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# **Achieving Results In Pressure Ulcer Prevention Across Care Settings**

## **Lessons from the New Jersey Pressure Ulcer Collaborative**

**Theresa Edelstein, MPH, LNHA  
VP, Continuing Care**

**Aline Holmes, RN, APNC, MSN  
Sr. VP, Clinical Affairs**

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LANE WEBINAR**

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# NJ Experience Prior to Collaborative

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- **NJ has had pressure ulcer initiatives for over 10 years**
  - Provided tools and resources
  - Focused solely on nursing homes
  - Little measurable improvement
- **Pressure Ulcer Collaborative (PUC) unique**
  - Focus across provider type
  - Generated dialogue across continuum to address problem
  - Demonstrated clinical improvements



# The NJHA Pressure Ulcer Collaborative

## Motivation – Fall 2004

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- The first imperative: It is the right thing to do.
- A very stubborn prevalence rate of pressure ulcers persists in New Jersey skilled nursing facilities, as measured by the Centers for Medicare and Medicaid Services Nursing Home Quality Initiative.
- Legal ramifications: 21% of cases involving pressure ulcers result in a claim being paid out at \$500,000 or more. (Baharestani)
- Annually, costs associated with care of pressure ulcers exceed \$1.335 billion, with \$355 million of that total spent in long term care settings. (Miller & Delozier; Morris, et. al.)
- Implementation of F314 CMS Guidance

# The NJHA Pressure Ulcer Collaborative

## Motivation – Fall 2004

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- Acute care inactivity on pressure ulcer prevention, yet hospital-acquired pressure ulcers have been associated with a greater risk of death within one year of hospitalization.(Barczak, et. al.)
- The 2001 Institute of Medicine Report “Crossing the Quality Chasm” called for greater integration of health care delivery systems across settings to improve quality of care transitions and reduce the threat of medical errors.
- New Jersey enacts the Patient Safety Act which 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

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- 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 in the U.S.
- NJHA established an advisory panel that includes the State Department of Health and Senior Services, the QIO, the Health Care Association of NJ (AHCA affiliate), the New Jersey Association of Non-Profit Homes for the Aging (AAHSA affiliate), the Home Care Association of NJ (NAHC affiliate).

# The NJHA Pressure Ulcer Collaborative

## Motivation – Fall 2004

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- NJHA proposed to undertake 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.
- 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?
- 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 NJHA Pressure Ulcer Collaborative

## The IHI Collaborative Model

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- **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 defects**

*Measure how you are doing*

# The NJHA Pressure Ulcer Collaborative Breakthrough Collaborative

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An Improvement Method that relies on SPREAD and adaptation of existing knowledge to multiple settings to accomplish a common goal.

A Breakthrough Collaborative is NOT:

- Research for new knowledge
- Single Setting Focus
- Small changes to existing systems

# The NJHA Pressure Ulcer Collaborative

## Key Elements of Breakthrough Improvement

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- 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

# The NJHA Pressure Ulcer Collaborative

## Three Fundamental Questions for Improvement

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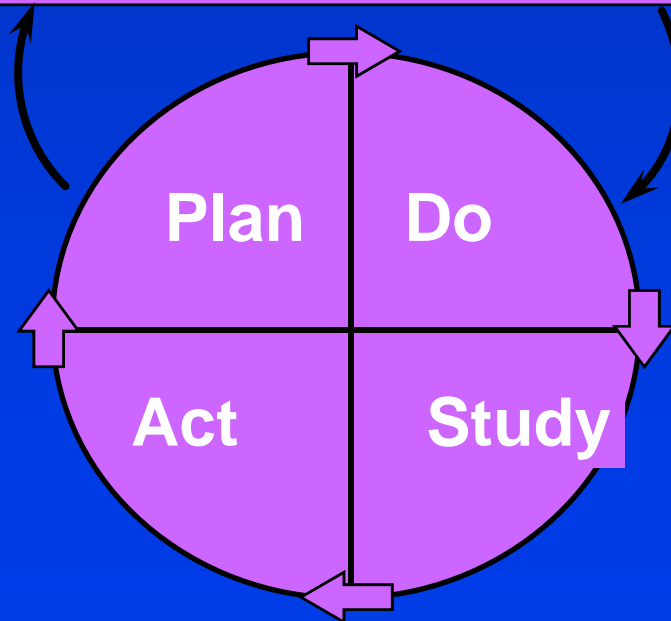
1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

# Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



# The NJHA Pressure Ulcer Collaborative

## Key Attributes of Collaborative Success

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- Action-Oriented
- All teach, all learn
- Create a sense of “family” and support and change the conversation
- Following NJHA’s use of this model in its Intensive Care Unit Collaborative, NJHA took the IHI Collaborative model and extended it to include multiple types of health care providers to address pressure ulcer prevention.

# The NJHA Pressure Ulcer Collaborative Background

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- To move forward, we believed it was important to have a chairperson for this initiative with a strong clinical practice and research reputation nationally who could assist us with bringing experts in the field together to serve as faculty and advisors.
- In Feb. 2005, Dr. Elizabeth Ayello, a nationally recognized expert in the field of pressure ulcer prevention and treatment, and Senior Adviser, The John A. Hartford Institute for Geriatric Nursing, New York University, agreed to be the chairperson of the Pressure Ulcer Collaborative.

# The NJHA Pressure Ulcer Collaborative Background

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- To facilitate participation by skilled nursing facilities, the NJ DHSS generously agreed to sponsor nursing facilities' participation in the Pressure Ulcer Collaborative through the use of Civil Monetary Penalty funds for any SNF that completed ALL the requirements of the Collaborative.
- SAGE, 3M Healthcare and Healthpoint, Ltd. provided some corporate sponsorship of the Collaborative.
- All-inclusive participation fee established for acute care hospitals at \$5,000 and for all other providers at \$1,000. This included all learning sessions, materials, conference calls, listserv, web site, technical assistance from NJHA staff on an ongoing basis for one year.

# The NJHA Pressure Ulcer Collaborative Content Development – Spring 2005

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## Collaborative Aim Statement

- Reduce the incidence of pressure ulcers by 25 percent by Sept. 2006
- Achieve 95 percent adherence with all components of the Pressure Ulcer Collaborative prevention bundle
- Improve communication, collaboration and teamwork between professionals across multiple settings so as to improve handoffs and transitions
- Demonstrate an improvement in safety culture

# The NJHA Pressure Ulcer Collaborative

## Content Development – Spring 2005

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### Collaborative Charter

- Expectations of sponsoring organization and participants
- Problem statement
- Mission
- Methods
- Timetable
- Preparation
- Defining an Aim & Assess Your Organization
- Baseline Data Collection
- Glossary

# The NJHA Pressure Ulcer Collaborative Content Development – Spring 2005

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## NJHA's Expectations of Itself as Sponsor

- Provide education on the latest and best subject matter application and research, as well as tools and interventions for process improvement
- Coach teams, organizations and partners
- Assess progress monthly and provide feedback

# The NJHA Pressure Ulcer Collaborative

## Content Development – Spring 2005

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### Participating provider organizations have been expected to:

- Connect the goals of the collaborative work to a strategic initiative in their organization
- Provide a senior leader to sponsor and actively support the team and champion the spread of improvements within the facility
- Provide the resources to support the team, including resources necessary for Learning Sessions and staff time to devote to this effort
- Provide expert staff from key support units in the organization to support the team as needed
- Perform tests of change leading to process improvements within the organization
- Communicate regularly with their partners in other health care settings
- Share information with the collaborative, including details of changes made and data to support these changes, both during and between Learning Sessions

# The NJHA Pressure Ulcer Collaborative

## Content Development – Spring 2005

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- In this collaborative, the mission of the NJHA Quality Institute, Department of Continuing Care, and participating healthcare organizations is to achieve -- within 12 months -- breakthrough improvement in the quality of care provided to elderly patients in pressure ulcer prevention across healthcare settings. The mission also includes developing a means to spread the initial learning and improvement more widely within the participating organizations.
- Our goals are to close the gap between what is known and what is practiced, and to establish new systems of care that will produce: better clinical outcomes, fewer adverse events, much higher levels of patient and family satisfaction, lower costs, better coordination of care, and enhanced communication among multiple healthcare settings.
- We are seeking a 25 percent reduction in the incidence of pressure ulcers.

# The NJHA Pressure Ulcer Collaborative Content Development – Spring 2005

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- **NJHA worked with faculty and the Advisory Panel to complete a review of the medical research literature, current research and identify a “bundle” of best practice preventive interventions for the Collaborative. Faculty included Dr. Elizabeth Ayello, Dr. Barbara Braden, Dr. Karen Zulkowski, and Dr. Janet Cuddigan, and many other well-respected experts in the field.**
- **A bundle is a grouping of best practices that have been individually proven to improve quality in a specific area. They include evidence-based protocols and practices that have been tried and tested to improve outcomes.**
- **If one of these best practices has been proven to work, then 2, 3 or 4 are likely to work even better. By applying the bundle to all patients/residents/clients for whom the bundle is directed, we provide the same consistent, high quality care no matter who is caring for them.**

# The NJHA Pressure Ulcer Collaborative

## Content Development – Spring 2005

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**The Pressure Ulcer Collaborative bundle includes:**

- **Complete head-to-toe skin assessment within 8 hours of admission.**
- **Assessment for intrinsic and extrinsic risk factors using the Braden scale within 8 hours of admission and reassessment every 24 hours in acute care, weekly in long term care (every 24 hours if at risk) and every RN or PT visit in home care.**
- **Institute appropriate pressure ulcer prevention techniques for all who are identified to be at risk within 24-hours, including use of pressure redistribution surfaces.**

# The NJHA Pressure Ulcer Collaborative

## Content Development – Spring 2005

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Care team and leadership level “interventions” are also part of the Pressure Ulcer Collaborative bundle.

### These include

- Use of PDSA cycles to implement small tests of change
- Moving toward a culture of safety
- Monitoring interventions
- Senior leadership “buy in” and reporting
- Establish regular method for partners to communicate and collaborate
- Create culture of collegiality between partners to enhance advocacy on behalf of patients
- Share learning – “all teach, all learn”

# The NJHA Pressure Ulcer Collaborative

## Content Development – Spring 2005

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### Organization Commitment

- develop an interdisciplinary work group
- evaluate current pressure ulcer assessment and management practices
- establish accountability for assessment
- provide education
- continually evaluate and work to improve

# The NJHA Pressure Ulcer Collaborative

## Content Development – Spring 2005

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### Partnership Commitment

- develop a work group of partner providers**
- evaluate current admission/transfer/discharge between organizations**
- establish accountability for skin and risk assessments**
- establish regular meeting schedule**
- continually evaluate and work to reduce incidence/prevalence of pressure ulcers and improve communication/teamwork between partners**

# The NJHA Pressure Ulcer Collaborative

## Content Development – Spring 2005

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- Pressure Ulcer Prediction, Prevention and Treatment Pathway
- Treatment Product Categories Table
- Turning and Positioning Tool
- Established Baseline Data Elements & Tool
- Determined Data Elements to be collected monthly
- Developed qualitative Senior Leader Report for monthly submission
- Prepared Collaborative Announcement and Invitation

# The NJHA Pressure Ulcer Collaborative

## Getting Started – Summer 2005

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- Invitation sent to all CEOs and administrators of all NJ health care providers (June).
- Invitation with registration sent to all health care providers statewide: 83 acute care hospitals, 20 rehabilitation hospitals, 6 long term acute care hospitals, 50 home health agencies, 365 skilled nursing facilities and 130 assisted living residences.
- NJ DHSS sent letter to all SNFs encouraging their registration and announcing dedication of CMP funds for the SNFs that fulfilled all Collaborative requirements. Registration fee to be reimbursed at the end of the Collaborative year based on verification of completion.
- QIO and provider associations (i.e., the Advisory Panel) strongly promote involvement.
- Finalize first learning session agenda for Sept. 2005.
- Enrolled participants and assisted with establishing partnerships.
- Developed web site and listserv.

# The NJHA Pressure Ulcer Collaborative Year 1 Experience

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- Three learning sessions, lasting two days each, were held in Sept. 2005, Feb. 2006 and July 2006.
- At Sept. 2005 Learning Session, each team of partners was seated together. They were required to complete two AIM statements – one for their individual organizations and one for their partnership. “WHAT WILL YOU DO BY NEXT TUESDAY?” was the focus of the AIM statements.
- Knowledge survey was administered at the beginning of each learning session to ascertain baseline knowledge and increase in knowledge over time as a result of the learning sessions and participation in the Collaborative.
- Agenda included presentations on wide range of topics based on participants’ interests and questions, as well as on the Collaborative’s goals.
- Learning Sessions were designed for networking, breaking down barriers, working together as a team, sharing ideas, discussing successes.

# The NJHA Pressure Ulcer Collaborative Year 1 Experience

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- In addition, we had monthly conference calls between learning sessions covering topics such as an in-depth look at the Braden Scale facilitated by Dr. Barbara Braden; end of life care and pressure ulcers led by Dr. Michele Elkins, showcase of participants; special focus on home health care; and an introduction to the NJ Patient Safety Act and reporting requirements led by Dr. Lisa Mazzia of DHSS.
- The listserv included as many individuals from the participating organizations as they requested. It is an active forum for posing questions, sharing resources. Faculty participate in the listserv.
- Website was activated and all learning session and supplemental resources are posted there, as well as Senior Leader Reports and aggregate data reports.
- As a result of participant input, a button (NO ULCERS mnemonic) was developed and distributed to all participating organizations, a patient/family education pamphlet on pressure ulcer prevention was created and distributed and a large poster was designed for each organization to place in a prominent location.

