ESTABLISHING A CULTURE OF MOBILITY IN THE HOSPITAL SETTING

Continuing the Conversation

Combined Sections Meeting 2015
February 4th-7th, 2015 – Indianapolis, IN

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Cleveland Clinic Rehab and Sports Therapy

Therapy Locations
- Cleveland Clinic Main Campus and 8 regional hospitals
- 100 IRF beds
- 65 SNF beds
- 3,277 Acute care beds
- 47 Outpatient locations

Rehab Team
- 350 Physical Therapists
- 100 PTAs
- 135 OTs
- 25 COTA
- 35 SLP
- 5 Audiologists
- 50 ATCs

The Johns Hopkins Hospital (JHH)
Baltimore, MD

Licensed Acute Beds - 994
Annual Admissions – 50,000
Acute Care Therapists – 65 FTEs
Description

Healthcare reform has reinforced the need to transform service models to focus on value by emphasizing efficiency and efficacy. This need for system re-design, culture change and the call for innovation presents an opportunity to overcome the long-standing challenges faced implementing an interdisciplinary mobility program as a standard of care.

In this educational session, we will build on the 2014 CSM discussion and will examine opportunities, strategies and tactics to position, implement, and evaluate interdisciplinary mobility initiatives in the hospital setting.

Objectives

• Review the evidence supporting mobility in the acute care setting
• Identify the value opportunities for mobility to enhance outcomes or reduce costs along the healthcare continuum.
• Demonstrate how Hospitals can successfully integrate many types of data to inform their decision making.
• Examine specific strategies to leverage organization Healthcare Reform initiatives to drive Interdisciplinary mobility
• Discuss strategies to initiate, conduct, and evaluate an interdisciplinary mobility model
• Discuss practical strategies to measure implementation success

ESTABLISHING A CULTURE OF MOBILITY IN THE HOSPITAL SETTING

Highlights from CSM 2014

• Evidence Supporting Activity
• Value and Waste
• The Systematic Use of Data
• 10 Critical Components of Creating a Culture of Mobility in the Hospital Setting
Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

Our next chapter...

• Updates on Systematic Use of Data
• Functional Reconciliation
• Interdisciplinary Mobility Care Path
• Implementing at scale

THE EVIDENCE SUPPORTING ACTIVITY

Why is promoting activity and mobility in the hospital important?

Most hospitalized patients currently spend most of their time in bed.

Lower levels of physical fitness are directly associated with all-cause mortality and increased complications:

• J Am Geriatr Soc. 2009; 57(9):1660-5
• JAMA. 1989;262(17):2395-2401;
• JAMA. 2008;300:1685–1690

Patient centered: Affects patient’s ability to perform activities of daily living and basic needs, which can affect a patient’s dignity.

2 Hoyer et al., 2013

Our current health-care environment is emphasizing patient centered outcomes (i.e. Hospital Readmissions)
Why is promoting activity and mobility important?

**Body Systems:**
- cardiovascular (orthostatic hypotension, thrombus)
- musculoskeletal (atrophy and contractures)
- urinary elimination (infection and dehydration)
- bowel elimination (constipation and dehydration)
- psychosocial (depression)
- respiratory (hypostatic pneumonia)
- integumentary (pressure ulcers)
- metabolic (fluid and electrolyte imbalance)
- cardiovascular (orthostatic hypotension, thrombus)

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**WASTE AND VALUE**

The Value Equation

“Achieving high value for patients must become the overarching goal of health care delivery, with value defined as the health outcomes achieved per dollar spent.” – Michael Porter, PhD Harvard Business School

Value = Outcome/\text{Cost} 

Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

Examples of Waste

- Failure of care delivery
  - poor execution
  - lack of widespread adoption of best practice resulting in patient injuries, worse clinical outcomes, and higher costs. (e.g. hospital-acquired complications)
- Failures of care coordination
  - care that is disjointed (e.g. handoffs, discharge plans)
  - unnecessary hospital readmissions, avoidable complications, and declines in functional status, especially for the chronically ill.
- Over-treatment
  - care that is rooted in outdated habits, that is driven by providers' preferences
  - unnecessary tests or diagnostic procedures to guard against liability
  - use of higher-priced services that have negligible or no health benefits over less-expensive alternatives


The Healthcare Challenge

Value Solutions:
- Improve Outcomes
- Decrease Cost

The big wins are when we can do both together.

