ALINE HOLMES, RN, AND THERESA EDELSTEIN

Pressure Ulcer Success Story

New Jersey providers from across the care continuum participate in a collaborative effort to prevent and minimize pressure ulcers statewide.

THERE THEY WERE, ASSEMBLED all in one room: scores of health care professionals representing 43 acute-care hospitals, three rehabilitation hospitals, 59 skilled nursing facilities (SNFs), 11 home health agencies, three continuing care retirement communities, two assisted living residences, and one hospice.

They didn't know each other, and they barely spoke. All thought pressure ulcers were the others' problem.

Two-Year Initiative

However, they had agreed to take part in a broad-based, collaborative effort to confront the problem of pressure ulcers—Goal No. 1 in the Advancing Excellence in America's Nursing Homes initiative. Certainly, other quality efforts have focused on reducing pressure ulcers, but this two-year initiative was built on a premise of communication and cooperation across the continuum of care.

Geographically based provider partnerships were formed, putting hospitals, long term care facilities, and others at the same table to share their successes and frustrations in keeping patients pressure-ulcer-free.

Two years after that initial meeting, the atmosphere had morphed from skepticism to celebration, as this group of disparate providers achieved dramatic results in reducing pressure ulcers in participating facilities throughout New Jersey—including a 70 percent reduction in the incidence of new pressure ulcers and at least 48 organizations that reported zero new pressure ulcers for periods of three months or longer. They accomplished it with a shared commitment to communication, a reinvigorated culture of safety, and faithful adherence to best practices.

How It Started

The collaborative's roots go back to the fall of 2004. Data from the Centers for Medicare & Medicaid Services showed that New Jersey had a stubborn pressure ulcer prevalence rate of 18 percent, compared with a national average of roughly 13 percent.

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National research had indicated that costs associated with treating pressure ulcers exceeded $1.3 billion annually—$335 million in long term care settings alone, according to a report by the Department of Health and Human Services. The 2001 Institute of Medicine report, "Crossing the Quality Chasm," had challenged providers to integrate better cooperation across the delivery system to improve quality-of-care transitions. And yet, only limited activity was occurring on a cross-setting basis in the United States.

The New Jersey Hospital Association (NJHA) was well-positioned to initiate a response. A longtime trade organization serving acute care hospitals, it had broadened its membership several years ago to welcome long term care facilities, home care agencies, and other continuing care providers.

NJHA established an advisory panel that included the Health Care Association of New Jersey, the state Department of Health and Senior Services, Healthcare Quality Strategies (New Jersey's quality improvement organization), the New Jersey Association of Homes and Services for the Aging, and the Home Care Association of New Jersey. It 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 the various levels of care.

The advisory panel struggled with

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issues such as the financial commitment expected of participants. Half of New Jersey's hospitals are losing money, and the state's long term care facilities are losing more than $200 million annually serving Medicaid patients, according to figures compiled by the American Health Care Association. Ultimately the organizers established a $5,000 all-inclusive, one-year fee for hospitals and $1,000 for all other providers. The state Department of Health and Senior Services stepped in with additional financial support for SNFs, dedicating civil monetary penalty fees to cover the expenses of facilities that met all of the collaborative's requirements.

Goals And Expectations

Using a model from the Institute for Healthcare Improvement, the initiative focused on creating a culture of safety, standardizing what is done and when it is done, and measuring and evaluating results as the effort progressed. The group wanted to create an action-oriented atmosphere of mutual support and foster a sense of "all teach, all learn."

As it continued the development process in the spring of 2005, the advisory panel began hammering out an aim statement. It established measurable data-driven goals, including a 25 percent reduction in the incidence of pressure ulcers by September 2006 and 95 percent adherence with all components of a pressure ulcer prevention bundle that included:

- Completing a head-to-toe skin assessment within eight hours of admission;
- Assessing risk factors (using the Braden Scale) within eight hours of admission and reassessing weekly in long term care (every 24 hours for at-risk patients) and every 24 hours in acute care; and
- Instituting appropriate prevention techniques for all who are determined to be "at risk" (score of 18 or lower on the Braden Scale), including the use of pressure redistribution surfaces.

But the collaborative's leadership also wanted to focus on the less tangible goals. One of those was a commitment to bolster communication and teamwork between professionals across multiple settings to improve transitions and handoffs of care.

Those goals helped the advisory panel develop a list of expectations for participants. They included connecting the collaborative's goals with the strategic initiative of participating organizations, providing a senior leader to champion the effort, supporting the team with time and resources, and performing tests of change leading to process improvements.

Importance Of Communication

Another expectation underscored the importance of communication:

Pressure Ulcers Drop In Provider, QIO Collaborative

The onset of new pressure ulcers in the most serious stages plummeted 69 percent at facilities participating in a voluntary collaborative with Medicare quality improvement organizations (QIOs).

