

# **HSAG Pressure Ulcer (PrU) Collaborative: Baseline/Remeasurement Results**

March 10, 2011

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## **Objectives**

- Summarize each HSAG PrU Collaborative Learning Session.
- Compare blinded, individual nursing home baseline and remeasurement PrU data.
- Compare Collaborative aggregate baseline and remeasurement PrU data.
- Learn about HSAG's efforts to spread Collaborative outcomes.

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## ***HSAG PrU Collaborative: A Retrospective***

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### ***Learning Session 1***

- PrU success stories
  - Providers' Coordination of Care (PCOC)
  - Cook Healthcare
- PrU tool kit
  - CASPER QI/QM Reports
  - QI/QM Technical *Specifications Manual*
  - F-314 definitions
  - Braden/Norton scales
- Collaborative sharing

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## ***Learning Session 2***

- PrU management and prevention
  - A surveyor's perspective
- The new Centers for Medicare & Medicaid Services (CMS) Nursing Home Five-Star Quality Rating System
- Hospital-acquired conditions
  - PrUs
- PrU tool sharing

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## ***Learning Session 3***

- HSAG PrU Collaborative progress to date
- The Agency for Healthcare Research and Quality (AHRQ) Nursing Home Survey on Patient Safety Culture (SOPSC)
- Storyboard sharing

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## Learning Session 4

- Root cause analysis (RCA)
  - Understanding the causes of events
- How to conduct an RCA
- Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) overview
- Collaboration sharing

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## Learning Session 5: AHRQ Teleconference

Patient Safety Culture Area	AZ Aggregate % Positive	NH Pilot Study Comparison: Average % Positive
1. Overall Perceptions of Resident Safety	83	87
2. Feedback and Communication About Incidents	81	85
3. Supervisor/Manager Expectations and Actions Promoting Patient Safety	76	81
4. Organizational Learning	68	76
5. Management Support for Resident Safety	68	72
6. Training and Skills	63	72
7. Compliance With Procedures	58	67
8. Teamwork	64	67
9. Handoffs	56	63
10. Communication Openness	51	58
11. Nonpunitive Response to Mistakes	43	55
12. Staffing	48	48

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## ***Learning Session 6***

- How transitions of care affect health care quality and cost
- Chronic-Care, High-Risk vs. Low-Risk PrU activity of daily living (ADL) coding
- *Advancing Excellence in America's Nursing Homes* Quality Campaign—Phase 2
- Draft MDS 3.0 overview
- Critical elements of the new CMS Quality Indicator Survey (QIS) process

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## ***Clinical Outcomes***

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## *Individual Nursing Home Results (Blinded)*

Facility	Q1–Q2 2007 Selection Data	Q1–Q2 2008 Baseline Data	Q1–Q2 2010 Remeasurement Data
1	31.71%	10.35%	11.54%
2	21.40%	14.29%	3.70%
3	25.81%	16.22%	19.30%
4	23.19%	14.46%	16.90%
5	44.00%	5.56%	4.17%
6	17%	0%	11.11%
7	21.43%	20.29%	12.5%
8	30.25%	25.21%	13.66%

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## *Aggregate Results*

	Numerator	Denominator	%
<b>Q1–2 2008 Baseline</b>	<b>75</b>	<b>461</b>	<b>16.27</b>
<b>Q1–2 2010 Remeasurement</b>	<b>68</b>	<b>527</b>	<b>12.90</b>

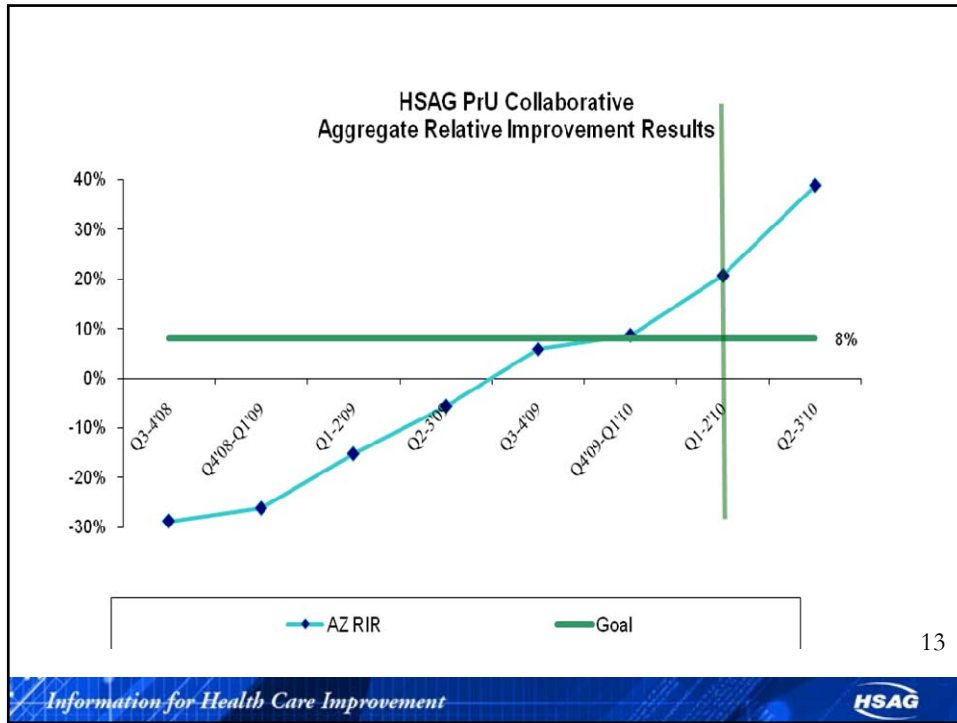
*Relative improvement rate  
of 20.7 percent*

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## HSAG Pressure Ulcer Collaborative: Baseline/Remeasurement Results



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## Spreading the Results

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## ***Lessons Learned***

- The Institute for Healthcare Improvement (IHI) Collaborative Model is effective.
- Nursing homes need clarification on the CMS QI/QM definitions of Chronic-Care, High-Risk vs. Low-Risk PrUs.
- “An ounce of prevention . . . ”
- Facilities that show significant improvement vigilantly monitor the effectiveness of PrU treatments.
- Medical Director involvement in weekly wound-care meetings is essential!

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## **Questions?**

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*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/azproviders/drugsafety.aspx>.



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

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, 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. AZ-9SOW-6.2.1-030811-01

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