# The NJHA Pressure Ulcer Collaborative Year 1 Experience

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- Learning Session 3 (July 2006) included participation by Collaborative partners, as well as by QIOs from AZ and KY and by Summa Health.
- Partners discussed their development of transfer tools
- AZ and KY QIOs and Summa Health shared their projects focused on coordination of care models
- 10 Collaborative partners displayed poster sessions describing their work
- Recognition for all participating partners

# The NJHA Pressure Ulcer Collaborative

## What We Learned in Year 1

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- This was the first time many providers have actually talked and worked together to improve coordination of care and to implement best practices for patients.
- Having the technical support and encouragement to pursue the partnership and dialogue was critical to breaking down barriers.
- The presence of the Advisory Panel members at the learning sessions, on the listserv and on the conference calls reinforced that we ALL were engaged and committed to this effort. We modeled the behavior we sought from them.
- Providers believe that a consistent, uniform set of data that would travel with the patient between settings is needed.
- Enormous enthusiasm, commitment and belief in this initiative.
- Increased knowledge about pressure ulcers translated to improved practice.
- The best practices bundle resulted in reduced prevalence.
- Emergency Department and Operating Room nurses need to be included.
- So, we decided to continue for a 2<sup>nd</sup> year in recognition of the fact that support was still needed as organizations moved beyond their pilot units/populations and sought to spread this change to their entire organizations.

# The NJHA Pressure Ulcer Collaborative

## Year 2

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- All existing participants invited to continue at reduced registration fee.
- DHSS committed CMS funds again.
- Invitations sent out to all non-participating health care organizations statewide, with registration fee set at the same rate as year 1.
- Several organizations across provider types have moved beyond their pilot unit/population and spread the “bundle” to additional areas or organization-wide.
- Additional corporate sponsor – Healthpoint, Ltd.
- Added pressure ulcer incidence to the data collection process.
- Focus on assessment and prevention continues, with added emphasis on treatment and spreading and sustaining change in practice.
- 110 organizations are involved, including approximately 29 new organizations and 80 continuing organizations ( a 66% retention rate). Total number of organizations over 2 years = 150
- Conference calls continue on topics such as bariatrics, documentation, critical care, infections.
- Series of meetings has begun with the NJ Emergency Nurses Association to discuss how they can participate in the assessment and prevention best practices bundle.

# The NJHA Pressure Ulcer Collaborative Participants – over 2 years

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**A total of 150 different organizations have participated:**

**53 acute care hospitals (out of 83 – 64%)**

**76 nursing facilities (out of 362- 21%)**

**12 home health agencies (out of 50 – 24%)**

**9 rehabilitation hospitals/LTACHs/assisted living/ CCRC/ hospice**

**Attrition was minimal during both years and was usually related to significant operational changes**

# The NJHA Pressure Ulcer Collaborative

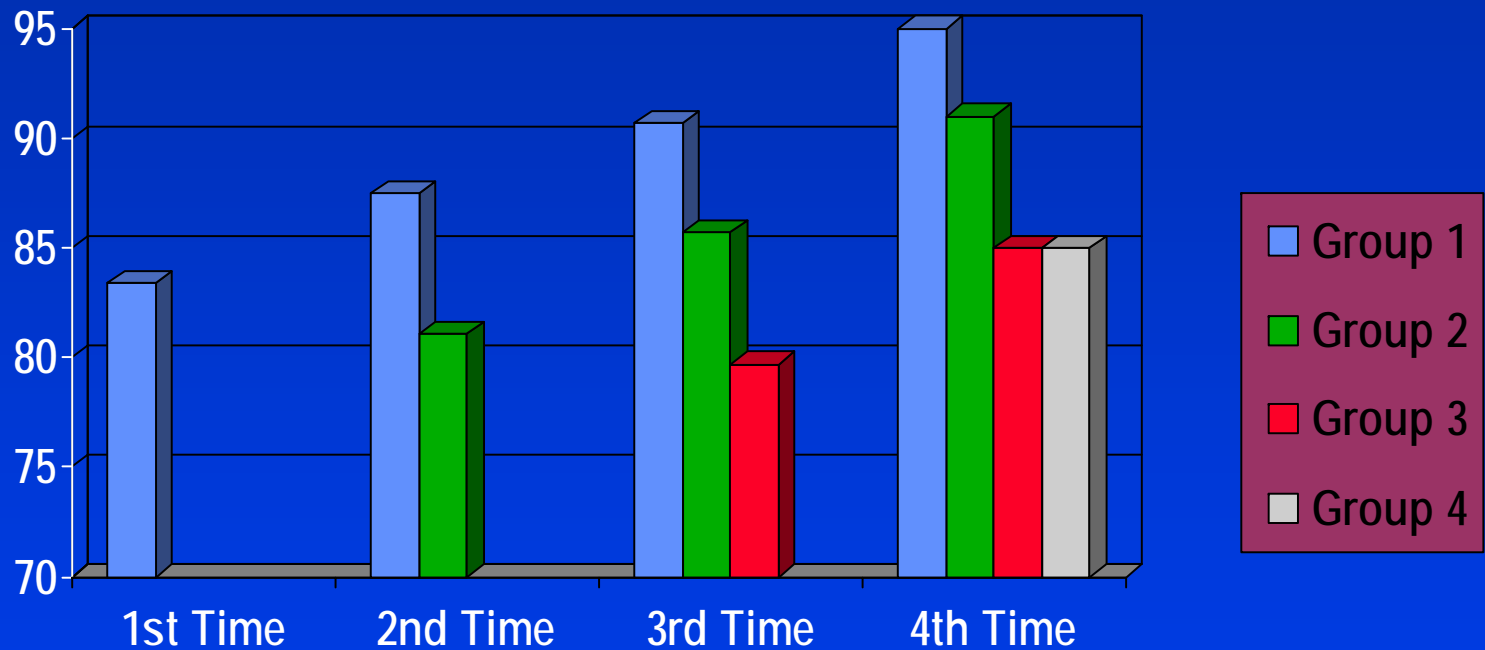
## What We Learned From The Data

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### Data points collected

- Comprehensive skin assessment within 8 hours of admission
- Patients assessed with Braden Scale within 8 hours of admission
- Patients receive preventive interventions within 24 hours of being identified as “at risk”
- Patients with a pressure ulcer at a point in time each month
- New pressure ulcers among individuals identified as being at-risk (via Braden scale) each month

