

Acknowledgements

The Virginia Pressure Ulcer Resource Team (VPURT) and the Virginia Chapter of the American Association of Retired Persons (AARP) organized and hosted a Summit conference of experts to develop strategic action priorities for pressure ulcer prevention in the long term care institutional setting. VPURT and AARP Virginia are grateful for all the experts who brought their expertise and passion to contribute to the discussion and development of the action priorities. VPURT and AARP Virginia are especially grateful to the Secretary of Health and Human Resources, the Honorable Marilyn B. Tavenner, for serving as the Honorary Chairperson of the Summit. The Summit was held at the Holiday Inn Select Koger South Conference Center in Richmond, Virginia on November 8, 2006.

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Virginia Pressure Ulcer Resource Team

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Executive Summary

On November 8, 2006, the Virginia Pressure Ulcer Resource Team (VPURT) and The Virginia Chapter of the American Association of Retired Persons (AARP) convened a *Summit for Change: Pressure Ulcers in Long Term Care*. This conference brought together key stakeholders, agents of change, and influential decision makers with the sole purpose of identifying and developing the strategic action priorities for pressure ulcer prevention within the long term care system for the Commonwealth of Virginia. The Summit provided an overview of Virginia's pressure ulcer challenge, as well as, four thematic panel discussions: 1) Quality Enhancement, 2) Regulatory Effectiveness, 3) Resource Revitalization, and 4) Workforce First. Each of these themes was the basis for participant discussion in breakout groups that developed their top action items. These action items were then combined, discussed and developed into the Summit's strategic action priorities.

The *Summit for Change* Strategic Action Priorities are:

- Make Pressure Ulcer Prevention a Key Outcome Parameter for Pay For Performance
- Increase Staffing Levels to Meet the Critical Needs of the Residents for Prevention of Pressure Ulcers
- Increase the Pay of the Direct Care Staff in Nursing Facilities
- Increase the Accountability of Every Health Care Professional in Pressure Ulcer Prevention
- Make Pressure Ulcers a Reportable Event
- Develop and Implement a Uniform Patient Transfer Form
- Create an Independent Center for Pressure Ulcer Prevention Education
- Redirect Unused DMAS \$10/day Bed Supplement to Pressure Ulcer Prevention in High-Risk Patients
- Revise COPN for Nursing Facility Beds to Emphasize Quality

VPURT and AARP Virginia encourage you to select any of the action priorities above and make it your independent mission to affect change and reduce the incidence of pressure ulcers. VPURT and AARP Virginia are available to assist you in any way to take up the challenge and bring the strategic action priorities into successful implementation.

PRESSURE ULCERS ARE PREVENTABLE

Introduction

Virginia Pressure Ulcer Resource Team (VPURT) is a team of dedicated health care professionals and advocates from various backgrounds and perspectives that are dedicated to improving quality of care in Virginia's long term care settings. Specifically, VPURT addresses the issue of pressure ulcers, which can be reduced with improved awareness, education, and legislation. Team members include doctors, nurses, administrators, and representatives from state agencies, professional organizations, and suppliers of health care services. The mission of VPURT is to decrease the incidence of pressure ulcers in Virginia through data collection and analysis, public awareness, education and training, and public policy recommendations.

AARP Virginia is a nonprofit, nonpartisan membership organization that helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. They produce AARP-The Magazine, published bimonthly; AARP Bulletin, a monthly newspaper; AARP Segunda Juventud, a bimonthly magazine in Spanish and English; NRTA Live and Learn, a quarterly newsletter for 50+ educators; and its website, www.aarp.org. AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors and sponsors. They have staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U. S. Virgin Islands.

This paper represents the summary proceedings and results of a summit meeting created by VPURT and AARP Virginia and held on November 8, 2006 in Richmond, Virginia. The purpose of the meeting was to bring together key stakeholders and agents of change within the long term care system of the Commonwealth of Virginia to develop strategic action priorities for pressure ulcer prevention. Specifically, the summit was to produce recommendations from thematic panels on the critical components of pressure ulcer prevention. The thematic panel topics included:

- **Quality Enhancement**
 - Issues included ways to improve quality of care, and more specifically, the prevention of pressure ulcers in long term care settings.
- **Regulatory Effectiveness**
 - Evaluation of current regulations and how compliance translates into pressure ulcer prevention.
- **Resource Revitalization**
 - Major issues in the reallocation and redistribution of resources.
- **Workforce First**
 - Factors related to quality of care, retention of caregivers, impact of resident centered care or culture change on quality of care, legislative policy changes, and pay for performance.

Background

Prevalence of Pressure Ulcers

It is estimated that as many as 23.9% of long term care residents develop pressure ulcers and the current prevalence rate for pressure ulcers in long term care is 8.9 percent (NPUAP, 2001). These ulcers can lead to devastating complications and place demands on an already stressed healthcare system. The prevalence of pressure ulcers as well as the effectiveness of preventative measures can be core indicators of overall health care quality. Management and prevention of pressure ulcers are the responsibility of the healthcare facility (Dharmarajan and Ahmed, 2003; Lyder, 2003). The inadequate use of preventative measures and inadequate management have been a basis for regulatory sanctions and litigation in certain cases (Spoelhof, 2000; Bennett, O'Sullivan, DeVito, et al., 2000).

By the year 2030, approximately 20% of the nation's population will be over the age of 65 (US Census Bureau, 2000). The population shift of the Baby Boomer cohort over the next two decades will greatly increase the demand for placement in a long term care facility or home health care services from a primary caregiver, unlikely to be a health professional (Meehan, M., 1999). Despite tremendous improvements in prolonging quantity of life, there is an ever-increasing number of debilitated individuals with chronic co-morbidities that put them at risk for immobility and decreased quality of life (Dharmarajan and Ahmed, 2003). Complicating the issue in maintaining quality of life in later years is the relationship between chronological age, immobility, and skin break-down. Age-related changes in the skin contribute to the susceptibility of developing pressure ulcers, and therefore, normal changes in aging skin put individuals at further risk for skin breakdown (Thomas, 2001). Approximately 70% of pressure ulcers occur in individuals over the age of 70 years and the alarming increase of the population's oldest old, those over the age of 80, will contribute to this statistic (Thomas, 2001).

