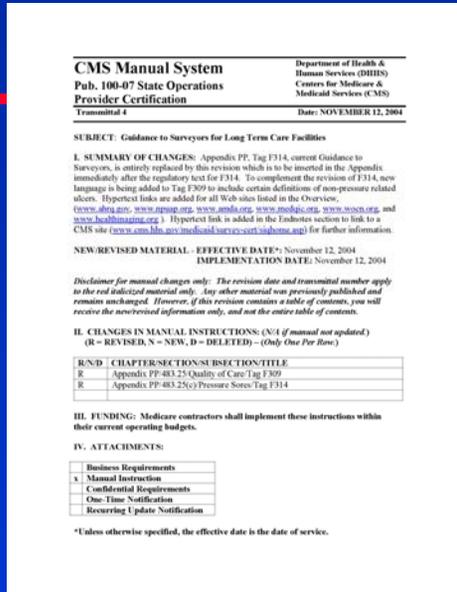
Avoidable

Even though the Facility did:

- Evaluate clinical condition & risk factors
- Define/implement interventions consistent with resident needs, goals/standards of practice
- Monitor/evaluate impact of interventions
- Revise interventions

Unavoidable

Regulation Creep?



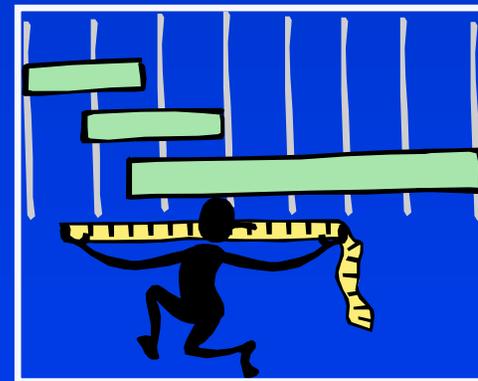
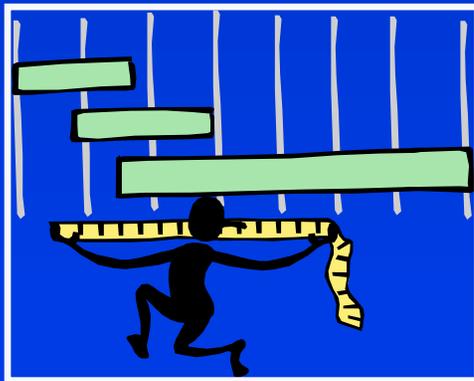
Tag F 314 Pressure Ulcers

http://new.cms.hhs.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf_

1989 NPUAP National Goal

“Reduce the incidence of pressure ulcers by 50% by the year 2000.”

Has Incidence Decreased?



**When faced with a choice
between changing and proving
there's no need to change,
most people
get busy on the proof.**

John Kenneth Galbraith

Lessons Learned #2

Get the right people

**What lessons can be
learned from NJHA
Collaborative?**

The NJHA Pressure Ulcer Collaborative Motivation – Fall 2004

- Acute care inactivity on pressure ulcer prevention (hospital-acquired pressure ulcers associated with a greater risk of death within one year (Barczak, et. al.).
- Need for greater integration of health care delivery systems across settings to improve quality of care transitions and reduce the threat of medical errors. (2001 Institute of Medicine Report “Crossing the Quality Chasm)
- New Jersey enacts the Patient Safety Act
 - Requires reporting to State Department of Health nosocomial Stage 3 and 4 pressure ulcers, first by hospitals and then by all providers

The NJHA Pressure Ulcer Collaborative Motivation – Fall 2004

- Home health quality initiative not focused on pressure ulcers, though OASIS measures are related to the incidence and prevalence of pressure ulcers.
- SNFs and acute care hospitals blame one another (and the ambulance company!) for occurrence of pressure ulcers in patients who move between levels of care.
- It is the right thing to do, and a new approach was needed! Only limited activity was occurring on a cross-setting basis.

Why New Jersey?



