CREATING VALUE BY ESTABLISHING A CULTURE OF MOBILITY IN THE HOSPITAL SETTING

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CREATING VALUE BY ESTABLISHING A CULTURE OF MOBILITY IN THE HOSPITAL SETTING

Cleveland Clinic
Rehab and Sports Therapy

Therapy Locations
- Cleveland Clinic Main Campus and 8 regional hospitals
- 100 IRF beds
- 85 SNF beds
- 47 Outpatient locations

Rehab Team
- 350 Physical Therapists
- 100 PTA’s
- 135 OT’s
- 25 COTA’s
- 35 SLP
- 5 Audiologists
- 50 ATC’s

Johns Hopkins Medicine
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.

This presentation 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 and reduce costs along the healthcare continuum
- Examine specific strategies to leverage organization Healthcare Reform initiatives to drive interdisciplinary mobility

Objectives

- Discuss strategies to initiate, conduct, and evaluate an interdisciplinary mobility model.
- Demonstrate how hospitals can successfully integrate many types of data to inform their decision making
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THE EVIDENCE SUPPORTING ACTIVITY

- Hospitals foster immobility
- Immobility adversely affects patients
- Those patients consume great healthcare costs
Do hospitals foster immobility?

• When patients enter the hospital they are often put on “bed rest” as that is historically the safest default until the patient is more extensively evaluated.

• In hospital-based medical care there is an enduring and widespread impression that “bed rest” is therapeutic and physical activity is harmful (Drolet et al, 2013).

• Despite research that shows that within 72 hours of physical inactivity skeletal muscle change occurs (Convertino et al 1997) the patient often remains on “bed rest” for several days until a PT/OT consult is initiated and the activity order must be changed to allow for the evaluation.

• “83% of the measured hospital stay was spent lying in bed.

• The average amount of time that any one individual spent standing or walking ranged from a low of 0.2% to a high of 21%, with a median of 3%, or 43 minutes per day.”

• 80% were independent with all basic ADL’s before hospitalization, and only 4 of the 45 patients had bed rest orders.

Why do hospitals foster immobility?

- The possibility of incurring- or even the perception of incurring- more inpatient falls.
- Patient death or serious disability associated with a fall while being cared for in a health care facility’ is on the CMS ‘Never Event’ list.
- Additional costs due to injury from an inpatient fall are no longer covered by Medicare.”


Does reduced mobility adversely affect patients?

- Low mobility is an important risk factor for adverse hospital outcomes. Low mobility and bed rest are common during hospitalization, and this study documents the serious adverse outcomes associated with this practice.”

- Changes in functional status are a clinical vital sign and the most important manifestation of illness in older adults across admitting diagnoses.”
  - Covinsky et al, p 1792.
Prolonged inactivity can lead to hospital complications including:

- pressure ulcers
- deep vein thrombosis
- respiratory complications
- decreased endurance
- increased debility

• The impact of loss of function, ambulation, and mobility is associated
  – with an increase in the Length of Stay
  – increasing admissions to nursing homes,
  – falls both during and after hospitalization,
  – continued loss of independence after discharge from the hospital.
• There was a slight decrease in the length of stay and more patients went home instead of to an extended care facility if the patient received exercise while in the hospital.
  de morton et al, 2009.
There was a slight decrease in the length of stay and more patients went home instead of to an extended care facility if the patient received exercise while in the hospital.

de morton et al, 2009

VALUE AND WASTE
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 = \frac{\text{Outcome}}{\text{Cost}}


Failures of care delivery

• poor execution or lack of widespread adoption of best practices (i.e. prevention, patient safety)

• delivery failures can result in patient injuries, worse clinical outcomes, and higher costs.

http://www.healthaffairs.org/healthpolicybriefs/
Failures of care coordination

- occur when patients experience care that is disjointed (i.e. handoffs, discharge plans)
- can include unnecessary hospital readmissions, avoidable complications, and declines in functional status, especially for the chronically ill.

http://www.healthaffairs.org/healthpolicybriefs/

Overtreatment

- care that is rooted in outmoded habits, that is driven by providers' preferences
- ignores scientific findings
- or that is motivated by something other than provision of optimal care for a patient
  - 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

http://www.healthaffairs.org/healthpolicybriefs/
The Healthcare Challenge

Value Solutions:

• Improve Outcomes
• Decrease Cost

The big wins are when we can do both together. In other words…..