Although prevention of pressure ulcers is an important goal in the interest of the resident and reputation of long term care facilities, once pressure ulcers develop, they may become chronic without vigilant and aggressive treatment. The presence of pressure ulcers and their status frequently play a role in the decisions made regarding ultimate management of the patient (Timiras, 2003).

Physiology of Pressure Ulcers

Pressure ulcers are usually a complication of immobility. Medical conditions that frequently lead to immobility and have a higher incidence in the elderly include hip fractures, gait abnormalities, and progressive neurologic disorders, such as Alzheimer's dementia and Parkinson's disease (Thomas, D.R., 2001). The most commonly affected sites for ulcers are bony prominences such as sacrum, hips, heels, etc. Pressure ulcers arise from four simple mechanisms: pressure, shear, friction, and moisture leading to maceration (softening of the tissues) (Timiras, 2003). The role of pressure is the single most critical component in the development of ulcers. Once they develop, medical conditions such as peripheral vascular disease, diabetes mellitus, renal disease, obesity, malnutrition, incontinence, sepsis, and systemic factors such as hypoalbuminemia, anemia, and vitamin deficiency are associated with protracted wound healing (Thomas, D.R., 2001 and Timiras, 2003). Persons at risk must move frequently in order to reduce the likelihood of developing a pressure ulcer.

A uniform classification system to identify the extent of tissue damage has been developed and revised by the NPUAP (National Pressure Ulcer Advisory Panel). This system has been universally adopted and provides a framework of consistency for clinicians. The following are the definitions and descriptions for the 6 stages of pressure ulcers. Stage I is defined as intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. May be difficult to detect in individuals with dark skin tones. Stage II is a partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum – filled blister. Stage II is further described as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Stage III pressure ulcer involves full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable. Stage IV pressure ulcer is defined as full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis likely to occur. Exposed bone/tendon is visible or directly palpable. Unstageable pressure ulcer is full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar is on the heels serves as “ the body’s natural (biological) cover” and should not be removed. Deep Tissue Injury (DTI) is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Despite their quick development, treatment of pressure ulcers is complex, time consuming and costly. Even if an ulcer heals, there is a significant chance that it will recur. Therefore, prevention of the development of pressure ulcers, as with many geriatric medical conditions, is the most important aspect of management.

Current Approaches to Prevention

Evidence clearly indicates that most pressure ulcers are preventable. The IHI campaign, “Protecting 5 Million Lives from Harm” in the Prevent Pressure Ulcers How-to Guide indicates that preventing pressure ulcers actually boils down to two major steps: first identifying patients at risk; and secondly, reliably implementing prevention strategies for all patients who are identified as being at risk. A comprehensive literature search would concur that both of the above stated action steps are critical elements to successful reduction or elimination of facility acquired pressure ulcers.

Identifying patients at risk begins with an admission assessment for all patients, including a comprehensive skin assessment to detect existing pressure ulcers and a risk assessment to evaluate their risk of developing a pressure ulcer. Timely identification of at-risk patients can trigger early implementation of prevention strategies. Reassessment of all patients should occur consistently at designated intervals to ensure that proactive adjustments are made for pressure ulcer prevention management according to the changing needs of the patient.

Developing individualized comprehensive prevention strategies requires the skills and knowledge of a multidisciplinary team.

Key elements include but are not limited to:

1. Managing moisture from incontinence, perspiration or exudates,
2. Optimizing nutrition and hydration,
3. Minimizing pressure by turning and positioning patients routinely, using pressure relieving surfaces, and floating heels
4. Encouraging maximum mobility potential
5. Educating patients, families and staff on pressure ulcer prevention
6. Communicating with health care providers across the continuum regarding the status of a patient’s skin integrity

Once a patient develops a pressure ulcer, treatment costs (products, therapies, personnel, pain and suffering etc) escalate exponentially, driving total health care expenditures to a level that far exceeds the cost of prevention. VPUPT, AARP Virginia, and all summit participants advocate a strategic approach using well-defined actions for a future program that focuses on prevention.

Section I: Summit Design, Components, Participants, and Report Organization

Summit Design

The design of the meeting began with the development of the list of key stakeholders, agents of change, and influential decision makers including legislators, providers, special interest groups, regulators, advocates, nursing facility owners, administrators, CEOs, health policy experts, and payers. The meeting format was designed to provide a concise and effective opportunity to change current policy and practice of the delivery of long term care by enlisting the invited participants to operationalize the desire for quality into consensus-driven action item priorities for improving pressure ulcer prevention.

Components

Keynote Speakers

The challenge of the keynote speakers was to remind the participants that pressure ulcers are a preventable disease that has disastrous ramifications on a person. Rosemary Gibson is a humanitarian who poignantly reminds us that innocent persons pay a dear price for inferior care. Dr. Rodeheaver is nationally known for his position that the vast majority of pressure ulcers are preventable. His message is that pressure ulcers do not occur when care providers are committed to prevention. Dr. Rodeheaver was also chosen because of his understanding of the complexities of providing cost-effective care in a nursing facility. With that understanding, he set the stage for how the Summit was designed and what was expected of each participant.

Thematic Panel on Critical Components of Pressure Ulcer Prevention

Prior to breakout sessions, a thematic panel on the pre-identified critical issues of pressure ulcer prevention was presented. The panel was charged with discussing pressure ulcer prevention in the context of the following critical issues:

- Workforce First
- Resource Revitalization
- Regulatory Effectiveness
- Quality Enhancement
- Empowered Consumer

Panel members were charged to break the critical issues down into their functional components. These functional components were designed to be the seeds or building blocks that would be discussed in the breakout sessions. These components were in essence the hurdles that historically have inhibited Virginia from reducing its unacceptably high level of pressure ulcer prevalence reported in nursing facilities.

Roundtable Discussions on Critical Issues

Following the panel discussion, participants were given instructions on how to build consensus on developing strategic action priorities. Participants in each breakout session were encouraged to share expertise, wisdom, and to think collectively. The

groups were charged to discuss issues and seek approaches and methods to address the critical issues. Also, participants were asked to provide input for the strategic action plan to enhance pressure ulcer prevention. Each breakout session was comprised of a moderator, issue expert, scribe, laptop recorder, and recording secretary.