In other words.....
Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

Institute for Healthcare Improvement
Triple Aim

- Improve patient experience
- Improve the health of populations
- Reduce health care costs

www.ihi.org
on Triple Aim

Strategy for Value Transformation

Goal – Improve value for patients
- Improve outcomes without raising costs
- Lowering costs without compromising outcomes.

What does that mean for physical therapist
- Patient level
- System level

SYSTEMATIC USE OF DATA

Chapter III
2014 was a big year!

What does the mean to us

- We used data from a validated tool to give us information about patients mobility

- We used that information to drive CULTURE change in our organization
  - Therapist Utilization
  - Patient Mobility
  - Discharge Planning

Our Journey at the Cleveland Clinic

Uniform data Collection

Use information from large uniform data sets to make decisions
What Cleveland Clinic was looking for in a tool?

- Minimal burden on staff
- Minimal burden on patients
- Incorporate functional items that therapists currently evaluated
- No more than 6 questions
- Ability to assist with moving patients to post acute settings

What is Cleveland Clinic’s 6 Clicks?

- Short form of the AM-PAC (Activity Measure for Post Acute Care)
- Patient Reported Outcome Tool
- 25 years in development
- Validated across all levels of care
- 240 items – 3 domains
- Computer Adapted Test
- Can be shortened, and answered by surrogates

AM-PAC Cleveland Clinic Short Form ‘Six Clicks’

PT
1. Turning over in bed
2. Supine to sit
3. Bed to chair
4. Sit to stand
5. Walk in room
6. 3-5 steps with a rail

OT
1. Feeding
2. O/F hygiene
3. Dressing Uppers
4. Dressing Lowers
5. Toilet (toilet, urinal, bedpan)
6. Bathing (wash, rinse, dry)

1= Unable (Total Assist) 2= A Lot (Mod/Max Assist) 3= A Little (Min Assist/CGA/Sup) 4= None (Ind./Modified Independent)
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PLAN
Treatment Frequency, Duration and Interventions: Branch
Development of Plan of Care: Branch
Therapist pager/Extension: Branch

AM-PAC Outcomes
Basic Mobility Domain
Turning over in bed: 3
Lying on his/her back to sitting: 3
Bed to a chair: 3
Sitting down and standing up: 3
Walk: 2
Climbing stairs: 1
Total Score: 15

Mobility Scale Score Table for AM-PAC

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How does Cleveland Clinic use 6 Clicks data to demonstrate value and improve functional mobility of our patients?

Use of 6 clicks Data

- Discharge Recs
- Improve patient mobility
- Guide therapist resource utilization

PT 6 Clicks Data Volume – CCHS Hospitals

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Total</th>
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<tr>
<td>Evaluation</td>
<td>27,876</td>
<td>43,132</td>
<td>54,876</td>
<td>125,884</td>
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<tr>
<td>Follow up</td>
<td>0</td>
<td>67,219</td>
<td>86,290</td>
<td>153,509</td>
</tr>
<tr>
<td>Total Visits</td>
<td>27,876</td>
<td>110,351</td>
<td>141,166</td>
<td>279,393</td>
</tr>
</tbody>
</table>
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6 Clicks Distribution – PT / Mobility – Never go to a meeting without this info!

Source: Medilinks, all Acute Care PT Evaluations for all Cleveland Clinic Hospitals 2013 n = 54,532

6 Clicks Publications

Resource Utilization

2013 - 4842 patients (8.8%) had a 6 clicks score of 24
Expanding the conversation to Interdisciplinary Functional Assessment achieving Functional Reconciliation?

And the Lord said, Behold, the people is one, and they have all one language; and this they begin to do: and now nothing will be restrained from them, which they have imagined to do.

Go to, let us go down, and there confound their language, that they may not understand one another's speech. — Genesis 11:4–9

Functional Reconciliation

...the comparison of a patient's functional ability prior to hospitalization with their current status.

