

HSAG Pressure Ulcer Collaborative
Learning Session 2

**Understanding
Hospital-Acquired Conditions –
Present On Admission (HAC-POA)
Initiatives**

**HSAG Pressure Ulcer Collaborative
Learning Session 2
January 20, 2009**

Presented by:

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Presentation Objectives

- Learn about the new CMS Hospital-Acquired Conditions – Present On Admission (HAC-POA) initiative, with a focus on pressure ulcer prevention/management.
- Understand components of successful hospital pressure-ulcer prevention/management programs.


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The HAC Problem

MEDICARE  **HEALTH INSURANCE**

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER SEX
000-00-0000-A **FEMALE**

IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986

SIGN HERE → Jane Doe

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The HAC Problem (cont'd)

- The IOM estimated in 1999 that as many as 98,000 Americans die each year as a result of medical errors.
- Total national costs of these errors are estimated at \$17–29 billion.

IOM: *To Err is Human: Building a Safer Health System*, November 1999. Available at: <http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf>.

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The HAC Problem (cont'd)

- In 2000, CDC estimated that hospital-acquired infections add nearly \$5 billion annually to U.S. health care costs.

Centers for Disease Control and Prevention: Press Release, March 2000. Available at: <http://www.cdc.gov/od/oc/media/pressrel/r2k0306b.htm>.

- A 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated with 99,000 deaths.

Klevens et al. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports*. March-April 2007. Volume 122.

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The HAC Problem (cont'd)

- A 2007 Leapfrog Group survey of 1,256 hospitals found that 87% of those hospitals do not consistently follow recommendations to prevent many of the most common hospital-acquired infections.

2007 Leapfrog Group Hospital Survey. The Leapfrog Group 2007. Available at: http://www.leapfroggroup.org/media/file/Leapfrog_hospital_acquired_infections_release.pdf

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Value-Based Purchasing (VBP) and Hospital-Acquired Conditions

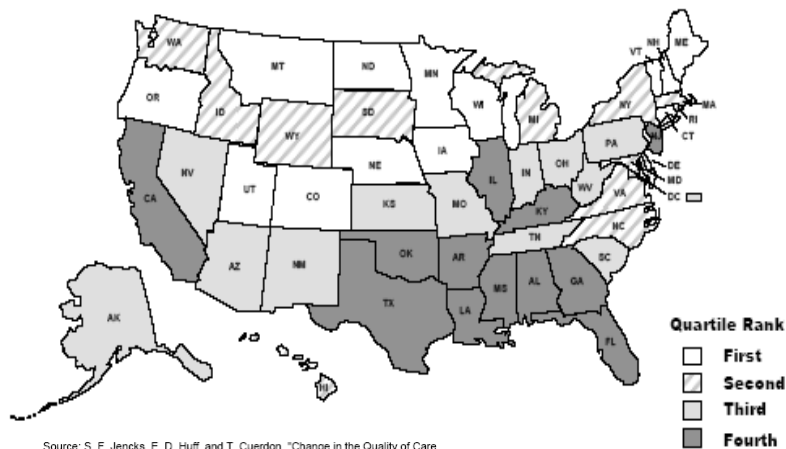
- The Hospital-Acquired Conditions payment provision is a step toward Medicare VBP for hospitals.
- There is strong public support for CMS to pay less for conditions that are acquired during a hospital stay.
- Considerable national press coverage of HAC has prompted dialogue of how to further eliminate healthcare-associated infections and conditions.

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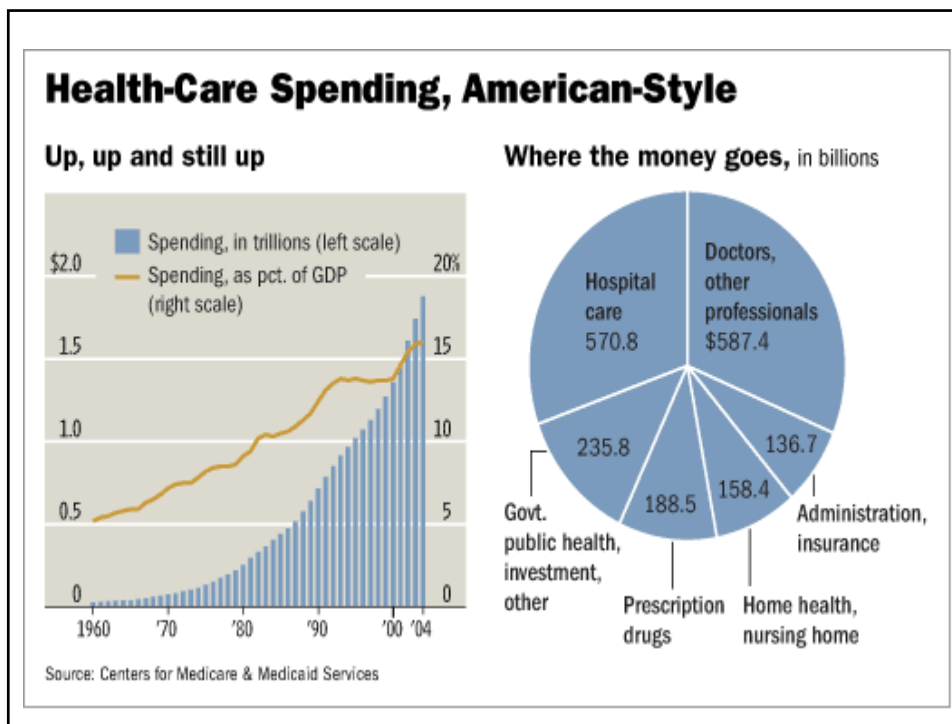
Practice Variation