The groups were also instructed to build consensus on the ideas expressed during the breakout sessions. Participants were told to let ideas flow freely, all ideas were valid, and to build on the ideas of others. Furthermore, participants were asked to use examples to illustrate points, welcome opposing thoughts/trends, and give responses in headline bullet format. Lastly, participants were reminded to be respectful.

Consensus Development Session

The breakout sessions by design divided the participants into effective working groups. In order to develop consensus, it was essential that each breakout group reported to all participants and allow all participants to discuss the strategic priorities of each breakout session. Through this mechanism, the outcome was a consensus of the knowledgeable experts in attendance.

Wrap-Up Session

It was important in closing the Summit that all participants were reminded that the most important element of the Summit would be the Action Plan that resulted from their input. All parties interested in preventing pressure ulcers to support their own individualized prevention strategies can use the Action Plan. It is VPURT's and AARP Virginia's expectation that many of the strategic priorities will take place concurrently by different interested groups. VPURT and AARP Virginia are willing to provide their resources to assist all interested groups with these strategic priority items.

Section II: Summary Proceedings

Opening Remarks

Kenneth Olshansky, M.D.

*Virginia Pressure Ulcer Resource Team, Clinical Professor of Plastic Surgery,
Virginia Commonwealth Health System*

The meeting began with an introduction by Dr. Olshansky and the topic of pressure ulcer prevention was discussed. Dr. Olshansky presented multiple slides of real pressure ulcers to help the attendees focus on the human aspects of this problem. In addition, he noted healthcare professionals should not accept excuses for pressure ulcer occurrence and work together for a solution.

Bill Kallio,

State Director of AARP Virginia

Bill Kallio stated that presently, 50% of the 1 million AARP members in Virginia are facing a long term care decision. With this influx of potential consumers in long term care, experts should look at quality issues, the number one component having the largest impact on helping consumers make a long term care decision. As reported in a recent AARP Virginia survey, 78% of Virginians are concerned about the question of quality in long term care.

The Honorable Marilyn B. Tavenner,

Secretary of Health and Human Resources, Commonwealth of Virginia

The Honorable Marilyn B. Tavenner Secretary of Health and Human Resources offered a welcome to the conference attendees. She stated that she is convinced that we have the resources and intelligence in Virginia to improve our ranking with regards to the prevalence of pressure ulcers. Governor Kaine has created a health reform commission with a focus on long term care and quality outcomes. This will include consideration of pay for performance around certain quality indicators in nursing homes – primarily pressure ulcer development and fall prevention. Workforce training should become specialized to encompass those in the long term care field and not just training for general nursing practices. Team training should focus on Licensed Practical Nurses, Certified Nursing Assistants and support staff working in nursing homes. Nursing home facilities should post their quality information for consumers including incidences of pressure ulcers.

Keynote Addresses - Commitment to Quality

Rosemary Gibson,

*Robert Wood Johnson Foundation - Author, "Walls of Silence"
(In absentia)*

Presented: Pressure Ulcers: What Can We Learn From Other Efforts to Prevent Unnecessary Harm to Patients?

Since the Institute of Medicine reported in 1999 that 44,000 to 98,000 people die each year from medical errors, patient safety has received enormous attention from the media and progressive health care organizations. As defined by Ms. Gibson, the necessary ingredients for redressing the problem are as follows: data on the scope of the problem, discovering what can be done to prevent or fix the problem, the will to change, and public pressure for improvement. Data is meant to persuade individuals about the problem at hand, and emotions are to motivate; every data point is a person. In 16 states, legislation requires hospitals to publicly report infections. Public awareness and media attention create a financial incentive to prevent infections. Some hospitals are dramatically reducing ventilator-associated pneumonia and central line blood stream infections as a result of media attention and public awareness. These lessons can be applied to the prevention of pressure ulcers as well.

George T. Rodeheaver, PhD,

University of Virginia Health System

Presented: Pressure Ulcer Prevention

George Rodeheaver, Ph.D. stated that after 20 years of dedicated work, Virginia has not achieved its goal of pressure ulcer prevention. The prevalence of pressure ulcers is the same today as it was 30 years ago. Dr. Rodeheaver challenged the group to keep their energy and commitment going after the conference to encourage pressure ulcer prevention. Education and training on pressure ulcer prevention has greatly advanced within the past 30 years, but the prevalence has not changed significantly. Even though the focus of this conference was centered on the nursing home setting, prevention cuts across all practice settings including acute care and home health. In order to keep the momentum going, a well-documented, bullet-pointed plan of action that can be applied to many different practice settings is necessary and was expected to be the result of the day's meeting.

In addition to a well-documented plan of prevention, individualized commitment plays a large role in prevention as well. An apathetic environment does not contribute to the fostering of individual commitment and sustainability in a highly advanced practice setting. Staff members typically follow by the example set by a champion. Prevention also requires a caring relationship between staff and resident and the long term care staff must provide this.

The first issue of agreement was that development of pressure ulcers is preventable and caused by unrelieved pressure. The skin is normally vital and resistant to the ischemic injury of unrelieved pressure. However, as a patient ages, and/or becomes ill, skin vitality is compromised. Prevention, therefore, involves maximizing the

vitality of the skin. This can be achieved by individualized care and treatment of chronic conditions that contribute to immobility, dry skin, and skin breakdown.

The three conditions most likely to contribute to loss of skin vitality and eventual pressure ulcer development are incontinence, malnutrition, and impaired mental status. Quantifiable pressure ulcer risk tools such as the Braden Scale for the patient, and the Pressure Ulcer Prevention Scale (P.U.P.S) for the facility can be used to determine the risk of skin breakdown. The Braden Scale shows the risk of developing a pressure ulcer and includes a person's level of mobility, shear and friction, moisture, sensory perception, activity and nutrition. If the score on the Braden Scale is lower than 16 out of 23, the person is at risk for developing a pressure ulcer. Staff in a long term care facility can utilize the Braden Scale to quantifiably determine what areas should be focused on for prevention. The ten items in the P.U.P.S. scale for the facility risk predictor can help staff members in a long term care setting determine how equipped they are at handling conditions that contribute to skin breakdown. The ten items include active skin care team, educational programs, commitment to caregiver, pressure-relieving devices, investigates each pressure ulcer, formal turning schedule, program for patient activity, PT/OT availability, nutritionist availability, and patient/family involvement. . The level of risk, then, determined either from the Braden Scale or the facility risk predictor (P.U.P.S. scale) can dictate the level of necessary intervention.