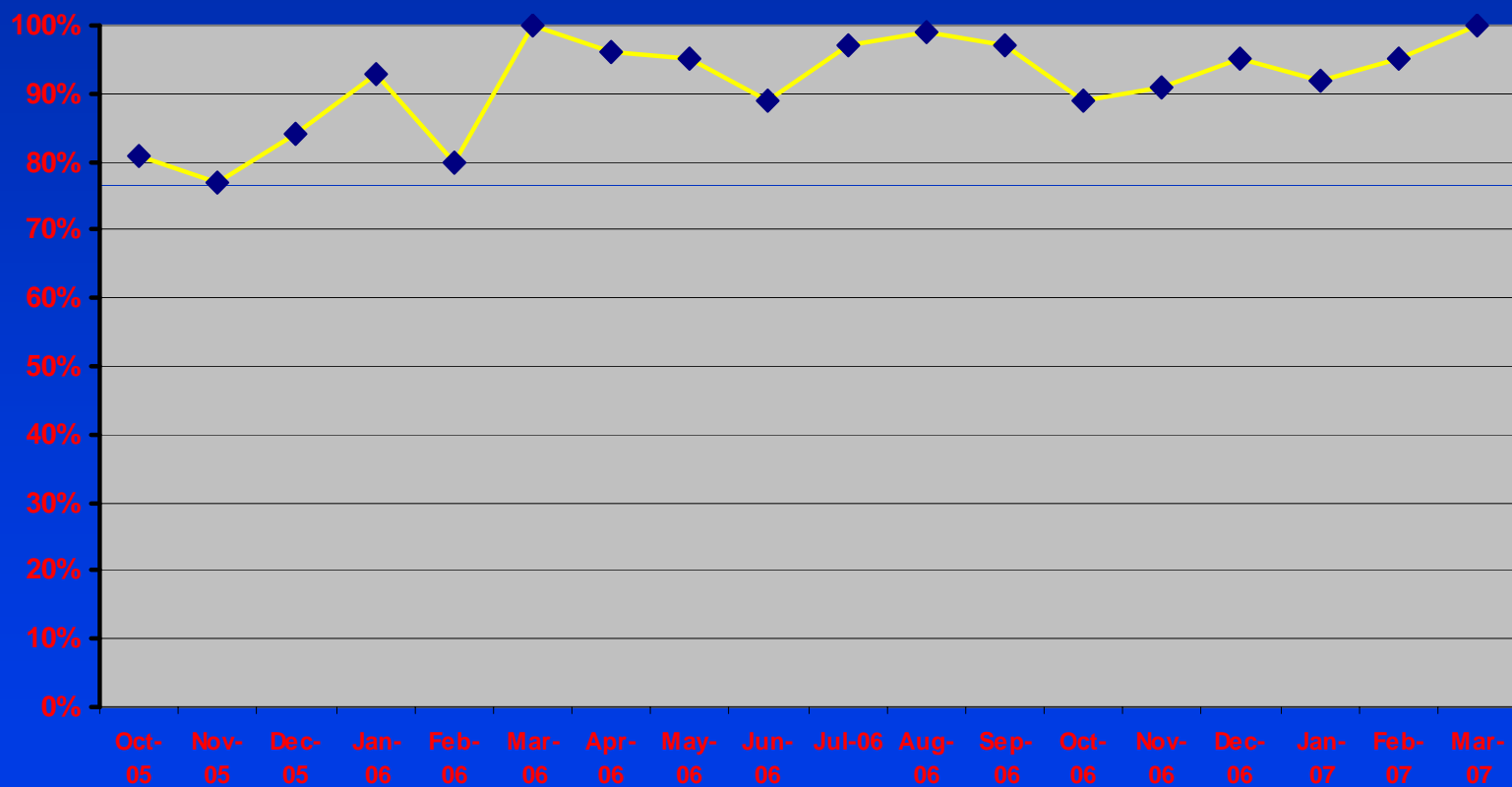
# The NJHA Pressure Ulcer Collaborative Mean Knowledge Scores



Source: New Jersey Hospital Association  
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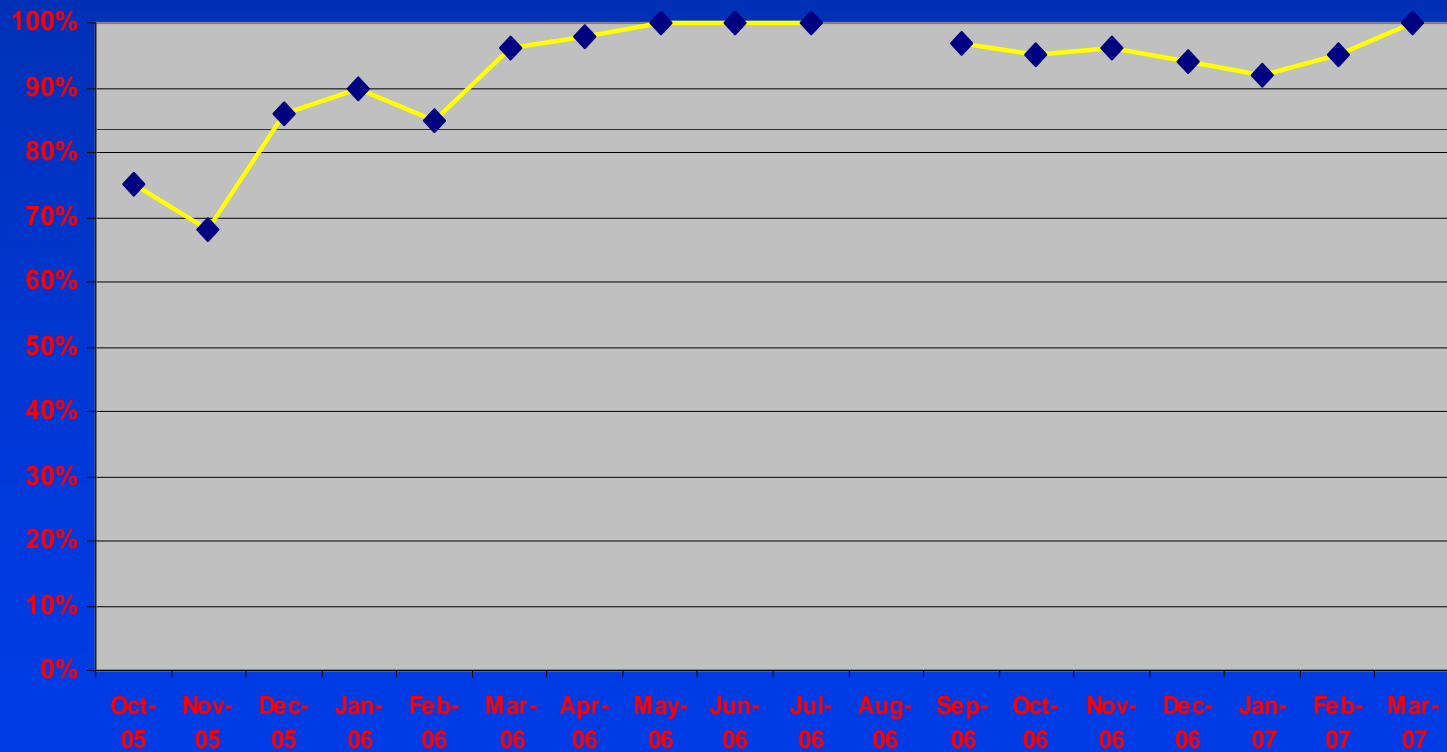
## Percent of Admissions Across All Organizations Who Have Risk Assessment Completed within 8 hours of Admission



Source: New Jersey Hospital Association  
Copyright 2000, New Jersey Hospital Association