IHI Triple Aim

1. Improve patient experience
2. Improve the health of populations
3. Reduce health care costs
SYSTEMATIC USE OF DATA

Development of a Uniform Data Set to Improve Outcomes and Decrease Cost

• Use of a standardized outcome tool
• Collect uniform data upon which both clinical and operational decisions are made.
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

How Does Therapy Measure Functional Mobility?

6 Clicks - on evaluation, each discipline completes a functional measure assessment.

PT evaluates the patient’s abilities in:
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 evaluates the patient’s abilities in:
1. Feeding
2. O/F hygiene
3. Dressing Uppers
4. Dressing Lowers
5. Toilet (toilet, urinal, bedpan)
6. Bathing (wash/rinse/dry)

Scale:
1 = Unable (Total Assist)  
2 = A Lot (Mod/Max Assist)  
3 = A Little (Min Assist/CGA/Supervision)  
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 steps: 1
- Total Score: 15

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### Mobility Scale Score Table for AM-PAC

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Scale Score</th>
<th>Scale Score Standard Error</th>
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<tbody>
<tr>
<td>6</td>
<td>23.95</td>
<td>4.57</td>
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<td>7</td>
<td>25.42</td>
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<td>8</td>
<td>28.58</td>
<td>4.64</td>
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<td>9</td>
<td>30.55</td>
<td>3.69</td>
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<td>10</td>
<td>32.29</td>
<td>4.42</td>
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<td>11</td>
<td>33.96</td>
<td>3.22</td>
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<td>35.23</td>
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<td>19</td>
<td>45.44</td>
<td>3.95</td>
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<tr>
<td>20</td>
<td>47.67</td>
<td>4.05</td>
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<td>21</td>
<td>50.25</td>
<td>3.89</td>
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<tr>
<td>22</td>
<td>53.26</td>
<td>5.43</td>
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<tr>
<td>23</td>
<td>56.93</td>
<td>6.22</td>
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<tr>
<td>24</td>
<td>61.14</td>
<td>6.94</td>
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</table>

### PT 6 Clicks Data Volume – CCHS Hospitals

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>9/2013</th>
<th>Total</th>
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<tr>
<td>Evaluation</td>
<td>27,876</td>
<td>43,132</td>
<td>41,445</td>
<td>112,453</td>
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<tr>
<td>Follow up</td>
<td>0</td>
<td>67,219</td>
<td>71,373</td>
<td>138,592</td>
</tr>
<tr>
<td>Total Visits</td>
<td>27,876</td>
<td>110,351</td>
<td>112,818</td>
<td>251,045</td>
</tr>
</tbody>
</table>
How does Cleveland Clinic use 6 Clicks data to demonstrate value and improve functional mobility of our patients?

6 Clicks Distribution – PT / Mobility

6-Clicks Scores from Initial PT Evaluation for 2013 Q1 - Q3

Source: Medilinks, all Acute Care PT Evaluations for all Cleveland Clinic Hospitals 2013 Jan - Sept n = 41,445
How does Johns Hopkins use 6 Clicks data and highest level of mobility assessments to demonstrate value and improve functional mobility of our patients?

10 CRITICAL COMPONENTS TO DRIVING VALUE THROUGH MOBILITY IN THE HOSPITAL SETTING
Critical Components to Success

1. 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.

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

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

4. Identify barriers to implementation

5. Assess workflow and hardwire operations and accountability

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

7. Develop an Education and Training Strategy
Critical Components to Success

8. Set expectations with patients and family upon admission

9. Measure, Measure, Measure

10. Have Fun

HOW CAN REHABILITATION DEPARTMENTS CREATE VALUE?
“It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness .... it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair…”

Charles Dickens

From the ICU to Readmissions

THE JOHNS HOPKINS ACTIVITY AND MOBILITY PROMOTION (AMP) INITIATIVE
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?