The facility will fail in its prevention and intervention attempts at the weakest link of the direct care team. Administrators often experience "burn-out" brought on by pressure from corporate bodies to fill quotas and administrators often change jobs. Administrators cannot adequately encourage staff to contribute appropriate attention to the patients, and these attitudes are compounded by the fact that Virginia has one of the lowest per diem reimbursement rates for long term care in the country. A suggestion by Dr. Rodeheaver for encouraging commitment at the leadership level and for reducing the incidence of pressure ulcers in Virginia by 50% by the year 2010 was to commit to the six Rs of pressure ulcer prevention: Reimbursement increase; Recruitment and Retention improvement; Regulation consistency; Recognition and Reward for quality

Thematic Panel on Critical Components of Pressure Ulcer Prevention

Moderated by **Julie Christopher**, Commissioner, Virginia Department for the Aging

Workforce First

Presented by:

Rebecca Lanier, EdD, RN, MPH

Legislative and Workforce Consultant

Rebecca Bowers-Lanier focused on placing the workforce first. The viability of the workforce is related to quality of care, retention of workers, and impacts resident centered care and legislative policy changes. The combined national turnover rate for all staff in nursing homes is 56.4%. Certified nursing assistants (CNAs) have the highest individual turnover rate, which varies from 43% in nursing homes to 13% in assisted living. In Virginia, the turnover rate for CNAs ranges from 38% to 143% according to a study performed by Virginia Tech in 2001. Licensed practical nurses (LPNs) have the next highest turnover rate at 39.7% on average in Virginia. The average age of nurses and CNAs is 44 years old. 48% of CNAs, 43% of RNs and 42% of LPNs plan to leave their occupation within the next 10 years. This undoubtedly will leave a shortage in the workforce caring for older adults.

The workforce shortage creates a significant problem for quality of care as mortality rate increases in a linear relationship to unavailability of staff. Staffing models that enable decision making at the lowest level of care often support collaboration and respect among team members, create roles for leadership associated with coaching and mentoring, and create a climate for honest disclosure. Ms. Bowers-Lanier emphasized the importance of training staff to provide honest disclosure without the fear of losing a job; it is not a question of if an employee will make a mistake, but what they can learn from their mistake without fear of reprimand. Training health care providers is one of the first objectives to be cut from educational initiatives when reimbursement is low.

The vicious cycle of decreased morale and premium labor contributes to the high turnover rates. An individual employed as a CNA can get a better paying job requiring far less on-the-job effort, which frequently contributes to resignation. Recognition, the work itself, the visibility of the supervisor, adequate wages, opportunities for growth, flexible scheduling, and minimal lift policy implementation were all cited as significantly contributing to retention of workers in a study published by the *Gerontologist* in 2006. Changing the culture in nursing homes to a system of rewards and respect, bringing accountability to the lowest level of direct care provider, involving supervisors in the actual care of residents, all employees having a voice in governance, and good communication within the facility will also contribute greatly to the retention and quality of life of both staff and residents. Increasing Medicaid funding will help retain workers by increasing wages. On a legislative level, Workforce Investment Funds encourage employees to devote themselves to the corporation. Even though Pay for Performance has received little attention in general health care, its emphasis on individual performance based on publicly reported quality indicators greatly encourages initiative for quality care.

Resource Revitalization

Presented by:

Cindi Jones

Chief Deputy Director, Department of Medical Assistance Services

Cindi Jones organized her presentation around four areas: an overview of the Virginia Medicaid expenditures, Virginia's nursing facility reimbursement system, past efforts to focus on wound care, and future plans for the Medicaid program that may address wound care issues.

Virginia Medicaid Expenditures: She began her remarks with a statistic that 30% of the Virginia Medicaid enrollees are aged, blind, or disabled while 71% of the Medicaid expenditures are spent on this group. The cost of serving the elderly and disabled is substantially greater than the cost of care for children. Children cost an average \$1,725 annually, the aged cost \$10,381, and the disabled \$11,505. Medicaid plays an essential role as the primary funding source for long term care. In 2004, Medicaid accounted for 47% of all long term care spending, the single largest source of financing for long term care. Medicare and private health insurance provide limited coverage for long term care costs and 80% of the elderly with long term care needs living in the community receive help solely from family and friends who are not paid for these efforts. In 2005, more than 25,000 Virginians received Medicaid funded care in a nursing facility and more than 19,000 received care in the community (including both paid and unpaid care).

Virginia Nursing Facility Reimbursement System: Virginia has a long history of reimbursing nursing facilities based on patient functioning and nursing resource needs. In 1990, the Patient Intensity Reimbursement System (PIRS) was implemented by DMAS placing patients into three groups with an additional specialized care category to recognize patients with high intensity needs, including pressure ulcer care. In 2002, the Resource Utilization Group –III (RUGS) replaced the PIRS system and the specialized care category for wound care with a more complex case mix reimbursement system.

Past Efforts to Focus on Wound Care: In 2003, the General Assembly directed DMAS and other stakeholders to study purchasing special mattresses and beds for nursing facility residents. In 2004, the General Assembly directed DMAS to provide \$10 per day (at a cost of \$1.3 million annually) for treatment beds for those residents who require specialized treatment for having a pressure ulcer in at least the first stage of development. All recipients must meet the criteria outlined in 12 VAC 30-60-350. Despite the availability of this funding, very few nursing facilities have submitted requests under this program. The average has been six requests over a 430-day period.