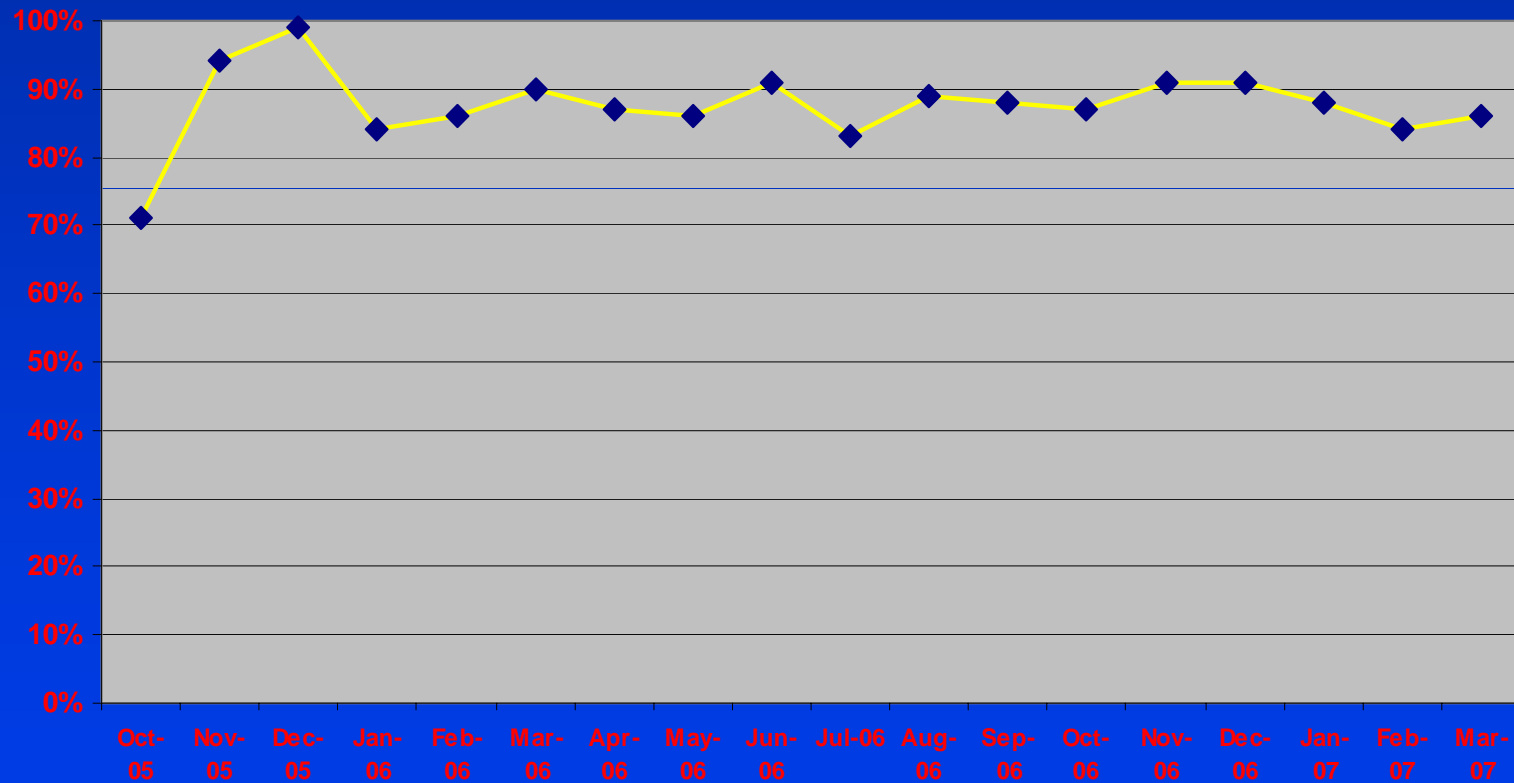
## Percent of Admissions Across All Organizations Who Had Comprehensive Skin Assessment Within 8 hours of Admission



Source: New Jersey Hospital Association  
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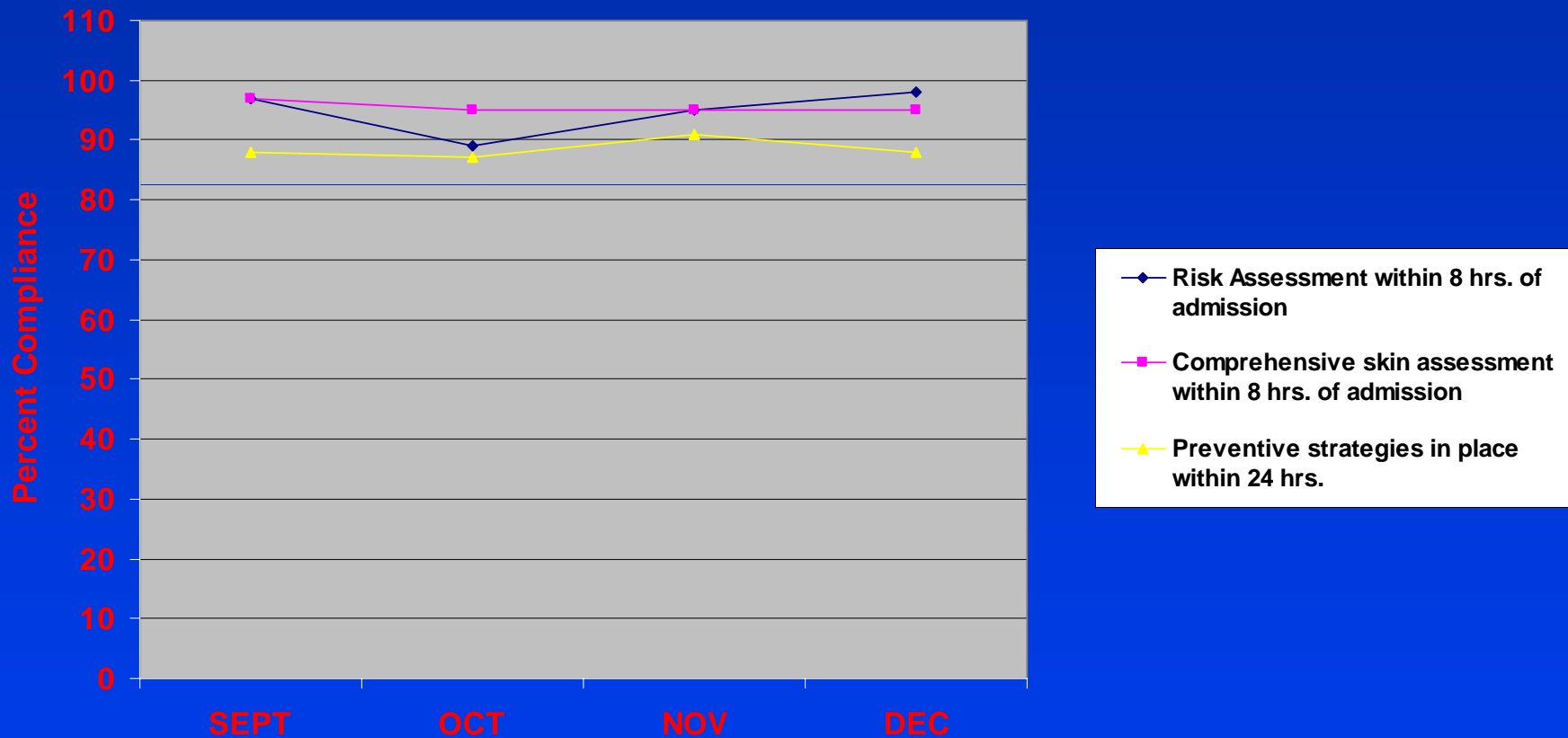
## Percent of At Risk Patients Across All Organizations Who Received Preventive Strategies within 24 hours of Admission