To occur at all transitions in level of care within institutions, and between institutions and out-patient/community resources.

similar to medication reconciliation


System Approach Value Opportunities

- Targeted intervention
- Protocol development
- Discharge planning
- Acquired complication risk
- Resource utilization
- Patient functional trending
- Predictive modeling
- Reconciliation across setting
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The Problem

Solving the Outcome Measurement Dilemma:

- Need many items or many condition-specific instruments to cover all the relevant functional outcomes across a broad range of patients
- The traditional administration of extensive instruments is burdensome to patient and clinician
- Instruments lack the comprehensiveness needed to track patient progress across settings throughout an episode of care.

Acknowledge Dr. Alan Jette for slide

The DYS-Functional Assessment Puzzle

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JHH Data Strategy – Tool Selection

- Interdisciplinary
- Documentation efficiency
  - EMR design
  - Regulatory requirements
- Meaningful across settings
- Meaningful across initiatives
- Composite and specific measures
  - Meaningful clinical difference
  - Ceiling and floor
- Drive Intervention

JHH Data Strategy – Execution

- "Interdisciplinary Functional Assessment" Policy
- Hospital-wide workflow
  - Johns Hopkins – Highest Level of Mobility (JH-HLM) for Nursing
  - AM-PAC Inpatient Mobility and Activity Scales (6 Clicks)
    - Nursing (frequency under re-evaluation)
    - PT and OT (every visit)
  - Interdisciplinary diagnosis specific measures
  - Population specific workflows for outliers
    (OB/GYN, Psychiatry, Inpatient Rehab, Pediatrics)
- Electronic data entry as part of the EMR
- Data System Infrastructure design and build
- Reports

The System Architecture was determined
Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

Johns Hopkins Highest Level of Mobility (JH-HLM)

<table>
<thead>
<tr>
<th>MOBILITY LEVEL</th>
<th>WALK 250+ FEET</th>
<th>5</th>
<th>7</th>
<th>10+ STEPS</th>
<th>1 MINUTE</th>
<th>STAND</th>
<th>25+ FEET</th>
<th>CHAIR</th>
<th>TRANSFER</th>
<th>BED</th>
<th>10+ STEPS</th>
<th>1 MINUTE</th>
<th>SCORE</th>
</tr>
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<tr>
<td>WALK</td>
<td></td>
<td>8</td>
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<tr>
<td>STAND</td>
<td></td>
<td>7</td>
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<tr>
<td>BED</td>
<td>SIT AT EDGE</td>
<td>6</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>TURN SELF/ACTIVITY</td>
<td>5</td>
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<td>LYING</td>
<td>4</td>
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</tbody>
</table>

Score: 46

How does Johns Hopkins use data to demonstrate value and improve functional mobility of our patients?

With each JH-HLM document:

- This information provides additional detail of the highest level of movement you are documenting:
  - Level of Assistance needed
    - None= Modified Independence/Independent
    - A lot= Max/Mod Assist
    - A little= Min/Contact Guard Assist/Supervision
    - Total= Total/Dependent Assist
  - Assistive Device
  - Number of Assistive Persons
  - Exercises (i.e. bed exercises, chair exercises)
  - Ambulation Distance (i.e. patient walked several laps around the unit)

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Change of JH-HLM on Day of Admission at JHH

Nurse JH-HLM to Therapist AM-PAC

Choosing Wisely – Resource Utilization Exemplars
  • JHH Neurosurgery
  • JHH Department of Medicine

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10 Critical Components to Creating Value Establishing a Culture of Mobility in the Hospital Setting

Critical Components to Success

Be able to clearly articulate to all members of the team the benefits of mobility and harmful affects of immobility while the patient is in the hospital setting.

Identify opportunities to integrate “Culture of Mobility” concepts within existing hospital initiatives (e.g. LOS, ICU, readmissions)

Physician and nursing support – Identify engaged physician and nurse champions with influence over practice with their peer groups

Critical Components to Success

Identify barriers to implementation

Assess workflow and hardwire operations and accountability

Have a good understanding of your baseline metrics. What do you want to achieve – have data to support it.