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

Net financial benefit $4.3 million

For details on ICU Financial Modeling see:
“It was the best of times, it was the worst of times…”

2008 Provider Expectations Survey…we all want the MICU

- **Service**
  - Increased therapy needed to achieve LOS targets
  - 24 hour response time
  - Up to daily therapy frequency

- **Barriers to Care**
  - Lack of adequate therapy staff
  - Patient unavailable for initial consult / treatment
  - Clarification / conflicting activity orders

- **Education and Training Gap**
  - Roles of therapy staff and front-line providers in care
  - What is skilled therapy intervention vs. mobility

- **Poor communication and care coordination with treatment teams**

### 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>6,891</td>
<td>16.5</td>
<td>$1,266,148</td>
</tr>
<tr>
<td>Meet acute care provider expectation</td>
<td>9,970</td>
<td>43.5</td>
<td>$3,498,300</td>
</tr>
</tbody>
</table>

does not account for response to consults within 24 hours, premium weekend pay or staff management/infrastructure/supplies
“Culture of Mobility” Vision (January – 2009)

- Standardize therapist approach, consistency among therapist
- Admitting service providers/admin input into the therapy prioritization process
- Effective discharge rounding models
- Physician Order Entry Solutions
  - Consult decision trees built with prescriber input
  - Required non-conflicting activity status
- Share prescriber referral appropriateness trends
- All providers, family, and patient driven mobility
- Policy delineating therapy resource utilization
- Monthly meetings with acute care services
- Communicate function “as a vital sign”
- Advocate for data optimization and solutions

March 23, 2010
Medicare, Post-Hospital Syndrome, and the Louisiana Purchase

CHAPTER 2

Translating Research into Practice (TRIP)

- Summarize the evidence
- Identify local barriers to implementation
- Measure performance
- 4 E’s
- Engage
- Educate
- Execute
- Evaluate

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

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.
Care Coordination “Bundle”

- **ED Care Management**
  - ED Care Protocols
  - Assess Risk and Ease Transition Back to Community
- **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
  - **Mobility initiative**
  - Projected discharge date on every patient

Care Coordination “Bundle”

- **Provider handoffs**
  - Discharge summary within 5 days
  - PCP follow-up within 7-14 days
- **Medication Management**
  - “Medications in hand” before discharge
  - Medication Reconciliation and Pharmacist Education
  - **Transitions of Care**
  - Phone calls
  - Home visits (Transition Guide/Pharmacy).
- **PAL Line: Patient “Anytime” Line**
  - Post-discharge phone calls
Clearly articulate to all members of the team the benefits of mobility while the patient is in the hospital setting supported by evidence.

Why is promoting activity and mobility in the hospital important?

For Patients

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.

*JAMA.* 1989;262(17):2395-2401;

*JAMA.* 2008;300:1685–1690

Affects patient’s ability to perform activities of daily living and basic needs.

- Can affect a patient's *dignity.*
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Why is promoting activity and mobility in the hospital important?

**Body Systems:**

- Psychosocial (depression)
- Respiratory (hypostatic pneumonia)
- Cardiovascular (orthostatic hypotension, thrombus)
- Musculoskeletal (atrophy and contractures)
- Integumentary (pressure ulcers)
- Urinary elimination (infection and dehydration)
- Bowel elimination (constipation and dehydration)
- Metabolic (fluid and electrolyte imbalance)

Why is promoting activity and mobility in the hospital important?

**For Providers and Administration:**

- Preventable Harms reduction
  - Decubitus ulcers
  - DVT and PE
  - Aspiration PNA
  - Fall
- Reduce length of stay
- Reduce hospital readmissions

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.