- Despite clinicians' efforts across different care settings, the number of PU was not decreasing
- 2005 mandatory reporting of Stage III and IV PU in hospitals
- NJHA initiated statewide collaborative to reduce PU across multiple healthcare settings

The NJHA Pressure Ulcer Collaborative Background – Fall 2004

NJHA proposed:

a statewide quality initiative that would bring together providers across the care continuum to tackle the prevention of pressure ulcers, especially in patients who move between levels of care.

The NJHA Pressure Ulcer Collaborative Background – Fall 2004

NJHA established an advisory panel:

- **State Department of Health and Senior Services**
- **Healthcare Quality Strategies, Inc. (QIO)**
- **Health Care Association of NJ (AHCA)**
- **New Jersey Association of Homes and Services for the Aging (AAHSA affiliate)**
- **Home Care Association of NJ (NAHC affiliate)**

The NJHA Pressure Ulcer Collaborative Background – Fall 2004

What were the challenges we faced
from the Advisory Panel?

- Would there be a financial commitment expected of them?
- How would we create the partnerships?
- What would the cost of participation be?
- Facilities are already strapped for resources
- Isn't the focus wrong – shouldn't it be skin failure?

The NJHA Pressure Ulcer Collaborative

The IHI Model

After thoughtful discussion, sharing of IHI Collaborative Model information and acknowledgement of the healthy skepticism...

NJHA asked for – and received – the enthusiastic support of the Advisory Panel members.

The New Jersey Hospital Association Pressure Ulcer Collaborative

- Structure
- Process
- Outcomes

The NJHA Pressure Ulcer Collaborative

The IHI Model

- **Create culture of safety**
 - Ensure team knows goals, evidence
- **Standardize what is done, when it is done**
 - Reduce complexity
 - Create independent checks for key processes
- **Measure and evaluate**

Key Attributes of a Collaborative

- Action-Oriented
- All teach, all learn
- Create a sense of “family” and support
- First time IHI collaborative model used in multiple settings

Changing Systems Changing Cultures

That x?!#*
place sent us
another person
with a pressure
ulcer



Can you
believe yet
another person
with a pressure
ulcer from
X?!#\$*!



Key Elements of Breakthrough Improvement

- *Will* to do what it takes to change to a new system
- *Ideas* on which to base the design of the new system
- *Execution* of the ideas

Collaborative Goals

- Close the gap between what is known and what is practiced
- Reduce pressure ulcer incidence by 25 %
- Achieve 95% compliance with the PU prevention Bundle
 - Skin assessment on admission
 - Risk assessment on admission
 - Reassessment of skin and PU risk
 - Prevention strategies implemented within 24 hrs
- Improved communication across care settings

Logistics

- Fee for participation
 - Hospitals \$5000
 - LTC \$1000 (reimbursed from CMP funds)
- Special Thanks - Corporate Sponsors
 - First Year – 3 M HealthCare & Sage
 - Second Year- 3M HealthCare & Healthpoint Limited