Source: New Jersey Hospital Association  
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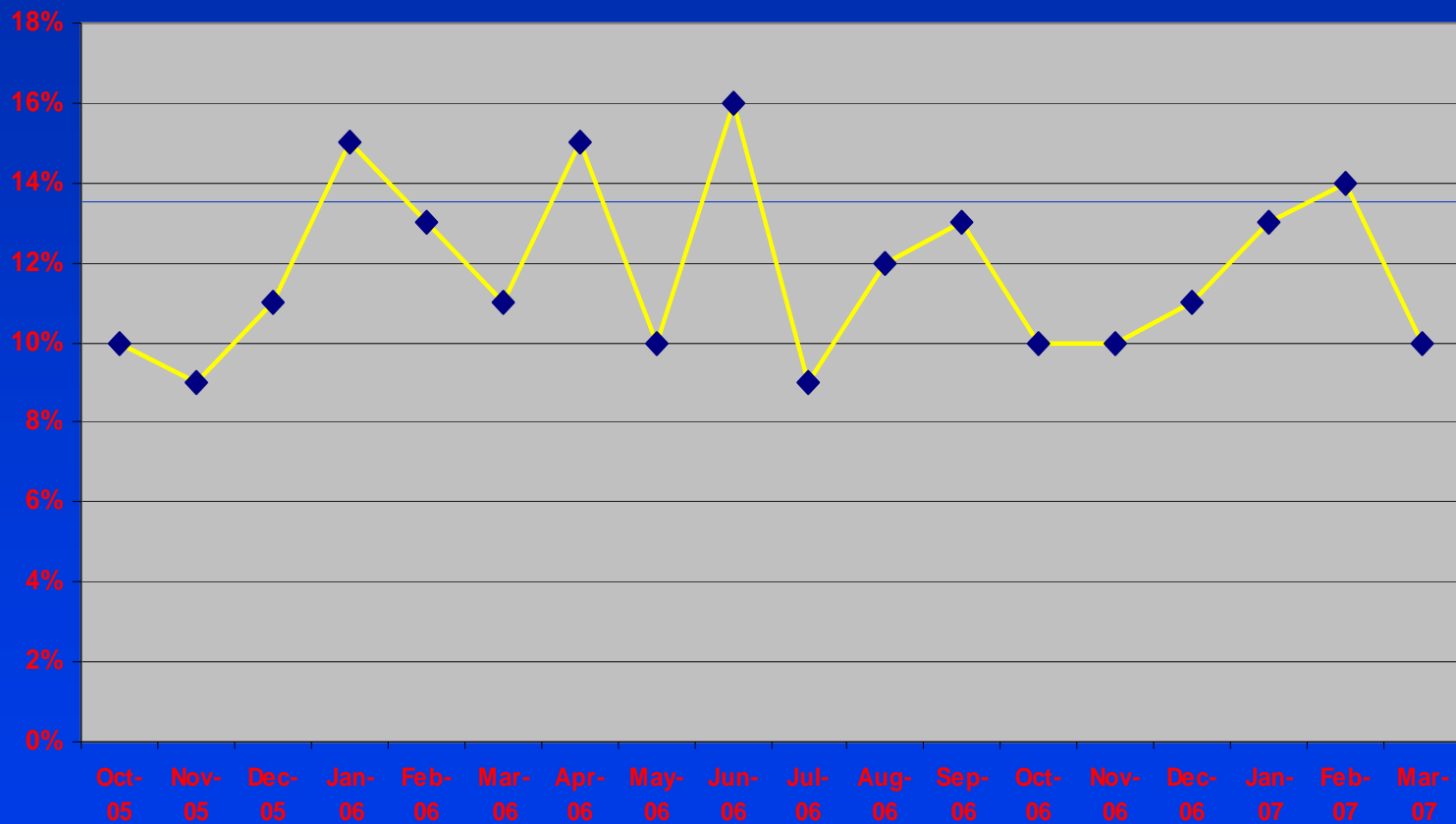
## Process Measures, Year 2, all sites



Source: New Jersey Hospital Association  
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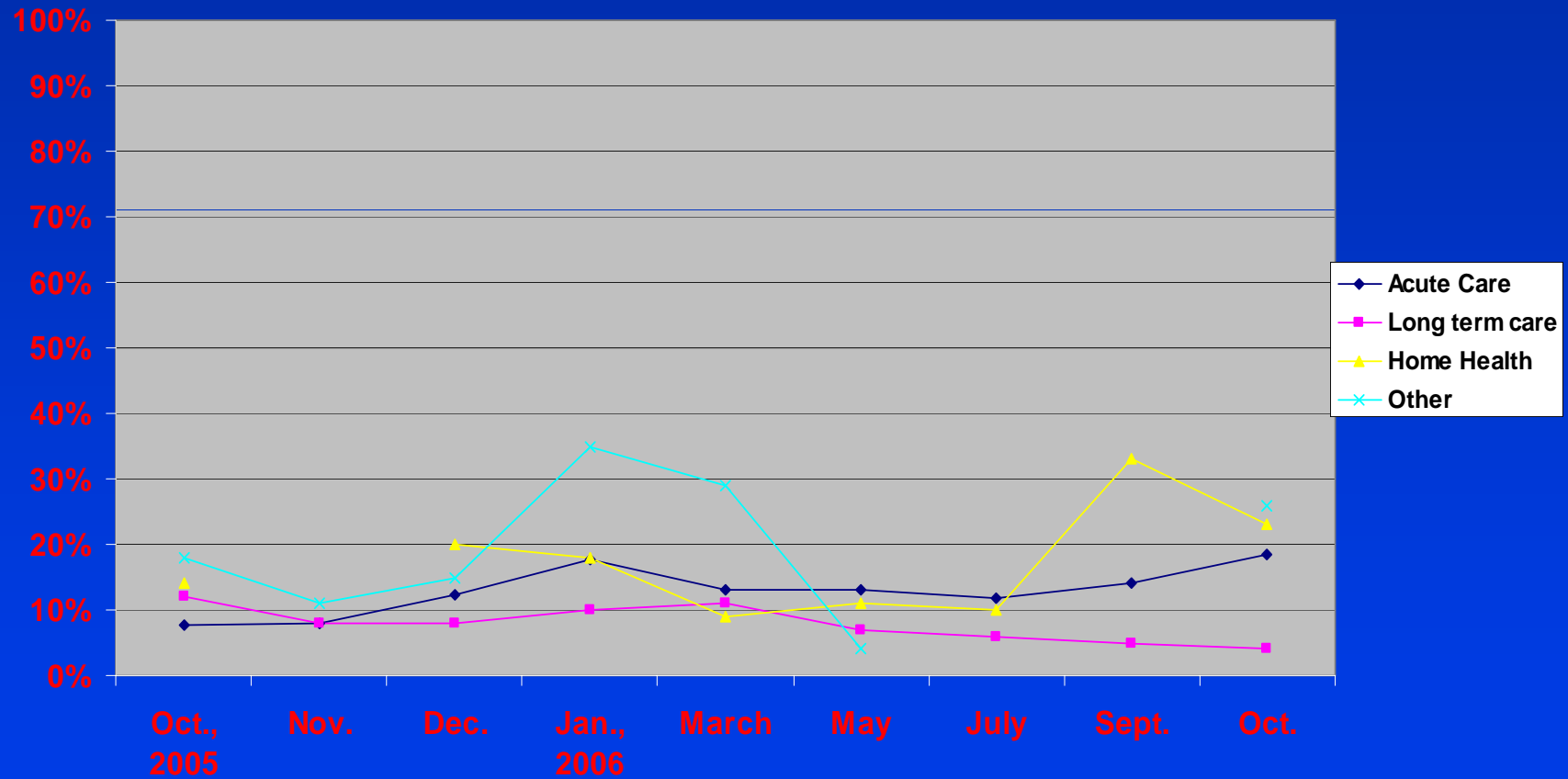
## Prevalence Rates of Pressure Ulcers Across All Reporting Organizations