Future Plans. DMAS is planning two activities that will have an impact on nursing facility care through a focus on quality and coordination. The first activity is a Pay for Performance plan for nursing facilities, which should encourage a better quality of care. This plan would reward higher quality facilities on a variety of performance indicators, including a lower incidence of pressure ulcers. The second activity is the integration of acute and long term care services. This plan could range from a capitated payment system for Medicaid (potentially integrating Medicare funding) for acute care costs with care coordination for long term care services, to a fully capitated system for all

acute and long term care services. Through care coordination, the prevention of pressure ulcers for long term care clients will be important to reduce the high costs associated with providing treatment.

Regulatory Effectiveness

Presented by:

Barbara Connors, D.O., M.P.H.

Chief Medical Officer, The Centers for Medicare and Medicaid Services

The Social Security Act established minimal health and safety standards for those participating in the Medicaid/Medicare program. As required by The Social Security Act, The Centers for Medicare and Medicaid Services (CMS) contracts with the State Survey Agencies to survey every long term care facility annually. The CMS monitors state agencies work by performing independent surveys known as a comparative survey or direct observation survey with the state.

Passed in 1986 The OBRA Nursing Home Reform gave more “teeth” to enforce standards (Civil Money Penalty or Denial of Payment for New Admission) for facilities found to be out of compliance during survey.

CMS has developed specific regulations long term care facilities must meet in order to participate in the Medicare program. These regulations apply to specific parameters of care and have been identified as Tags. These tags are periodically updated with revised guidance for surveyors based upon changes in acceptable standards of care or scientific findings.

The F314 Tag is the Pressure Ulcer tag. Revised guidance for surveyors was issued on 11/12/04. The revised guidance more clearly defines the provider’s responsibility to prevent the occurrence of a pressure ulcer or treat an existing pressure ulcer. The regulation requires the facility to perform an assessment on the resident to identify risk factors for pressure ulcer and implement preventive measures if necessary. Also, the regulation requires the facility provide treatment of the pressure ulcer including treatment of resulting infection and pain.

The guidance includes a section about residents’ rights to refuse treatment but the facility must determine why that resident is refusing treatment and if necessary the facility must intervene. For residents at end of life, the guidance describes the facilities responsibility to prevent and treat pressure ulcers. Finally, the F-314 revised guidance for surveyors includes the investigative protocol for the surveyors to determine whether the pressure ulcer was avoidable or unavoidable, the degree of harm to the resident and the immediacy of correction required. In the event the facility is found out of compliance, a Plan of Correction from the facility might be required.

CMS Region III did an analysis of Plans of Correction between facilities that were cited for F-314 in the first of three surveys and corrected the deficiency and compared the Plans of Correction to those facilities that received a citation and continued to be found out of compliance in two subsequent surveys. The reasons for citations between the two groups were no different. There were some differences found in the Plans of Correction between the two groups. The facilities that no longer received F-314 citations included a provision requiring the staff to perform shower/bath skin assessment (40% vs. 0%). This represents the importance of engaging the everyday caretakers in the process of prevention and assessment for pressure ulcers. Those facilities that continued to receive further citations on subsequent surveys included a paper or electronic tracking system for PU. This might suggest too heavy a reliance on systems rather than processes of care.

Surveyors are trained to review multiple regulations (tags) during a survey as they relate to quality of care. The F-314 tag is an outcome tag. The outcome is the development of a pressure ulcer. Surveyors look at associated process and structure tags that might be deficient and contribute to an overall lack of quality of care leading to the development of a pressure ulcer. Examples of what the surveyor reviews include the following:

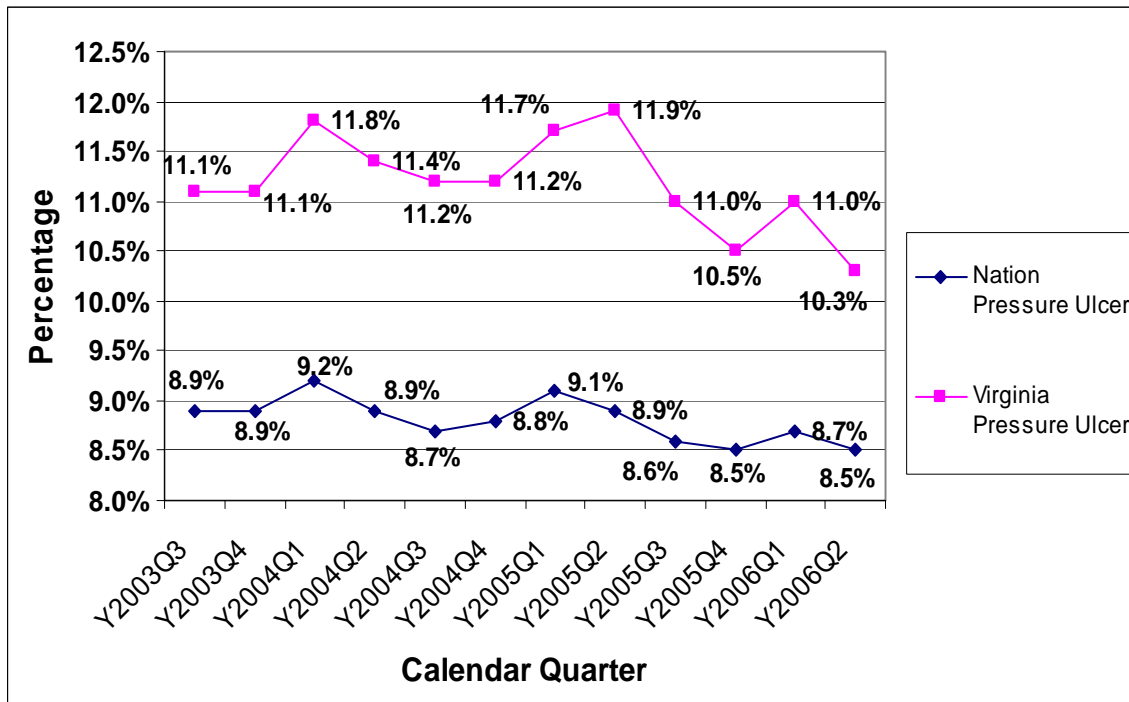
- Was the resident identified as at risk for pressure ulcer?
- Was the assessment accurate?
- Does the resident's care plan reflect all risk factors for pressure ulcers?
- Were preventive measures put in place?
- Is there enough staff to carry out the prevention and treatment?
- Were the interventions carried out?
- Is the documentation accurate?
- What is the residents' nutritional status and hydration status?
- Did the treating physician assess/oversee care?
- Did the physician respond if staff notified the physician of resident skin breakdown, and if not, what is the facility policy?
- Was there a delay in treatment?
- Is Medical Director participating?