Identify Engaged Physician and Nurse Champions with influence over practice with their peer groups

- Nursing
  - Director
  - Manager
  - Educator
  - Unit Champions
  - Front-line nurses
- Rehabilitation
  - Leader of Operations
  - Therapist champion
  - Front-line therapists
- Physician
  - Departmental Leaders
  - Service or Unit Attending
- Administration
  - Resources and Utilization Department
- Support Staff
Identify barriers to implementation

Known Barriers

- Who is the primary provider to mobilize patients?
- Minimal documentation of function by MD and RN – 2 unit focused review
- Nurses (29 surveyed):
  - Only 55% of nurses said they had received training on how to safely mobilize patients.
  - 78% of nurses said there wasn’t the proper equipment and/or furnishings to mobilize patients.
  - 86% of nurses said they think their patients will be resistant to being mobilized.
  - Only 20% of nurses said they had time during their day to mobilize patients during their shift.

Nurses Responses

<table>
<thead>
<tr>
<th>Question #</th>
<th>Statement/Question</th>
<th>Number responses Agree or Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>My inpatients are NOT too sick to be mobilized.</td>
<td>15/22 (68%)</td>
</tr>
<tr>
<td>2</td>
<td>I have received training on how to safely mobilize my inpatients.</td>
<td>16/22 (73%)</td>
</tr>
<tr>
<td>3</td>
<td>I DO have time to mobilize my inpatients during my shift/work day.</td>
<td>5/21 (24%)</td>
</tr>
<tr>
<td>4</td>
<td>Nurse-to-patient staffing is adequate to mobilize inpatients on my unit(s).</td>
<td>4/22 (18%)</td>
</tr>
<tr>
<td>5</td>
<td>We HAVE the proper equipment and/or furnishings to mobilize my inpatients.</td>
<td>12/22 (55%)</td>
</tr>
<tr>
<td>6</td>
<td>I DO feel confident in my ability to mobilize my inpatients.</td>
<td>12/21 (57%)</td>
</tr>
<tr>
<td>7</td>
<td>Increasing the frequency of mobilizing my inpatients DOES NOT increase my risk for injury.</td>
<td>8/22 (36%)</td>
</tr>
<tr>
<td>8</td>
<td>Inpatients who can be mobilized usually have appropriate physician orders to do so.</td>
<td>12/22 (55%)</td>
</tr>
<tr>
<td>9</td>
<td>My inpatients are NOT resistant to being mobilized.</td>
<td>7/21 (33%)</td>
</tr>
<tr>
<td>10</td>
<td>I believe that my inpatients who are mobilized at least three times daily will have better outcomes.</td>
<td>20/21 (95%)</td>
</tr>
<tr>
<td>11</td>
<td>I AM sure when it is safe to mobilize my inpatients.</td>
<td>14/21 (67%)</td>
</tr>
<tr>
<td>12</td>
<td>My departmental leadership is very supportive of patient mobilization.</td>
<td>14/22 (64%)</td>
</tr>
</tbody>
</table>

Overcoming Barriers

- **Trans-disciplinary Engagement:**
  - Administrators – ie. Furnishings, resources.
  - Physicians – i.e. orders, walk patients or examine at chair-side, patient engagement, facilitate interdisciplinary rounds.
  - Nursing Staff – i.e. documentation, co-education, mobilize patients
  - Therapists – i.e. train nurses, facilitate interdisciplinary rounds.
  - Clinical staff – help with documentation and mobilizing patients.

*Through Documentation*

- **Accountability:** Documentation of function
Have a strong understanding of baseline metrics you hope to influence.

Assess workflow and hardwire operations and accountability

Measurement: coordination-of-care Nurse-to-nurse & Nurse-to-therapist communication

- Sign off and Daily 08:15 huddle to ask (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
  - Highest Level of Mobility
- Therapist documentation
  - “6-Clicks” each visit
  - Gait speed (PT) and Medication Management Risk (OT)
- Mobilize all patients **three times per day** to out-of-bed or ambulating (twice during day, once at night)
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Daily Documentation:
Highest Level Of Mobility (HLM)

Activity (or Equivalent)
1- Lying in bed
2 -Turned self in bed – Bed Activity
3- Sat at edge of bed
4- Transferred to chair/commode
5- Static Standing (1 or more minutes)
6- Walked 10 steps or more (i.e. walked to restroom)
7- Walked 25 feet or more (i.e. walked outside room)
8- Walked 250 feet or more (i.e. several laps on unit)

Since the last time the patient was assessed, what did the patient ACTUALLY DO, NOT what the patient is capable of?