Develop an Education and Training Strategy
Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

Critical Components to Success

- Set expectations with patients and family upon admission
- Measure, Measure, Measure
- Have Fun

From the ICU to Readmissions

THE JOHNS HOPKINS ACTIVITY AND MOBILITY PROMOTION (AMP) STORY

Experience in the Intensive Care Unit

Critical Care Rehabilitation Quality Improvement Project  2007

Shown decrease in:

- Medical ICU (MICU) days in patients with benzodiazepine and narcotic use and improved delirium status.
- Average length of stay in the MICU (4.9 vs. 7.0 days) and hospital (14.1 vs. 17.2) compared to the prior year.

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MICU LOS sustained success

Potential Benefits to Hospital

Why so many empty MICU beds? patients are awake and moving, patients are better

Versus same 4-month period in 2006:
• 20% increase in MICU admissions
• 10% reduction in hospital mortality
• 30% (2.1 day) reduction in MICU LOS
• 18% (3.1 day) reduction in hosp LOS

For details on ICU Financial Modeling see:

Is a therapist driven model sustainable across all units?

• Long MICU and overall LOS
• $$$ per MICU day
• Higher skill to mobilize
• Therapist underutilization
• Significant ROI potential

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Dedicated Therapist 2008 Reality Check

<table>
<thead>
<tr>
<th>Service Level</th>
<th>Additional Visits per month</th>
<th>Additional FTEs</th>
<th>Total Incremental Cost (Salary + Benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet therapist recommended treatment frequency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet acute care provider expectation – Provide same level of therapy every day during patient stay, 7 days a week</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Everyone agrees people need to move?
Does it take a therapist?
If not then who and how?

Who is the “Right” provider to mobilize patients?

![Therapist vs. Nurse/Tech/Other Complexity to Mobilize Patient](image)

Identify opportunities to integrate “culture of mobility” concepts with existing hospital initiatives

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March 23, 2010

The Activity and Mobility Promotion Initiative (AMP)

Johns Hopkins AMP Initiative

- Phase I – AMP Inpatient Care Coordination Bundle Development and Pilot
- Phase II – Expansion of AMP Bundle and Adult Inpatient Functional Reconciliation
- Phase III – Homecare, Pediatrics, Ambulatory Specialty Practice and Primary Care Functional Reconciliation

March 23, 2010

ICU Innovation
Surveillance of Cancer Or Cancer Recurrence
Value and Choosing Wisely
Patient Centered Care
Length of Stay
Preventable Harms (DVT, Pressure Ulcers, etc)
Activity Mobility Promotion
Interdisciplinary Care Coordination
Readmissions

The Activity and Mobility Promotion Initiative (AMP)
Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

Johns Hopkins AMP - Readmissions

Johns Hopkins Health System Goal to reduce 30-day readmissions 10% below state mandated cap

Value of Rehab was to champion the importance of function in reducing readmission risk

Focused to 2 General Medicine units initially

Post-Hospital Syndrome

• post-hospital syndrome, an acquired, transient period of vulnerability

• During hospitalization …. receive medications that can alter cognition and physical function, and become deconditioned by bed rest or inactivity.

• more assertively apply interventions aimed at promoting practices that reduce the risk of delirium and confusion, emphasizing physical activity and strength maintenance or improvement, and enhancing cognitive and physical function.


JHH Care Coordination “Bundle”

• ED Care Management
• Risk screening—Early and periodic
• Patient family education
  – Self-care management
  – Condition-Specific Education Modules
  – “Teach-back”
• Interdisciplinary care planning
  – Multidisciplinary team-based rounds: every day, every patient
  – Activity and Mobility Promotion (AMP)
  – Projected discharge date on every patient
• Transition of Care and Follow Up Resources
Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