Lessons Learned #3

Make it realistic

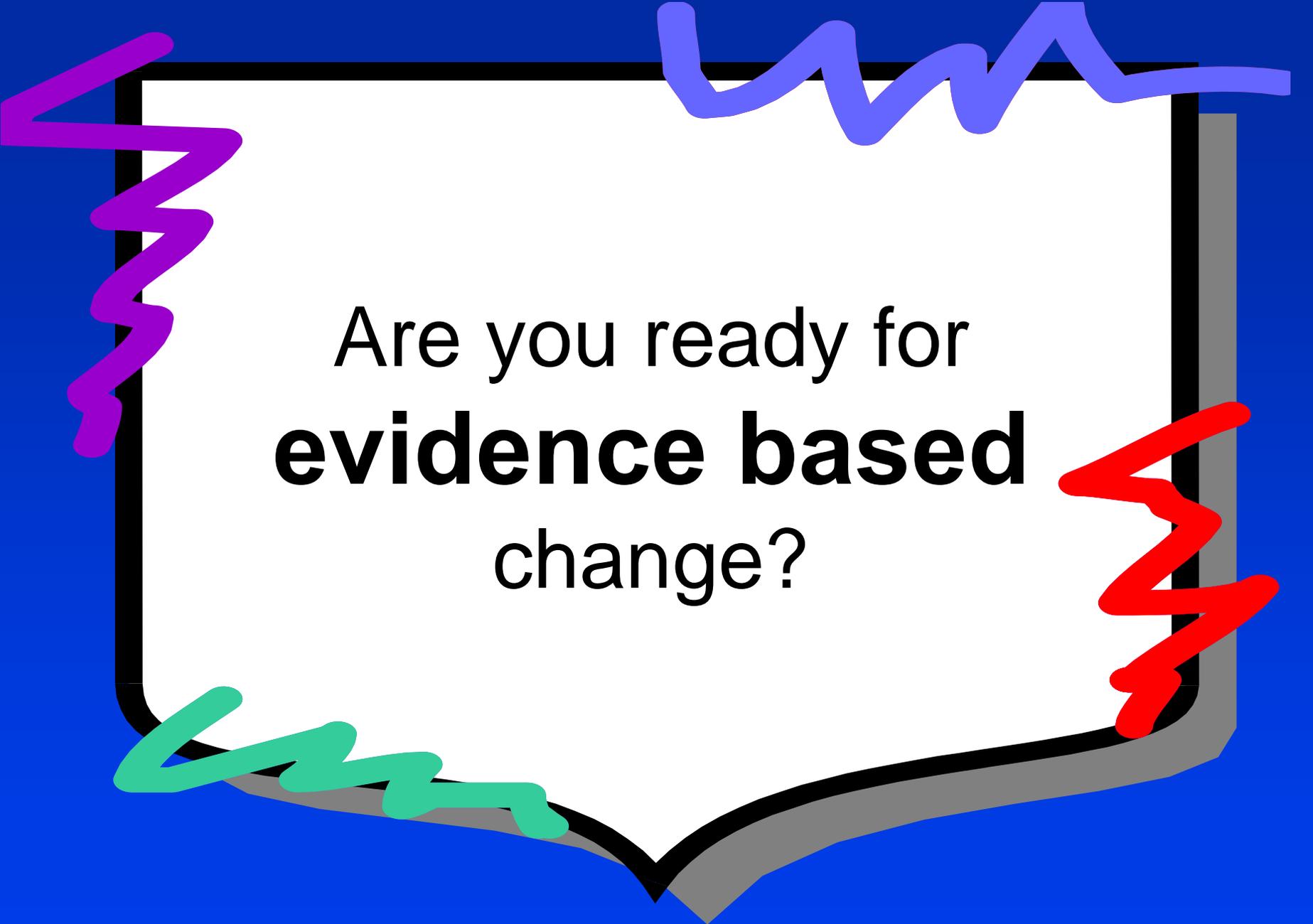
**What lessons can be
learned from NJHA
Collaborative?**

The New Jersey Hospital Association Pressure Ulcer Collaborative

- Structure
- Process
- Outcomes

**Listen
to your
partners!**





Are you ready for
evidence based
change?

Ayello's Change Process

- ✓ “We can’t”
- ✓ “We must”
- ✓ “ We are excited”
- ✓ “ We are tired”
- ✓ “ We did it!”
- ✓ “ We published it”
- ✓ “ We celebrated!”



Components of the Collaborative

- ✓ Education Program
National experts NPUAP, WOCN
- ✓ Patient Education Book
- ✓ Poster for participating organizations
- ✓ Monthly Conference Calls
- ✓ Web site
- ✓ Active Listserv
- ✓ Data Driven

Lessons Learned #4

live your theme

**What lessons can be
learned from NJHA
Collaborative?**

Wanted: NO ULCERS©!