6 Clicks Mobility
Stakeholder Accountability

Physician:
- Nursing order for Activity
- Counseling patients
- Rounding at “Chair-Side”

Multi-Disciplinary Rounds (ABCs)
- A: Activity
- B: Barriers
- C: Continue (progress)

Nurses and Aides

Physicians

Therapists

Patients

Care Coordination Rounds
Functional Profile

- Highest Level of Mobility
- AM-PAC “6-Clicks”
  - Mobility
  - ADL
- Gait Speed
- EFPT – Medication Management Risk
- Discharge Recommendation
- Aspiration Risk
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

### SICU Collaborative Mobility Model

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Activities</th>
<th>Contraindications</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>No/Low Cooperation</td>
<td>Basic Assessment</td>
<td>Normal SBP, Pain management, Sedation/analgesia, No contraindications</td>
</tr>
<tr>
<td>2</td>
<td>Moderate Cooperation</td>
<td>Full Coop EBEP</td>
<td>SBP &gt; 90, Sedation/analgesia, No contraindications</td>
</tr>
<tr>
<td>3</td>
<td>Full Cooperation</td>
<td>Engagement</td>
<td>SBP &gt; 110, Sedation/analgesia, No contraindications</td>
</tr>
<tr>
<td>4</td>
<td>Full Cooperation</td>
<td>Full Engagement</td>
<td>SBP &gt; 110, Sedation/analgesia, No contraindications</td>
</tr>
</tbody>
</table>

**SBP** = Systolic Blood Pressure

**EBEP** = Early Bed Exit Pilot

**Sedation/analgesia** = Sedative/analgescic agents

**Pain management** = Pain-related interventions

**Contraindications** include conditions that may prevent safe mobilization, such as acute bleeding, unstable medical conditions, or patient discomfort.
Therapist Delivery of Care Paradigm Shift

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Completed (Date)</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1. Review service specific presentation and algorithms for provision of therapy care specific to service. (TL/Mgr)</td>
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<td></td>
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<tr>
<td>2. Review materials on readmissions program and rounds coverage. (TL/Mgr)</td>
<td></td>
<td></td>
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<tr>
<td>3. Review algorithm for provision of co-treatment. (TL/Mgr)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Review “Discharge Planning for ACS” (CS/TC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Documentation (3 samples) reflects correct leveling for patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Audit (3 samples) reflects completion of activity status forms and calendars.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Shadow (3x) rounds coverage with TC or CS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Observation of staff member at rounds reflects proactive communication for therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Complete mylearning module on Teach Back Patient Education Method v. 1.0.</td>
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</table>

Patient and Family Engagement

- 2 minute video intro “Get up and Move”
- Admitting RN scripting
  - Importance of mobility
  - Activity Status and Calendar
  - Patient and Family Choices
- Interactive tablets – provider directed
CREATING VALUE BY ESTABLISHING
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Activity Status

Room #: ________ Patient Name: ____________ Date: ________
Precautions/Weight Bearing: ___________________________
Bed Mobility: ______________________________________
Transfers: ___ Sit to Stand ___ Stand to Sit ___ Stand to Pivot ___
Time OOB: ____________
Walking, Device, & Distance: ____________________________
Activities of Daily Living:
Grooming __________________________
Upper Body _______________________
Lower Body _______________________
Feeding __________________________
Comments: _________________________

Occupational Therapist: ________ Pager: ________
Physical Therapist: _____________ Pager: ________
Speech Language Pathologist: ______ Pager: ________

Activity Calendar for ____________

Becoming and staying active plays a huge part in your recovery. This
calendar is for you (and your family) to track your progress with daily activity. Please make note of
any activity you perform — some examples include:–
~walks (including those with family and nursing)
~getting out of bed to sit in the chair
~trips to the bathroom

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Good luck on your road to recovery! Strive for 3 walks daily and ask for assistance when needed.
Measure, measure, measure