Performance on Medicare Quality Indicators, 2000–2001



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HAC-POA Initiative

Section 5001(c) of the Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are:

- (a) High cost or high volume or both
- (b) Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
- (c) **Could reasonably have been prevented through the application of evidence-based guidelines.**

Source:

http://www.cms.hhs.gov/HospitalAcqCond/06_HospitalAcquired_Conditions.asp#TopOfPage

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HAC-POA Initiative (cont'd)

On July 31, 2008, in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision.

For discharges occurring on or after October 1, 2008, IPPS hospitals will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission).

The 10 categories of HACs include:

Source:

http://www.cms.hhs.gov/HospitalAcqCond/06_HospitalAcquired_Conditions.asp#TopOfPage

HAC-POA Initiative (cont'd)

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- **Stage III and IV Pressure Ulcers**
- Falls and Trauma
- Manifestations of Poor Glycemic Control
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)

Source:

http://www.cms.hhs.gov/HospitalAcqCond/06_HospitalAcquired_Conditions.asp#TopOfPage

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Selected HAC	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Foreign Object Retained After Surgery	<ul style="list-style-type: none"> • 750 cases • \$63,631/hospital stay 	998.4 (CC) 998.7 (CC)	NQF Serious Reportable Adverse Event www.ahrq.gov/qual/nqfpract.htm
Air Embolism	<ul style="list-style-type: none"> • 57 cases • \$71,636/hospital stay 	999.1 (MCC)	NQF Serious Reportable Adverse Event www.ahrq.gov/qual/nqfpract.htm
Blood Incompatibility	<ul style="list-style-type: none"> • 24 cases • \$50,455/hospital stay 	999.6 (CC)	NQF Serious Reportable Adverse Event www.ahrq.gov/qual/nqfpract.htm

Selected HAC	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Catheter-Associated Urinary Tract Infection (UTI)	<ul style="list-style-type: none"> • 12,185 cases • \$44,043/hospital stay 	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)	www.cdc.gov/ncidod/dhqp/gl_catheteassoc.html

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Selected HAC	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Vascular Catheter-Associated Infection	<ul style="list-style-type: none"> • 29,536 cases • \$103,027/hospital stay 	999.31 (CC)	Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html
Surgical Site Infection- Mediastinitis after Coronary Artery Bypass Graft (CABG)	<ul style="list-style-type: none"> • 69 cases • \$299,237/hospital stay 	519.2 (MCC) And one of the following procedure codes: 36.10–36.19	Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_surgicalsites.html

Selected HAC	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Stage III & IV Pressure Ulcers	<ul style="list-style-type: none"> • 257,412 cases • \$43,180/hospital stay 	707.23 (MCC) 707.24 (MCC)	NQF Serious Reportable Adverse Event www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.4409
Falls and Trauma: - Fractures - Dislocations - Intracranial Injuries - Crushing Injuries - Burns	<ul style="list-style-type: none"> • 193,566 cases • \$33,894/hospital stay 	CC/MCC codes within these ranges: 800–829 830–839 850–854 925–929 940–949 991–994	NQF Serious Reportable Adverse Event www.ahrq.gov/qual/nqfpract.htm

Components of Successful Pressure Ulcer Prevention/ Management Programs

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Assessment

Based on the WOCN Prevention and Management of Pressure Ulcers Clinical Practice Guidelines, assessment includes:

PREVENTION:

1. Risk assessment—*Braden per shift in short-term acute care (STAC)*
2. Identifying high-risk settings/groups—*identified as ICU and if Braden < 12*
3. Regular skin inspection—*daily Q shift*

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Treatment

1. Assess and monitor pressure ulcer with each dressing change—*nursing to document wound drainage, wound bed appearance, and surrounding skin*
2. Assess factors that impede healing—*WOCN nurse monitors*
3. Evaluate healing—*WOCN follows 3x/wk in STAC*

Successful Strategies

Implement the Minnesota Hospital Association
SAFE SKIN Road Map:

INFRASTRUCTURE (SAFE):

S: Skin safety coordination

A: Accurate (real time) tracking of all stages of
HAPUs

F: Facility expectations and staff accountability

E: Education and mutual goals

Successful Strategies (cont'd)

PATIENT CARE BUNDLE (SKIN):

- S: Skin inspection, assessment, and early detection
- K: Keep the pressure off
- I: Incontinence skin protection
- N: Optimize nutrition

SAFE SKIN Road Map Best Practices

- Develop Skin Integrity Committee
- Create Unit Skin Champions (Ex: Nurses Under Pressure)
- Quarterly PU Prevalence and Incidence studies on each unit
- Have unit skin champions validate each staff nurse on ability to do a thorough skin inspection

Wait, there's more . . .