Nutrition and fluid status

Observation of skin

Up and walking or turn and position

Lift, don't drag skin

Clean skin and continence care

Elevate heels

Risk assessment

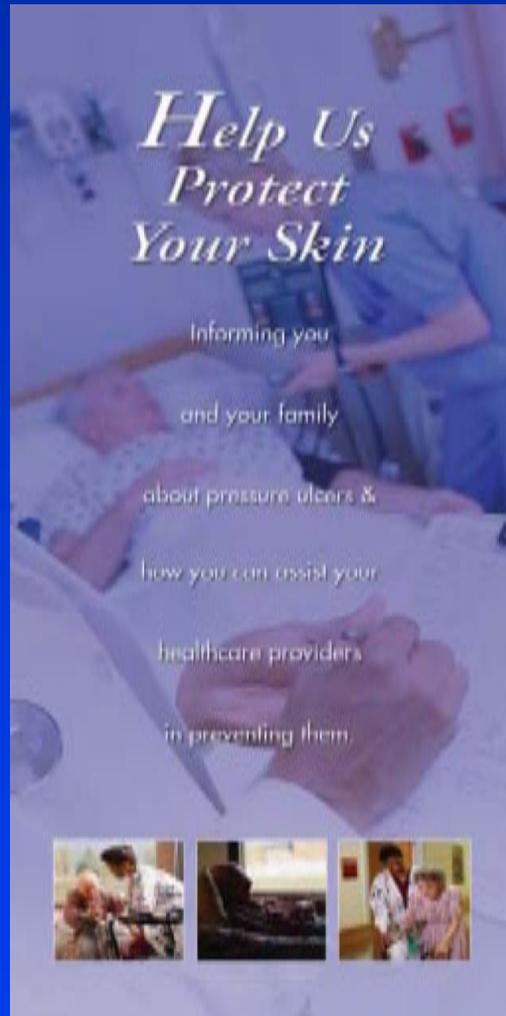
Support surfaces for pressure redistribution



NJHA Collaborative Button



The NJHA Skin Health Brochure



Source: New Jersey Hospital Association
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Lessons Learned #6

Active participation

What lessons can be learned from NJHA Collaborative?

Our Partners

First Year

3 Learning Sessions

- 125 Partners
- Hospitals
- Home Care
- Long Term Care
- Others

Second Year

3 Learning Sessions

- 110 Partners (total 150 cumulative)

- CMS Region II
- NJ Department of Health and Senior Services-
- QIO of NJ
- Nursing Home and Home Health Provider Associations
- WOCN and NPUAP
- Corporate Sponsors

Lessons Learned #5

REWARD people

**What lessons can be
learned from NJHA
Collaborative?**

Our NJHA Partners!



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NJHA Data !

1. Demographic Form

NURSING DEMOGRAPHIC SHEET: Pressure Ulcer Survey

DIRECTIONS: Please answer each of the following questions by checking the appropriate box(es).

1. Where do you work: Hospital Long term Care
 Home Care Other (Specify) _____
2. Age: _____
3. Gender: Male Female
4. RN LPN CNA Administrator
 Other (specify) _____

2. Pieper Pressure Ulcer Knowledge Tool

The New Jersey Hospital Association Pressure Ulcer Collaborative

- Structure
- Process
- Outcomes

Lessons Learned #7

Highlight results

What lessons can be learned from NJHA Collaborative?



SO HOW DID WE DO?





The forms!!!!!!



1. Demographic form

- NURSING DEMOGRAPHIC SHEET: Pressure Ulcer Survey
- DIRECTIONS: Please answer each of the following questions by checking the appropriate box(es).
- 1. Where do you work: Hospital Long term Care Home Care Other Specify _____
- 2. Age: _____
- 3. Gender: Male Female
- 4. RN LPN CNA Administrator
 Other (specify) _____

2. Pieper Pressure Ulcer Knowledge Tool

Conclusions

- The more learning sessions attended the higher the nurse's knowledge
- Nurses certified in areas other than wound care increased their knowledge equal to nurses certified in wound care
- Overall knowledge increased and incidence decreased

Lessons Learned #8

RELY ON DATA

**What lessons can be
learned from NJHA
Collaborative?**

Baseline Data

- Data gathered prior to beginning of collaborative in summer of 2005
- Overall prevalence rate at approximately 21%
- Overall incidence rate averaged 16%

Our Goal in 2005

- Reduce the incidence of pressure ulcers by 25%
- While not specifically stated, we also wanted to reduce the prevalence of pressure ulcers

So How Did We Do?