Measure and Data Display

- Process measures
  - Minutes to complete huddles
  - Documentation compliance
- Safety
  - Falls and other safety events
- Length of stay
- Attitudes and beliefs
- Reporting – Care Coordination
Encourage creativity and fun

This is a marketing campaign

- Posters
- Competition
  - Provider
  - Patient
- Prizes
- Walking Trails
CREATING VALUE BY ESTABLISHING A CULTURE OF MOBILITY IN THE HOSPITAL SETTING

Translating Research into Practice (TRIP)

Overall concepts
- Envision the problem within the larger healthcare system
- Engage collaborative multidisciplinary teams centrally (stages 1-3) and locally (stage 4)

1. Summarise the evidence
- Identify interventions associated with improved outcomes
- Select interventions with the largest benefit and lowest barriers to use
- Convert interventions to behaviours

2. Identify local barriers to implementation
- Observe staff performing the interventions
- "Walk the process" to identify defects in each step of implementation
- Enlist all stakeholders to share concerns and identify potential gains and losses associated with implementation

3. Measure performance
- Select measures (process or outcome)
- Develop and pilot test measures
- Measure baseline performance

4. Ensure all patients receive the interventions
- Implement the "Four Es" targeting key stakeholders from front line staff to executives

Evaluate
- Regularly assess for performance measures and unintended consequences

Educate
- Share the evidence supporting the interventions

Execute
- Design an intervention "toolkit" targeted at barriers, standardisation, independent checks, reminders, and learning from mistakes

Translating Research into Practice (TRIP)

Big Data

Policy Functional Assessment

EPIC EMR

6-Clicks .gov

Functional Profile in Rounds

Budget Alignment

Post-hospital syndrome

Mobility Bundle QI

Dr. Porter

ICU QI

The AMP Expedition

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THE CLEVELAND CLINIC STORY

Cleveland Clinic LOS initiative

- Cleveland Clinic
- Enterprise-wide Goal for 2013… Decrease LOS on all units by 10%
- Value of Therapy was to lead a “Culture of Mobility” Project
- Focused Project on four on Medical Floors H80/81 and G80/81
CREATING VALUE BY ESTABLISHING A CULTURE OF MOBILITY IN THE HOSPITAL SETTING

Project Timeline

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<tr>
<td>Create educational materials</td>
<td>Nursing/PCNA training</td>
<td>Physician training</td>
<td>Audits for mobility</td>
<td>Project Team Meetings</td>
<td>GO-LIVE for interventions Doc Flowchart in EPIC</td>
<td>Develop tools for sustainment</td>
<td>Data Collection</td>
<td>GO-LIVE for PT consult changes in EPIC</td>
<td>GO-LIVE for EPIC Activity order changes (TBD)</td>
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6 Clicks Distribution – PT / Mobility

6-Clicks Scores from Initial PT Evaluation for 2013 Q1 - Q3

Source: Medilinks, all Acute Care PT Evaluations for all Cleveland Clinic Hospitals 2013 Jan - Sept n = 41,445

Ideal for nursing mobility
Engaging the Team

- Started with Nursing Directors over Medicine floors and Medical Director
  - Explained intent of culture change
  - Reviewed Data
  - Asked them to take the lead with their staff
- Both need to make significant changes to practice to in order to change culture
- Have influence over their own peer groups

- Perception among medical team was that our patients were acutely ill and very immobile. Patients were not able to move without a physical therapist.
- Lack of equipment on nursing units (walkers, gait belts)
- Lack of knowledge on HOW to move patients.
- Medical team holding off on mobility because they are waiting for therapy to give them the “green light”.
- Physicians routinely ordering therapy on admission for all patients.
Assess workflow and hardwire operations and accountability

Focus areas at Cleveland Clinic

– Orders for therapy – PT/OT Consults were “orderable’s” and there was very little critical thinking on when to place an consult to PT

– Nursing Documentation of mobility – Inconsistent between nursing staff.
Enhancements to Nursing Documentation

Have a good understanding of your baseline metrics

Cleveland Clinic
- Number of inappropriate consults (6 Clicks Score)
- Fall Rate
- Pressure ulcers
- % of patients discharges home
- LOS
Develop an Education and Training Strategy

- MD - Appropriate consults (who should we see) Where do therapists add the most value?