These factors of care are considered during the survey to determine whether the appropriate care structure and processes are in place.

The CMS looked at the number of F-314 citations issued nationally before and after the release of the revised F-314 guidelines. Although there has been a decrease in the number of facilities in the U.S (16,846 to 16,175) between 2004 and 2006, there was an increase in the number of F-314 citations given 3,045 to 3,345.

Virginia has a higher than national average prevalence of pressure ulcers for all residents in all long term care facilities regardless of the risk factors of the patient and size of the facility. However, the prevalence rates for Virginia are showing a downward trend as shown on the chart below. This is likely due to increased awareness, revised guidelines for the F-314 Tag and increased overall awareness of the severity of pressure ulcers in long term and acute care.

Pressure Ulcer Prevalence*



*Government Performance Results Act measure

Pressure ulcers are considered a major benchmark of nursing care. Health care and regulatory agencies are collaborating towards developing goals and initiatives to reduce the incidence, prevalence, morbidity and mortality of pressure ulcers. Regulatory agencies have identified the need for greater inter and intra-agency communication, collaboration, and accountability.

The state survey agencies have partnered with the CMS in reducing the prevalence of pressure ulcers in their respective states. The CMS has adopted the reduction of restraint use and pressure ulcer prevalence as goals under The Government Performance Results Act (GPRA). The CMS continues to develop revised guidelines for Tags. The CMS is currently piloting the QI/QIS revised survey methodology. The State Survey Agencies are working with Quality Improvement Organizations (QIOs) to train facilities in best practices. Many state agencies use collected Civil Money Penalties (CMPs) to fund work in their states to achieve a reduction of pressure ulcers and restraint use. Finally, many of the State Survey Agencies have joined The Advancing Excellence in America's Nursing Homes Campaign to help achieve these goals.

Quality Enhancement

Presented by:

Sallie S. Cook, M.D.

Chief Medical Officer, Virginia Health Quality Center

George T. Rodeheaver, PhD

University of Virginia Health System

Dr. Sallie Cook began her talk by stating that Virginia ranks #6 nationally in high risk pressure ulcers (i.e. patients at high risk for pressure ulcers) for the first quarter of 2006 according to Nursing Home Compare, the Centers for Medicare and Medicaid Services (CMS) database updated quarterly with quality measures for all nursing homes nationally. This exceeds the average national rate. She asked participants to visit www.medicare.gov for national and local data on nursing homes, hospitals, and home health services. She explained that Quality Improvement Organizations (QIOs) are currently focused on quality measures associated with pressure ulcers, physical restraints, chronic pain and worsening symptoms of depression or anxiety. The website allows you to look at nursing home quality based on a number of quality measures including presence of pressure ulcers; however, it should be noted that the development of pressure ulcers is not just a nursing facility problem. The nursing facility data reflects a much broader issue as patients often arrive in nursing homes with pre-existing pressure ulcers, developed at home, in hospitals or other settings.

Dr. Cook recommends a strong leadership/organizational commitment, operational ties with other organizations and community stakeholders, effective systems for assessing and monitoring residents for pressure ulcers, and evidence-based processes for prevention and treatment. She charged the participants to set goals, and to create a continuous improvement learning environment which is patient-centered and data vigilant. Furthermore, all facilities should aim for a zero tolerance for avoidable pressure ulcer development.

She then reviewed the Advancing Excellence Campaign and barriers to successful pressure ulcer prevention that include staff turnover with direct care and leadership, inconsistent care practices, data accuracy and interpretation problems. She concluded by stating that there is a deficiency in accurate patient risk assessment and staging of pressure ulcers and that in the future, there may be unintended consequences associated with financial incentives, if not properly aligned with quality measures. Currently, nursing homes receive higher reimbursement for residents with pressure ulcers. Future pay for performance programs should reward facilities reducing the numbers of residents with pressure ulcers and appropriately treating those arriving with pre-existing ulcers that are progressively healing. Future legislation must be written carefully to align these incentives to promote continual improvement in the care of nursing home residents as well as other health care settings.

Dr. Rodeheaver began his comments with a review of the Certificate of Public Need (COPN), stating that it is controversial, but is needed to ensure cost-effective services to underserved areas. For nursing homes, no new beds can be built in an area until the occupancy rate of the existing beds exceeds 95% over a 3-year period. This occurs regardless of the quality of care provided for those beds. Thus, poor-quality-of-care beds are guaranteed an unfortunate occupant. Dr. Rodeheaver encouraged a critical review of the COPN review process so that quality of care was an important

component of the certification process. This proposal would not only involve new beds, but also the transfer of existing beds from one owner to a new owner.

With regard to the Civil Money Penalty (CMP) fund, Dr. Rodeheaver encouraged DMAS to develop creative programs to recognize and reward improvement in quality of care. He noted that several nursing facilities kept getting deficiencies and kept paying fines. He suggested that paying the fines may cost less than making the improvements, and may be considered a cost of doing business by some nursing facility operators. He noted that the facilities are not incentivized to make change; incentives could be the key to solving this problem instead of penalization. People have learned how to get around or deal with the penalization. If incentives are available, they will work toward the goal of improved quality of care. Dr. Rodeheaver reminded the group that the Certified Nursing Facility Educational Initiative (CNFEI) funded by CMP money in 2000 failed even though it was strictly voluntary and was developed to help facilities eliminate their deficiencies. Dr. Rodeheaver suggested that the CNFEI program should be reevaluated and consideration given to make it mandatory for facilities with a history of deficiencies to participate. Lastly, Dr. Rodeheaver charged participants to support the continuation of the successful Virginia Health Quality Center Initiative.