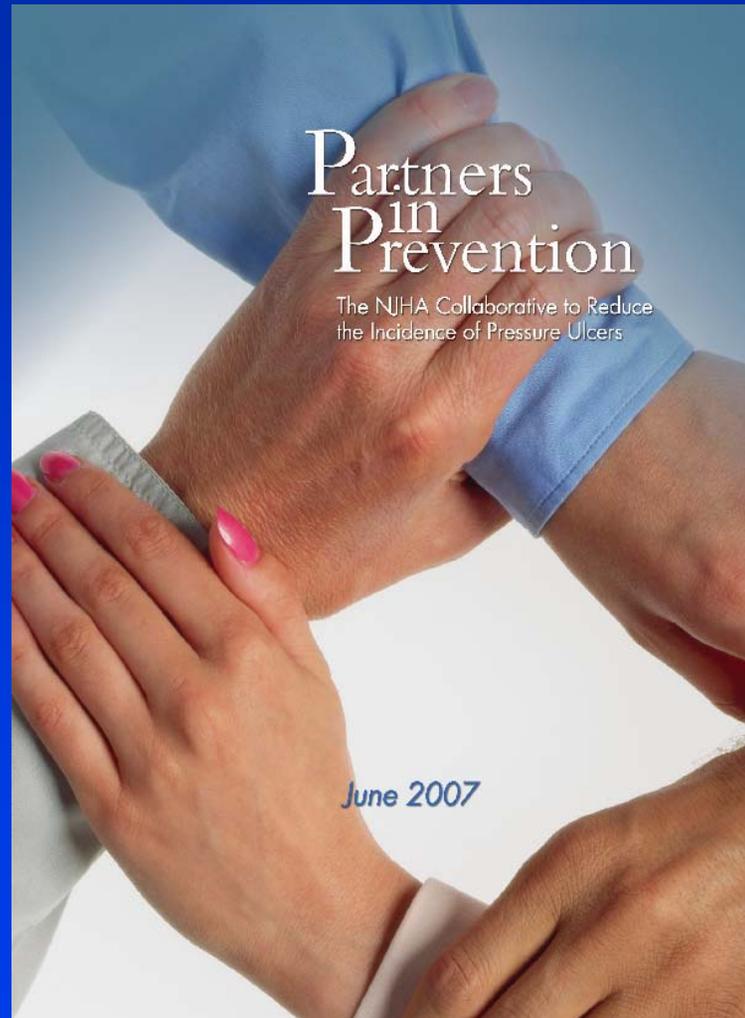
- Incidence reduced by 70% - from 16% to average of 5% across all organizations
- 48 organizations achieved results of 0 new pressure ulcers for three months or more!
- Prevalence rate across all organizations reduced by 30%

Lessons Learned #9

Keep Supporting

**What lessons can be
learned from NJHA
Collaborative?**

Celebrating Our Partners



Source: New Jersey Hospital Association
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Knowing is not enough;
we must apply.
Willing is not enough;
we must do.

Goethe

Historical perspective

Why have gains been lost?

- Prevention strategies throughout agency-nothing else to do
- Success dependent on one person
- Skin Care champion left
- No skin care team
- The goal was achieved
- Commitment reduced
- No longer a priority
- Work became invisible
- PU rewards reduced
- Diminished education for staff on PU prevention

Continuing the Momentum

- **Sustainability**
 - *Ability to be kept going, continue – as an action or a process*
 - *Ability to keep in existence*
 - *Ability to support from below*

The NJHA Pressure Ulcer Collaborative: What's Next?