**CHAMPIONS REQUIRED**

**JHM Activity and Mobility Barriers Survey**

Sample questions and response from a nursing unit

<table>
<thead>
<tr>
<th>Statement/Question</th>
<th>Number responses Agree or Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My inpatients are NOT too sick to be mobilized.</td>
<td></td>
</tr>
<tr>
<td>I have received training on how to safely mobilize my inpatients.</td>
<td></td>
</tr>
<tr>
<td>My inpatients and family understand my approach to mobilization.</td>
<td></td>
</tr>
<tr>
<td>I have received training to mobilize my inpatients.</td>
<td></td>
</tr>
<tr>
<td>Nurse-to-patient staffing is adequate to mobilize inpatients on my unit.</td>
<td></td>
</tr>
<tr>
<td>Staff assistance is available to mobilize inpatients.</td>
<td></td>
</tr>
<tr>
<td>I have received training on how to mobilize my inpatients.</td>
<td></td>
</tr>
<tr>
<td>I have received training on how to mobilize my inpatients.</td>
<td></td>
</tr>
<tr>
<td>Increasing the frequency of mobilizing my inpatients DOES NOT increase my risk for injury.</td>
<td></td>
</tr>
<tr>
<td>I have received training on how to mobilize my inpatients.</td>
<td></td>
</tr>
<tr>
<td>Inpatients who can be mobilized usually have appropriate physician orders.</td>
<td></td>
</tr>
<tr>
<td>My inpatients are NOT resistant to being mobilized.</td>
<td></td>
</tr>
<tr>
<td>I believe that my inpatients who are mobilized at least three times daily will have better outcomes.</td>
<td></td>
</tr>
</tbody>
</table>


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Overcoming Barriers

- **Engagement:**
  - Finance – therapist dedicated time to rounds
  - Administrators – Furnishings, resources.
  - Physicians – orders, walk patients or examine at chair-side, patient engagement, facilitate interdisciplinary rounds.
  - Nursing Staff – documentation, co-education, mobilize patients
  - Therapists – train nurses, facilitate interdisciplinary rounds.
  - Clinical staff – help with documentation and mobilizing patients.

Through Documentation

- **Accountability:** Interdisciplinary documentation of function
- **Sustainability:** Using IT to automate data extraction

Have a strong understanding of baseline metrics you hope to influence.

- Length of Stay
- Readmissions
- Therapist Overutilization
- Fall Rates
- Hospital Acquired Complications
- Daily documentation compliance
- Call Bells
- % of patients discharged home

Assess workflow and hardwire operations and accountability

- Hand off and care coordination rounds **ABC**’s:
  - Activity: What activity did the patient do?
  - Barriers: What barriers does the patient have to be mobilized?
  - Continue: How can we continue to progress activity with the patient?
- Nurse Daily documentation
  - Johns Hopkins Highest Level of Mobility Scale
  - AM-PAC Inpatient Short Forms (Mobility and ADL)
- Therapist documentation
  - AM-PAC Inpatient (6-Clicks) each visit
- Mobilize all patients **three times per day** to out-of-bed or ambulating (twice during day, once at night)
- JH-HLM Interdisciplinary Goal Setting
- JH-HLM Progression Protocol
Develop an education and training strategy

- **Nurses:**
  - Online: My-Learning for Nurses
  - Huddles with Therapists
  - Curbside Consult
  - Mobility instructional videos

- **Physicians:**
  - Contraindications to mobilizing patients
  - Engaging Patients
  - Orders to Mobilize Patients

### Therapist Delivery of Care Paradigm Shift

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Completed (Yes)</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Review service specific presentation and algorithms for provision of therapy care specific to service. (TL/Mgr)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review materials on readmissions program and rounds coverage. (TL/Mgr)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review algorithm for provision of co-treatment. (TL/Mgr)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review: “Discharge Planning for ACS” (CS/TC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation: (3 samples) reflects correct leveling for patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit: (3 samples) reflects completion of activity status forms and calendars.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review: (3 samples) reflects completion of activity status forms and calendars.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation: (3 samples) reflects proactive communication for therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete mylearning module on Teach Back Patient Education Method v. 1.0.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete other modules on Teach Back Patient Education Method v. 1.0.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient and Family Engagement

- **Video intro “Get up and Move”**
- **Admission scripting**
  - Importance of mobility
  - Activity Status and Calendar
  - Patient and Family Choices
- **Interactive tablets – provider directed**
- **Pediatrics**
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Measure, Measure, Measure

- Accountability – Nurse documentation compliance to three times per day increased during the project
- Safety – there was no change in falls with implementing the AMP project
- Communication - Nursing utilization of JH-HLM and Therapists (PT, OT) use of “Six Clicks” directly correlated
- Nurse Utilization – correlation between JH-HLM and call bell utilization

Association between JH-HLM and LOS, D/C Home, Costs, and Readmission

Encourage creativity and fun

- Promotion
- Competition
  - Provider
  - Patient
- Rewards
Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

Strategies to Improve the patient JH-HLM Trajectory

• Formalize and integrate the common “Interdisciplinary Functional Assessment” as part of care planning and EMR
• Patient and provider compliance reports
• Physician engagement of patient/family in mobility
• Patient specific daily mobility goals
• Target Therapy resources (i.e. Choosing Wisely)
• Optimize resources within nursing infrastructure to best execute mobility
• Formal internal messaging campaign

PASSING THE TORCH

What I learned this year...

