

**Welcome to The Health Services Advisory  
Group (HSAG) of California, Inc.**

**Nursing Home and Hospital  
Pressure Ulcer (PrU) Quality  
Improvement Collaborative!**

Please take a moment to:

1. Complete your pre-test.
2. Write down a PrU obstacle on your index card that you experienced during transfers.

We will collect both items when completed.

1

**HSAG of California—The Medicare  
Quality Improvement Organization  
(QIO) for California**

- The Centers for Medicare & Medicaid Services (CMS) issues 53 QIO contracts (one for each state, D.C., Puerto Rico, and the U.S. Virgin Islands)
  - Health Services Holdings, Inc. (HSH)—HSAG of California’s parent company—holds QIO contracts in Arizona, California, and Florida
- Three-year QIO contracts are called Scopes of Work (SoWs)—currently in the 9SoW
  - August 2008 through July 2011

2

## HSAG of California's Targeted Counties

- 62 Hospitals
- 61 Nursing Homes
  - Fresno
  - Kern
  - Los Angeles
  - Orange
  - Riverside
  - Sacramento
  - San Bernardino
  - San Diego



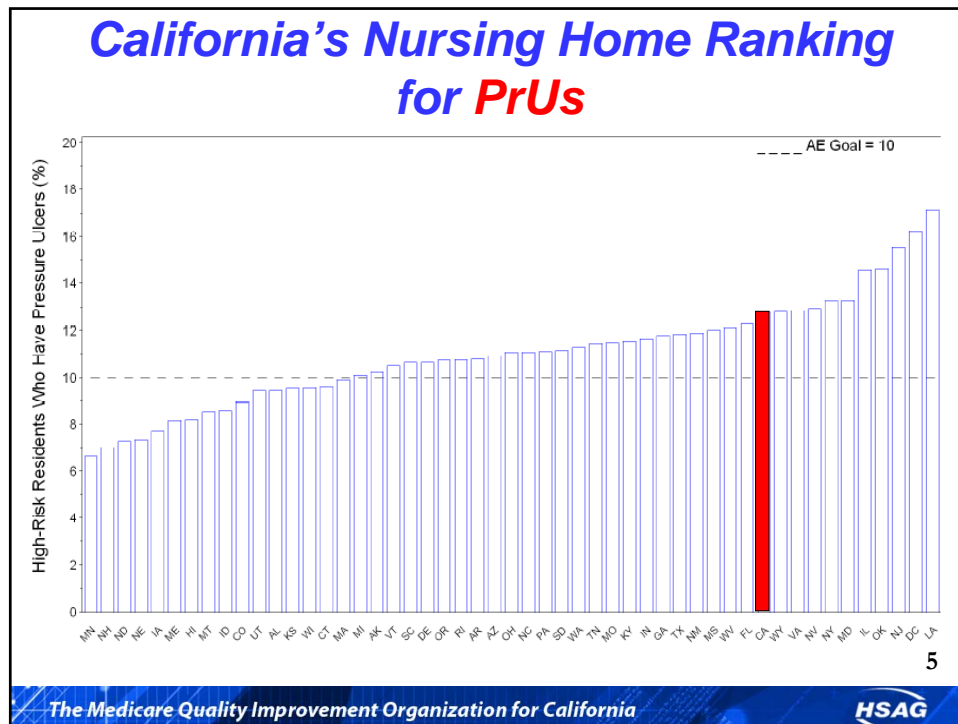
## Part of the 9SoW Vision

*Help hospitals and nursing homes  
reduce the incidence of PrUs.*

**PrUs—HOT TOPIC**



## Nursing Home/Hospital Pressure Ulcer Quality Improvement Collaborative



### Why Act Now?

- The cost of treating one full-thickness ulcer is estimated at \$70,000.
- Fifty-four percent of PrUs occur in persons 70–89 years of age.
- New regulations and policy changes provide external motivation to improve PrU care.
- Approximately 60 percent of PrUs develop in acute-care settings.
  - Where do the other 40 percent develop?

6

## **Objectives:** **Coordination of Care Across Settings**

- **Improve PrU care** in nursing homes and hospitals through effective cross-setting coordination of care.
- **Identify barriers and solutions** to improve PrU care across hospital and nursing home settings.
- Identify consistent ways to **send/receive PrU information**.
- Learn to use a **standardized model** for assessing pressure ulcer **risk, staging** wounds, and **assessing skin** to ensure consistency across settings.

7

## **Today's Agenda**

- A Model for Collaboration Across the Continuum of Care
- Common Barriers to Accurate Scoring of the Braden Scale for Predicting Pressure Sore Risk
- Are We Speaking the Same Wound Language?
- “It’s Not Us, It’s Them:” Barriers and Solutions to Cross-Setting Collaboration
- Next Steps

8

## *Introducing HSAG's Team*

- Joseph Bestic, NHA, BA
- Tom Carter, MA, MSPH
- Charisse Cassell, BSN, MPH
- Darla Farrell, RN, BS, MBA
- Sheila Gray, BSHCA
- Lindsay Holland, MHA
- Patsy Jones, RN, MN, CLNC
- Maridette Schloe, BA
- Andrea Silvey, PhD, MSN
- Jennifer Wieckowski, MSG

9

## *Who Is Here Today?*

- **Hospitals**
  - Pomona Valley Medical Center
  - Riverside Community Hospital
  - St. Joseph Hospital
  - Riverside County Regional Medical Center
  - St. Vincent
- **Nursing Homes**
  - Bella Vista Healthcare Center
  - Upland Rehabilitation & Care
  - Palm Grove Healthcare
  - Vista Cove Care Center of Rialto
  - AFVW Health Center
  - Cherry Valley Healthcare
  - Beaumont Care Center

10

## ***Announcements***

- Cell phones (turn off or set to vibrate)
- Parking
- Restroom logistics
- Lunch at noon
- Please complete the evaluation so we can improve our learning sessions
- CEUs and certificates will be on the back table at the end of the learning session

11

## ***Ground Rules***

- Safe environment to share ideas.
- Confidential information stays in the room.
- Relax. Be yourself. Be honest.
- Listen to and respect everyone's opinion.
- Be open to new concepts. Keep an open mind.
- Within our group, we have the resources to solve any problem that arises.
- Get excited about working with each other!
- We are all in this together, and we should never compete on quality!

12

Nursing Home/Hospital Pressure Ulcer  
Quality Improvement Collaborative

*Over 1 million drug-related injuries occur every year in health care settings. The Institute of Medicine estimates that at least a quarter of these injuries are preventable.*

**To find out how to prevent medication errors, go to**  
<http://www.hsag.com/camedicare/drugsafety.aspx>



[www.hsag.com](http://www.hsag.com)

This material was prepared by Health Services Advisory Group of California, Inc., the Medicare Quality Improvement Organization for California, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. CA-9SOW-6.2.1-101509-01

13