SAFE SKIN Road Map Best Practices (cont'd)

Regarding the Braden:

- Complete risk-assessment validation article about computer-based testing in which all staff were given scenarios and asked to score the PU risk.
- Most inconsistent scores were the subcategories of mobility and moisture. Post the actual Braden document on the units for staff to refer to.

Source: Maklebust, J., Sieggreen, M.Y., Sidor, D., Gerlach, M.A., Bauer, C., Anderson, C. (2005) Computer-based testing of the Braden Scale for predicting pressure sore risk. OWM, 51 (4): 40-52

Regarding the Braden

Sensory Perception Concerns:

- Pad, protect, and/or apply skin prep to fragile skin
- Position body with pillows/support devices, protect bony prominences
- Offloading vs. turning/repositioning

Source: Adapted from *The WOCN Society's Guideline for Prevention and Management of Pressure Ulcers* and from AHRQ (formerly the AHCPR) *Clinical Practice Guideline Number 3 "Pressure Ulcers in Adults: Prediction and Prevention"* and *Clinical Practice Guideline Number 15 "Treatment of Pressure Ulcers"* 12/04

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Opportunities for Improvement

- Development of INDIVIDUALIZED care plans
- Ensure you have supplies needed either at the facility or, better yet, at the bedside
- Ensure you know how and when to use equipment that focuses on interventions based on Braden subscores vs. Braden total score
- Promote critical thinking skills related to pressure ulcer prevention (30,000 ft. view of the patient!)

Source: “Strategies for Pressure Ulcer Prevention” Patient Safety Quality Improvement Organization Support Center National Call, December 17, 2008

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Opportunities for Improvement (cont'd)

- Ensure all bedside staff members realize pressure ulcer prevention is their responsibility, not the WOCN.
- By the time the WOCN nurse is consulted we have already failed to prevent a pressure ulcer!

Source: “Strategies for Pressure Ulcer Prevention” Patient Safety Quality Improvement Organization Support Center National Call, December 17, 2008

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Opportunities for Improvement (cont'd)

Ensure staff members understand a pressure ulcer prevention program is a combination of:

- (1) Assessing risk (looking at each subcategory separately).
- (2) Inspecting the skin.
- (3) Implementing appropriate interventions.

It is not enough to audit that the Braden and/or skin inspection is conducted. The RN needs to process the information and DO something.

Source: “Strategies for Pressure Ulcer Prevention” Patient Safety Quality Improvement Organization Support Center National Call, December 17, 2008

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Opportunities for Improvement (cont'd)

- Implement a team approach: Nursing assistant, bedside nurse, CNS, WOCN, PT/OT, transport, dietitian, etc.
- Ensure both new and existing staff regularly have the “latest and greatest” of pressure ulcer prevention.
- Communication: Make sure there is the opportunity (maybe a prompt) on change-of-shift handover to report on skin care concerns. (Include C.N.A.s!)

Source: “Strategies for Pressure Ulcer Prevention” Patient Safety Quality Improvement Organization Support Center National Call, December 17, 2008

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Opportunities for Improvement (cont'd)

But most of all . . .

Realize the skin is a body system, just as important as the heart and lungs, which means skin failure may be an outcome of multi-system failure!

Source: “Strategies for Pressure Ulcer Prevention” Patient Safety Quality Improvement Organization Support Center National Call, December 17, 2008

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Top Communication Issues

- Communication of pressure ulcer risk—i.e., don't leave a patient on a cart in radiology without turning after two hours, or sooner.
- Communication of skin concerns with facility/care provider to which patient is transferring.
- Consistent documentation of the wound description by the staff nurse dependency on WOC nursing service.
- Lack of communication of interventions being utilized for prevention.

Source: “Strategies for Pressure Ulcer Prevention” Patient Safety Quality Improvement Organization Support Center National Call, December 17, 2008

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Helpful Web Sites

Wound, Ostomy, and Continence Nurses Society:
<http://www.wocn.org>

Quality Improvement Tools:
<http://www.medqic.org>

Health Services Advisory Group, Inc (HSAG):
<http://www.hsag.com>

Institute for Healthcare Improvement:
<http://www.ihl.org>



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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/drugsafety/>.



www.hsag.com

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