Source: New Jersey Hospital Association  
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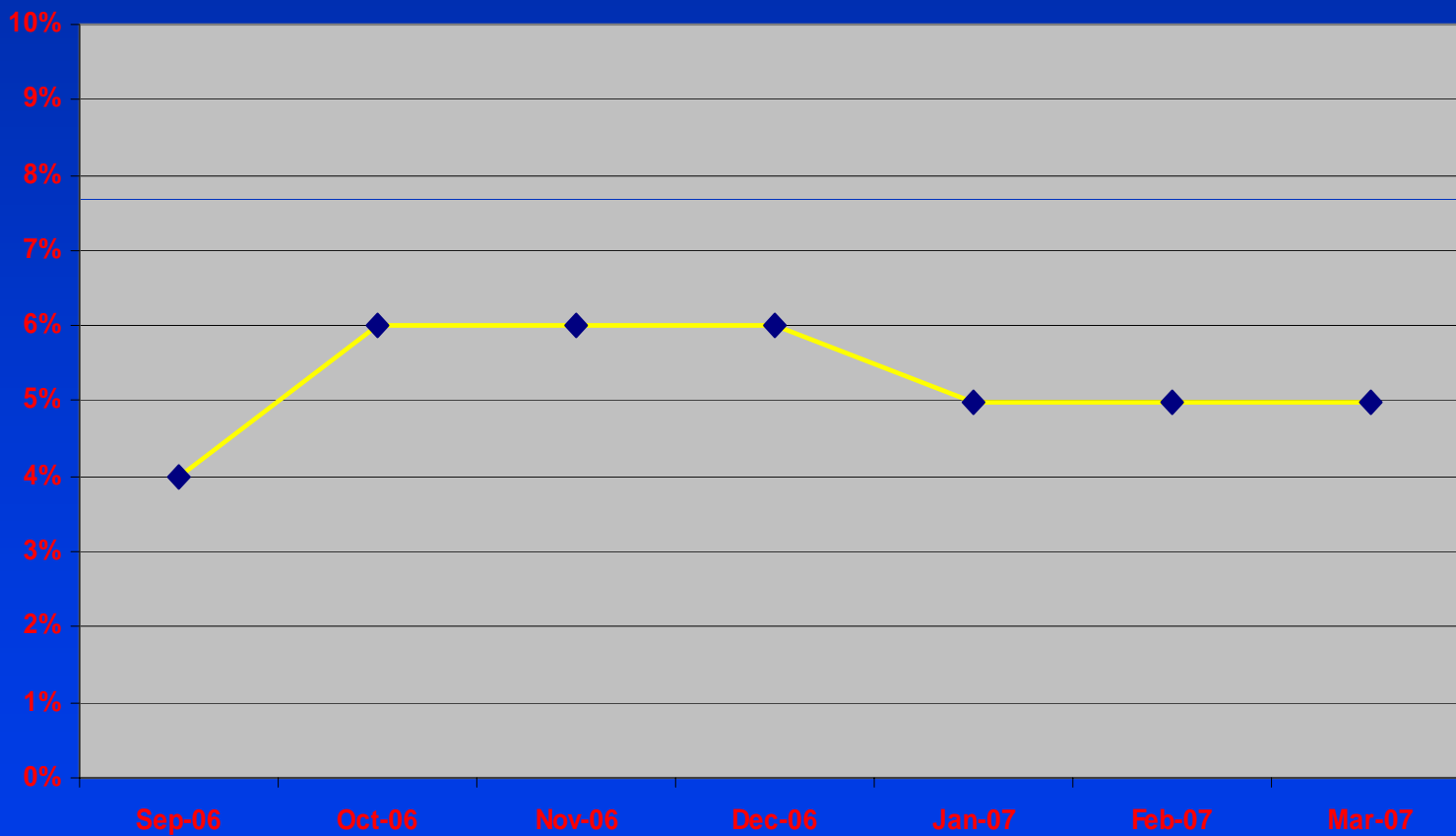
## Prevalence rates 10/05 - 10/06



Source: New Jersey Hospital Association  
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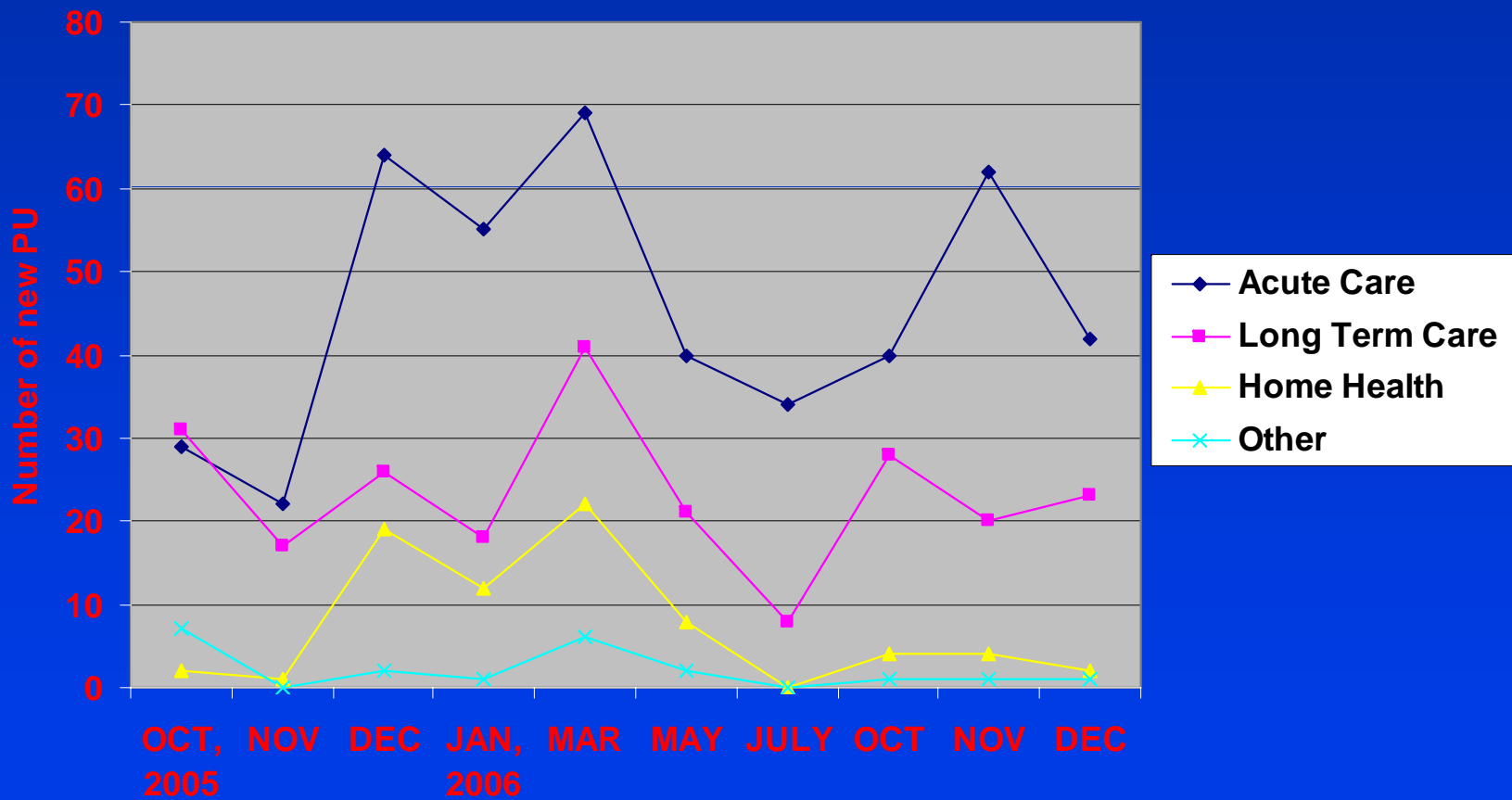
## Incidence Rates Across All Healthcare Organizations Year 2