• Physical Therapy can influence but we can’t drive Culture Change

• Data and the Medical Team need to drive culture change in the Hospital
Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

Development of an Interdisciplinary Mobility Care Path

THE CLEVELAND CLINIC STORY AS TOLD BY KAREN GREEN, PT, DPT

Who owns Mobility?

Prior State

Goal.....

Nursing
Therapy
Patient Centered
Medical Team

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How we got (are getting) there...

Culture of Mobility  Safe Patient Handling  Ongoing Education  Nursing Mobility Care Path

Step One...

- Partnered with Nursing Leaders to create a culture change on 4 medical nursing units then expanded to multiple units and hospitals

How...

- Revised Nursing Documentation
- Changed PT and OT orders to Consults
- Provided Nurse Training
- Provided Physician Training

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Therapy Consult...

Culture of Mobility

Outcomes...

Therapy Consult...

Culture of Mobility

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Outcomes…

• Patient Education Video

Step Two…

• Partnered with the Safe Patient Handling Committee to provide a therapy perspective as well as assist with education and training.

Group consists of:
– Nursing Managers
– Clinical Nurse Specialists
– Director of Safety
– Ergonomist
– Director of Rehab

Outcomes…

• Teach portions of the Safe Patient Handling and Mobility Champions class

• 3 Therapy Staff Members are SPHM Champions

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Step 3...

• Mid Level Providers
• Nurse Residency Students
• Nursing Floors
• Pediatric ICU Staff
• Regional Hospital Staff

Step 4...

• Developing a standard of care that included nurse driven mobility for the hospitalized patient
• Goal is to have all patients appropriate for mobility mobilize early and often by the most appropriate caregiver

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Establishing a Culture of Mobility in the Hospital Setting...Continuing the Conversation

“THE MOMENT OF CRITICAL MASS, THE THRESHOLD, THE BOILING POINT” -MALCOLM GLADWELL

Health Care is Changing in Fundamental Ways

SYSTEM SKILLS

- Interest in Data
- Devise Solutions for System Problems
- Develop an Ability to Implement at Scale

How we got (are getting) there...

Culture of Mobility | Safe Patient Handling | Ongoing Education | Nursing Mobility Care Path

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Johns Hopkins Highest Level of Mobility (JH-HLM)

<table>
<thead>
<tr>
<th>MOBILITY LEVEL</th>
<th>WALK 250+ FEET</th>
<th>WALK 25+ FEET</th>
<th>WALK 10+ STEPS</th>
<th>STAND 1 MINUTE</th>
<th>CHAIR TRANSFER</th>
<th>BED SIT AT EDGE</th>
<th>BED TURN SELF / ACTIVITY</th>
<th>BED LYING</th>
</tr>
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<tbody>
<tr>
<td>Score</td>
<td>8</td>
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<td>5</td>
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<td>3</td>
<td>2</td>
<td>1</td>
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</tbody>
</table>

Institutional Change is Hard…

…It is easy to say NO!

Ability to Implement at Scale

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JHM AMP Bundle

Cleveland Clinic to Scale

Johns Hopkins to Scale
ERAS and EPIC pushing AMP 2.0

- Resource Assessment and Business Plan
- Required Champions (RN, MD, Admin)
- Pre-op and post-op visit AM-PAC (in process)
- Required common functional assessment
- JH-HLM progression protocol
- Interdisciplinary Mobility Goals (JH-HLM)
- Smart Order Sets
- Patient Pre-op and Admission education
- Patient/nurse/unit incentives
- Internal messaging campaign

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References


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Covinsky KE, Pierluissi E, Johnston CB. Hospitalization-associated disability: “She was probably able to ambulate, but I’m not sure”. JAMA. 2011;306(16), p. 1782.