He concluded by saying, "Improved quality requires 'incentivization.' The stick hasn't worked well... we need the carrots."

Empowered Consumer

Presented by:

Ilene R. Henshaw

National Coordinator, Health and Long Term Care, AARP

Ms. Henshaw began her comments by stating that nursing home residents and their families can and should play an important role in preventing and treating pressure ulcers. She stated that many consumers want to take an active role in their care and the care of their loved ones. Unfortunately, according to Ms. Henshaw, most nursing homes do little to partner with consumers towards their mutual goals.

Ms. Henshaw's comments first focused on what consumers needed to know in order to prevent pressure ulcers. First, it is important for consumers to know how to select nursing home by using inspection reports, websites, referrals, and information from Ombudsmen. She continued by stating that consumers must know what questions to ask, what to look for, understand the law and their rights, know the pressure ulcer risk factors, how they can be active in care, how to partner, how to advocate, how to communicate with staff, how to take part in care-planning and assessment, understand the survey and complaint process, how to form/access family councils, and how to advocate for other residents and staff.

Ms. Henshaw noted that nursing home administration and staff should understand and support the role of the resident and families as active participants in their health care decision-making, welcome residents and families as partners in prevention and to open the lines of communication. She stated that nursing home leadership should foster a culture of trust, respond promptly to questions and concerns and provide education for residents and their families on pressure ulcers using adult learning strategies.

Ms. Henshaw stated that residents and families should be encouraged to report changes in skin condition. Ms. Henshaw gave an example that one nursing facility distributed a diagram of the body to friends and family of residents and whenever anyone spotted a red area, they were ask to mark on the diagram and show a staff member immediately. Another recommendation made by Ms. Henshaw was that families should be encouraged to be present at care plan meetings, and nursing facilities should do their utmost to schedule these for the convenience of the resident and family members, including suggesting the use of teleconferencing.

Ms. Henshaw noted that nursing homes should foster a culture of trust and open communication. Ways to do this include notifying families promptly of any changes in their loved one's condition, letting them know what the facility is doing to address these changes, and letting them know how the family can help. In addition, Ms. Henshaw suggested that nursing homes proactively share and/or respond affirmatively to any requests for reports and/or records about treatment and therapies. Families should be notified and invited to be present when a wound specialist comes in so that they can ask questions and obtain information. Ms Henshaw noted that many cases of dissatisfaction, which can lead to negligence claims, can be diffused by reasonable explanations from health care professionals who have established a good working relationship with the resident and the family.

Ms. Henshaw concluded by stating that it is in everyone's best interest to welcome residents and their families into a partnership to prevent pressure and treat pressure ulcers. She noted that this might take a rather radical change of mindset, but that it was her belief that it is the only way to solve this serious problem.

Roundtable Discussion on Critical Issues

Workforce First

This roundtable discussion was charged with discussing the question “How can the workforce issues of retention, culture change, consistent assignment and pay for performance result in a reduction of incidence of pressure ulcers?”

Key issues that emerged were:

- Lack of best practice training
- A need for culture change
- Evaluation of improved economic models

Recommendations that followed these issues were:

➤ Best Practice Training

- Improve the formal training of all levels of healthcare providers to include pressure ulcer prevention
- Enhance accountability for best practices
- Implement competency training at all levels of staffing
- Learn from facilities that are successful in preventing pressure ulcers

➤ Culture Change

- Programs to enhance building of relationships
- Special retreats for CNAs
- Establish a stable workforce
- Better describe the profile of each staff position
- Translate effective practices across the continuum
- Involve family members in the culture change
- Evaluate the outcome of consistent assignment

➤ Economic Models

- Increased reimbursement for direct labor
- Special money dedicated to CNA workforce development
- Reward facilities that prevent pressure ulcers

Resource Revitalization

This roundtable discussion focused on the question, “How can our limited resources be best allocated to most effectively prevent pressure ulcers?”

Key issues that emerged were:

- Culture change towards person-centered care
- Support pay for performance
- Better utilize money that already exists

Recommendations for action were:

- Request money to evaluate pilot programs involving culture change.
- Provide input to DMAS to assist in optimizing the pay for performance program
- Adjust State criteria for prevention bed reimbursement to those of CMS
- Utilize the \$10/day reimbursement from DMAS for a prevention bed

Regulatory Effectiveness

This roundtable discussion was charged with answering the question, “What do you see as the major issues for regulatory effectiveness to prevent pressure ulcers?” Responses were as following:

- Provide incentives within the regulatory process for achievable goals.
- Providing Evidence-based practices
- Regulations can be a better clinical path to provide better care.
- Poor performers – special focus on these facilities with more intense regulatory scrutiny and assistance with education
- Offer loans, like small business or disaster loans that help facilities that are in trouble
- Hold the owner, operator, administrator, medical director, and board responsible for regulatory compliance with a “good driver”/bad driver”-like system which assigns then removes “points” contingent upon staff development relative to person-centered care and quality improvement.
- Become a Center of Excellence as a component of CON and Pay for Performance
- Mandate a transfer form as a condition of licensure

This question also spurred many to ask more questions such as:

- Are providers paying attention despite CMPs, lawsuits? What about charging user fee to facilities that have to be re-inspected?
- May already have resource issues and does this exacerbate the problem?

- Why take away the CNA program when facilities are already under stress?
- If regulations were lessened would there be a greater return on investment (ROI)?
- What is the threshold from voluntary to mandatory focus?
- Is the assumption that higher DMAS population correlates with increased pressure ulcers?