Findings from the initiative, published in the October issue of the *Journal of the American Geriatrics Society*, stem from a collaboration between nursing facilities in 39 states and 29 QIOs working together to develop and implement care practices designed to prevent pressure ulcers and better understand their measurement, staging, and healing processes. Results were based on data from 35 participating facilities, from November 2003 through September 2004.

"This is a remarkable gain in a large number of facilities, against a condition that is as devastating and costly as it has been resistant to improvement," said Kerry Weems, acting administrator of the Centers for Medicare & Medicaid Services (CMS), in a statement.

Because pressure ulcers often develop before a resident is admitted to a nursing facility, the teams also reached out to other providers—hospitals, home health agencies, and emergency services—to "identify and reduce the causes" of pressure ulcers, Weems said.

The dramatic reduction in pressure ulcers was achieved through the application of new care techniques and measurement guidelines, said Bruce Yarwood, president and chief executive officer of the American Health Care Association. The project "reaffirms that collaborative efforts between nursing homes, QIOs, and the federal government are effective in improving the care and patient outcomes for our nation's most vulnerable populations."

Barry Straube, MD, CMS' chief medical officer and director of the Office of Clinical Standards and Quality, said the results of the initiative would enable CMS "to separate the serious pressure ulcers from the superficial ones, a change that will help beneficiaries and their families to see whether a nursing home has implemented the best practices available."

The materials used to improve pressure ulcer care are available at no charge on the Medicare Quality Improvement Web site, at www.medqic.org, under the "Nursing Homes" tab.

—Lynn Wagner

Collaborative participants would be expected to communicate regularly with their regional partners in other health care settings. Specifically, participants were encouraged to work with their colleagues across care settings to:

- Develop a work group of partner providers;
- Evaluate current admissions, transfers, and discharges between organizations;
- Establish accountability for skin and risk assessments;
- Establish a regular meeting schedule; and
- Continually evaluate and work to reduce pressure ulcers while improving communication and teamwork among partners.

One other order of business for the organizers was to recruit an expert faculty to lead the charge. NJHA was fortunate to secure the expertise of Elizabeth Ayello, RN, a senior adviser for the John A. Hartford Institute for Geriatric Medicine at New York University, who signed on as the collaborative's chairperson.

The Model In Action

With the legwork complete, the Pressure Ulcer Collaborative issued invitations to health care providers statewide, including acute-care hospitals, rehabilitation hospitals, long term care acute-care hospitals, SNFs, home health agencies, and assisted living residences. All told, 122 facilities signed on for the project. They met together for their first learning session in September 2005.

The learning sessions were an integral part of the collaborative. These two-day events were held three times a year, bringing together all partners to share their successes, failures, and frustrations in an interactive give and take. In addition, Ayello and other national experts presented on pressure ulcer prevention, research, nutrition, and other relevant topics.

The learning sessions were augmented with monthly conference calls that offered an in-depth dialogue on topics such as the Braden Scale (facilitated by its creator Barbara Braden), end-of-life care, and legislative requirements in reporting pressure ulcers. Other resources available to participants included an e-mail listserv, a password-protected Web site, and ready access to collaborative staff members.

Resources shared with participants included an educational pamphlet for patients and families; posters and staff buttons; a pressure ulcer prediction, prevention, and treatment pathway; a treatment product categories table; a turning and repositioning tool; and data tools.

Data were a critical component. Each learning session started with a knowledge test, and those scores were tracked over time.

Lessons Learned

Many participants said the collaborative marked the first time they actually talked and worked together across care settings to improve coordination of care. The technical support and encouragement offered by the collaborative was critical to breaking down old barriers. With this new-found spirit of cooperation, participants cited the need for a consistent, uniform data set that would travel with the patient between care settings. That conversation gave rise to a universal transfer form that is now in development in the state of New Jersey.

Armed with information, support, data, and communication, the collaborative entered its second year. Most participants signed on for year two, and 29 additional facilities joined. Altogether, 150 organizations took part over the course of two years. The learning sessions continued, along with conference calls and other activities.

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In July 2007, collaborative participants gathered for their last learning session and the announcement of the final data results. The knowledge scores gathered at the beginning of each learning session reached nearly 100 percent, and compliance with the process measures from the prevention bundle averaged in the mid-90s.

But the most dramatic result was the overall decline in the incidence of new pressure ulcers.

At the collaborative's launch in September 2005, New Jersey's overall incidence rate for all settings was 18 percent. Two years later, that number had declined to 5 percent among collaborative participants, a 70 percent reduction, with 48 of the participating organizations reporting no new pressure ulcers in a period of three months or longer.

The results were universal across all care settings. By working together and supporting one another, acute care, long term care, and home health providers all had accomplished dramatic reductions in the incidence of pressure ulcers. ■