Source: New Jersey Hospital Association  
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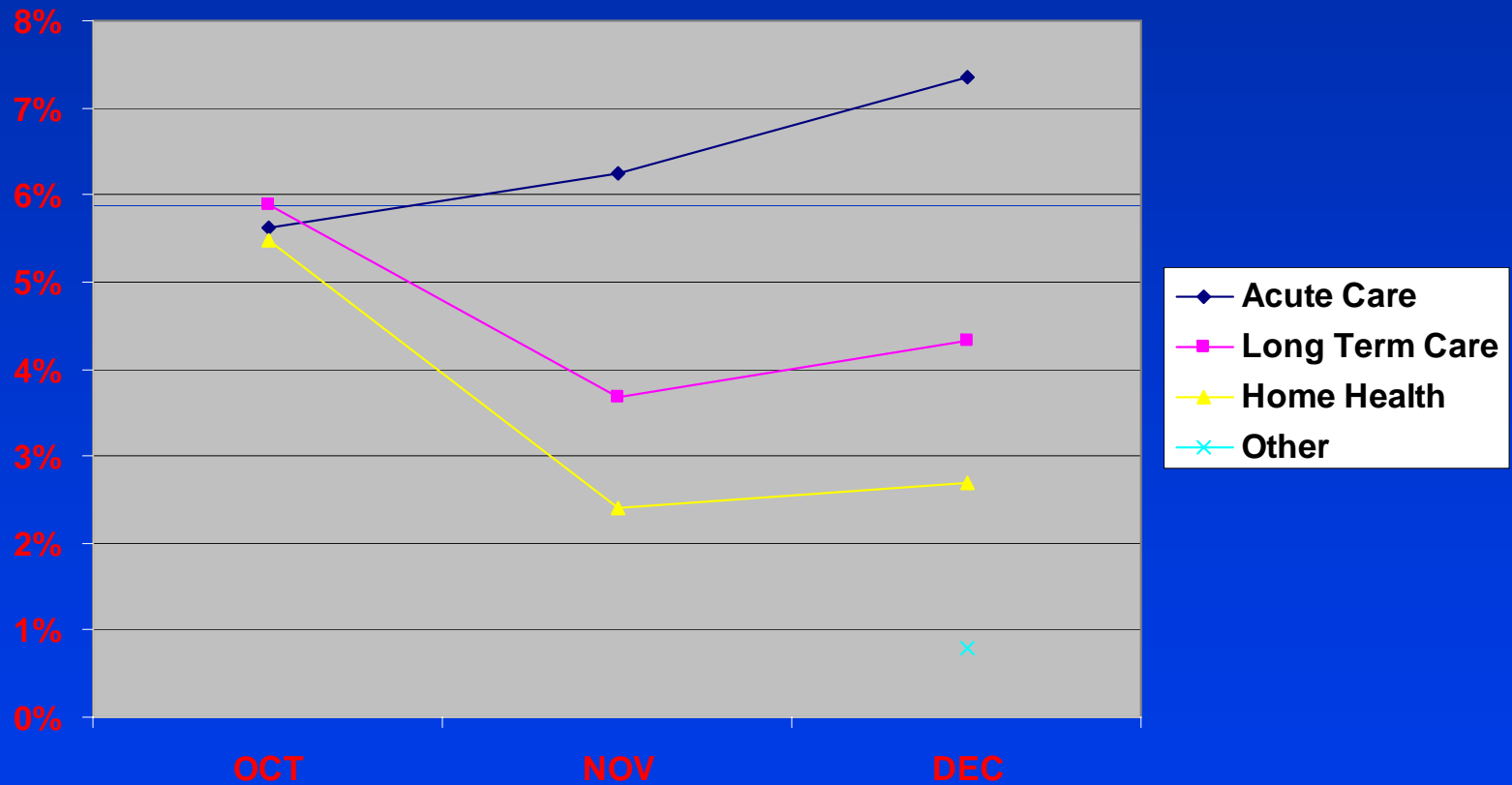
# New Pressure Ulcers



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# Pressure Ulcer Incidence Rates



Source: New Jersey Hospital Association  
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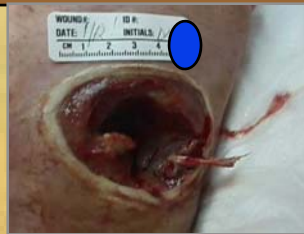
# The NJHA Pressure Ulcer Collaborative

## What's Next?

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- 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
- Development of Statewide Wristband Coding
- 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

**WANTED: NO ULCERS<sup>©</sup>!**



- N**utrition and fluid status
- O**bservation of skin
- U**p and walking or turn and position
- L**ift, don't drag skin
- C**lean skin and continence care
- E**levate heels
- R**isk assessment
- S**upport surfaces for pressure redistribution

**© NJHA Collaborative Partner 2005**

# Our NJHA Partners!



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# The NJHA Pressure Ulcer Collaborative

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Questions?

Thank you!

## Contact information:

**Theresa Edelstein**

**609-275-4102**

**[tedelstein@njha.com](mailto:tedelstein@njha.com)**

**Aline Holmes**

**609-275-4157**

**[aholmes@njha.com](mailto:aholmes@njha.com)**