Quality Enhancement

This roundtable was charged with addressing the issue of enhancing quality of care in long term care facilities as it relates to the prevention of pressure ulcers. Some of the issues that came to the surface during the discussion are as follows:

- Pressure ulcers develop in the hospital when a person is transferred for a specific incident and the person is often returned to the long term care facility with a pressure ulcer
- There is poor adherence to a turning schedule (every 2 hrs.) by staff, and some residents are non-compliant and refuse to turn even after the pressure ulcer gets to stage III. They may not feel the ulcer because the nerves have died or the resident does not wish to move or be disturbed.
- Research on what impacts quality is needed. This research requires quantifiable outcomes. Controlled studies focused on successful components of pressure ulcer prevention are also needed. The statement “enough has been said, we just need to do it and provide adequate staff to get it done,” countered these points. Comments continued to reinforce a strong adherence to the basics. “All that needs to happen is to turn, move around, and alleviate pressure. Also, quantifiable research takes much time and money so instead conduct semi- research by looking at high performance facilities, and just copy what they have.”
- Need to use outside resources from retired nurses and volunteers
- Increase the education/training for staff
- Public reporting – what are they doing to improve and is this information available to others? Incentive = peer recognition, which is a selling point, “We ranked number one...”
- Increase accountability and staff consistency - assigning staff to specific people so get to know each other
- Introduce culture change- CNA retreats
- Different acronyms of quality in each place. Should one acronym be the standard for all?

After identifying the key issues of quality enhancement, the roundtable was then asked to rank order the most important factors for quality enhancement. They were as follows:

- 1) Corporate leadership
- 2) Staffing
(appropriate number of staff and assignment consistency between residents and staff)
- 3) Education – for everyone (legislators, family, board of directors, physicians) and customized for facilities.
- 4) Career ladder development – make it easier for CNAs and LPNs to progress.
- 5) CEUs - mandatory for deficient programs or poor performers or make CEUs mandatory for everyone
- 6) Accountability - document outcomes, be aware, establish achievable goals, and stronger enforcement system at all levels.

Group Reports and Creating a Strategic Action Plan

Kenneth Olshansky, M.D., VPURT Chairman

Dr. Olshansky presented all the recommendations from the breakout groups that focused on the critical issue of pressure ulcer prevention. Of those recommendations, the following themes emerged:

- Adjust survey process to focus on outcomes and reward them
- Connect the process tags to the outcome tags - inconsistent survey process that overlooks some quality problems
- Reward compliance and quality outcomes with pay for performance, quality-incentive COPN, and bed expansions
- Identify and set a threshold to make intervention mandatory for focus facilities
- Reward sustained improvement
- Require the use of a mandated transfer form as condition of licensure

Once the themes were identified, further discussion led to these consensus plans for action:

1. Voluntary versus mandatory use of QIO or other compliance education arm
ACTION PLAN:
 - 1) Define threshold and make intervention mandatory for focus facilities.
 - 2) DMAS to routinely allocate an amount of CMP funds for education/consultation. First offense G or higher- penalty waived, but must participate in ongoing education program. If you don't participate you don't get waiver.
 - 3) Increase the CMP
2. Recognition of quality in the COPN process
ACTION PLAN:
 - 1) Support Secretary Tavenner's task force to examine regulating COPN in recognition of quality and standardize the criteria to define quality.
 - 2) Change the state law to have a greater recognition of quality including shifting beds from non-quality and/or terminated facility beds to quality Centers of Excellence
3. Bring owner, operator, Board, Medical Director into the process
ACTION PLAN:
 - 1) As a condition of compliance, hold owner, operator, Board, Medical Director accountable using signed attestation statements with less frequent inspections for those in continued compliance.
 - 2) Hold accountable for non-compliance

Following the Summit, VPURT and AARP Virginia convened further meetings to discuss the information received at the Summit in greater detail. From these additional meetings, a set of Strategic Action Priorities for Pressure Ulcer Prevention were developed.

Summary / Wrap-up

Kenneth Olshansky, M.D., VPURT Chairman

Dr. Olshansky ended the conference by first thanking all participants for their work put forth throughout the day. He also extended a special thank you to Secretary of Health and Human Resources, the Honorable Marilyn B. Tavenner, for serving as the Honorary Chairperson of the Summit. He reviewed the key topics discussed throughout the summit and assured the participants that the ideas presented would be developed into strategic priority action items and a plan to improve the prevention of pressures ulcers in Virginia would emerge. He continued to thank the participants for all of their effort and ended the meeting with confidence and enthusiasm that Virginia will make great strides over the next few years in reducing the incidence of pressures ulcers.

Section III: Strategic Action Priorities for Pressure Ulcer Prevention

- Make Pressure Ulcer Prevention a Key Outcome Parameter for Pay For Performance
- Increase Staffing Levels to Meet the Critical Needs of the Residents for Prevention of Pressure Ulcers
- Increase the Pay of the Direct Care Staff in Nursing Facilities
- Increase the Accountability of Every Health Care Professional in Pressure Ulcer Prevention
- Make Pressure Ulcers a Reportable Event
- Develop and Implement a Uniform Patient Transfer Form
- Create an Independent Center for Pressure Ulcer Prevention Education
- Redirect Unused DMAS \$10/day Bed Supplement to Pressure Ulcer Prevention in High-Risk Patients
- Revise COPN for Nursing Facility Beds to Emphasize Quality

Section IV: Summary

VPURT and AARP Virginia convened a summit to discuss and develop a strategic action plan designed to address quality improvement in the prevention of pressure ulcers for Virginians in long term care facilities. This summit brought together a cross-section of stakeholders including government officials, healthcare providers, long term care providers, nurses, consumers, and advocates to review and consider the critical issues centered on pressure ulcer prevention. Furthermore, the action plan items identified in the summit are for implementation by all stakeholders in the Commonwealth of Virginia (including government officials, government agencies, providers, advocates, and consumers).

VPURT and AARP Virginia encourage you to select any of the action plan items discussed and make it your independent mission to affect change and reduce the incidence of pressure ulcers. VPURT and AARP Virginia are available to assist you in any way to take up the challenge and bring the action items into successful implementation.

PRESSURE ULCERS ARE PREVENTABLE

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Appendix 3: Additional Resources

Websites

Virginia Pressure Ulcer Resource Team
<http://www.vpurt.org>

AARP in Virginia
<http://www.aarp.org/states/va/>

Assorted Publications

Courtney Lyder, RN, ND, FAAN; Lia van Rijswijk, RN, MSN, CWCN: "Pressure Ulcer Prevention and Care: Preventing and Managing Pressure Ulcers in Long-Term Care: An Overview of the Revised Federal Regulation. Ostomy Wound Management Supplement to April 2005. HMP Communication.

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