- Nursing –
  - How to move patients
  - Equipment
  - Walkers, gait belts

- Patients – Importance of mobilization

Changing our Culture

- Medical team should attempt to mobilize the patient within the first 24 hours.

- Mobilization should be as important to the patient as eating and drinking.

  ✓ Make sure activity orders are updated in EPIC
  ✓ Discontinue bed rest orders
  ✓ Verify with nursing that patient is being mobilized
Ordering Therapy Decision Tree for Physicians

Are there documented attempts to mobilize the patient that have been deemed ineffective or unsafe by nursing?

- IF YES... 

Is the patient’s limitation due to a chronic, stable condition?

- IF NO... 

Is this a change from the patient's prior level of function?

- IF YES... 

Is the impairment expected to spontaneously recover?

- IF NO... 

Is the patient able and willing to participate in physical therapy?

- IF YES... 

PLACE PT or OT CONSULT

* Discontinue any bed rest orders and consult PT/OT in EPIC

See next page for guidance on which service to request

DO NOT PLACE PT or OT CONSULT.

Patient can be mobilized by medical team or family member.

Training Module for Nurses and PCNA’s

- Standardized for all nursing units
- Completed by Physical Therapy staff
- Nurses take off of the unit for training
- Both didactic and lab components
Safely Mobilizing Patients-
Medical Team Training

Supine to Sit

- Instruct patients with the logroll method to get out of bed
  - Start with HOB elevated and work towards HOB flat
  - Decrease reliance on bedrails as patient gets ready to go home
  - Dangle the patient with feet on the floor and arms on bed at each side
- Let the patient acclimate to sitting, ask if they are dizzy
- Assess vital signs if needed
- Assist patient with socks, robe, gait belt
Assisting a Patient from Bed to a Commode

- Lower the arm of the commode chair closest to the bed – if able
- Use the principles of “Bed to Chair”
- Provide the patient privacy (close the curtain) so that you can move the patient’s gown out of the way
- Make sure the floor is dry prior to transferring back to bed

Make Mobilization a PRIORITY

- Patient education about mobility given with admission packet
- Encourage patient to log their activity on the “Activity Log”
- Sit the patient up in bed or move the patient to the chair during assessments/rounding
- Move the patient to the chair for meals
- Talk about mobility during morning huddle
- Physician and Nursing Leadership needed to reinforce the “Culture of Mobility”

Good Physician/Nurse communication around patient mobilization and activity orders is CRITICAL!
Set expectations with patients and family upon admission

- Review benefits of mobility from admission packet
- Track activity on “Active Recovery” chart in room
- Questions regarding mobility embedded into nurse manager rounding tool
  - Are you able to ambulate on your own or do you need assistance?
  - Did anyone assist you ambulating in the hallway in the past 24 hours?
Measure, measure, measure

- Aggregate and display data at every opportunity

- Continually evaluate and measure
  - Number of inappropriate consults (6 Clicks Score)
  - Fall Rate
  - Pressure ulcers
  - % of patients discharges home
  - LOS
# 10 Encourage Creativity and Fun

TAKE HOME POINTS
Take Home Points

• Activity is good, bedrest is bad
• Improve outcomes without increasing cost
• Eliminate waste
• Collect, aggregate and display data is essential to creating change
• Agree with multi-d team on elements to measure
• 10 Critical Components

Be Persistent and Don’t Give Up!!

Resources

• Health System Rehabilitation Community (HSRC)
  – Follow on Twitter: @healthsysrehab
  – www.apta.org/HSRC

• Johns Hopkins Critical Care Rehabilitation Program
  – www.hopkinsmedicine.org/OACIS
  – www.mobilization-network.org
  – Follow on Twitter:
    • @icurehab @DrDaleNeedham @mkfrdmn
  – Contribute to Twitter at: #icurehab
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