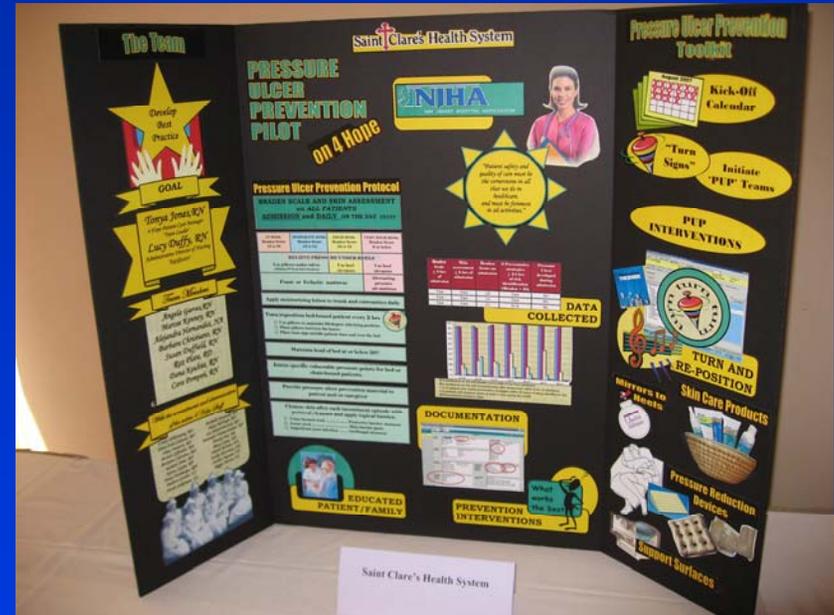
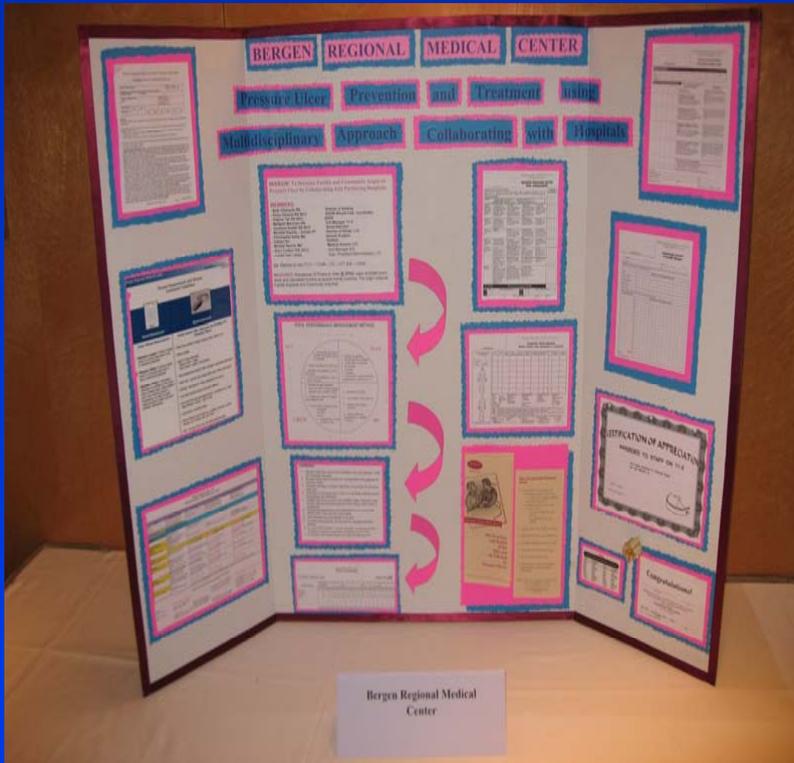
- Sustainability will be supported by ongoing education, data collection and analysis from those who volunteer to continue submitting data, maintenance of the listserv and web site, journal writing, site visits, Institute for Healthcare Improvement 5 Million Lives Campaign.
- Development of Statewide Universal Transfer Form
- CMS considering non-payment under Medicare for hospital-acquired conditions – Pressure Ulcers are near the top of the list because of high volume, high cost and because evidence-based prevention guidelines exist.
- We will monitor New Jersey's activity and progress and consider new ways to bring providers together based on what we observe and learn

Lessons Learned #10

Share and publish

What lessons can be learned from NJHA Collaborative?

Some NJHA Partner Posters



NJHA Posters at Various Wound Care Conferences





Institute for
Healthcare
Improvement

Strategies to Win The 5 Million Lives Campaign

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New Jersey Hospital Association Pressure Ulcer Collaborative

Driving down pressure ulcers



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Thank you!