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

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Presenters
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Senior Director, Cleveland Clinic Rehabilitation and Sports Therapy
Over the past 4 years, she has led the integration and consolidation of rehabilitation services across a health system consisting of 10 hospitals, 47 outpatient therapy centers, and more than 700 therapy professionals. This reengineering project included successful development of unified electronic documentation, productivity, compliance, and billing platforms. She received her BS in physical therapy from Marquette University and her DPT from Simmons College. She is an active member of APTA and OPTA.

Michael Friedman, PT, MBA
Director of Rehabilitation Therapy Services at the Johns Hopkins Hospital
oversees physical therapy, occupational therapy, and speech language pathology services. He also is a faculty member in the Johns Hopkins School of Medicine, Department of Physical Medicine and Rehabilitation. He received his master of physical therapy degree from Shenandoah University and a master of business administration degree from the Robert H. Smith School of Business at the University of Maryland.
Cleveland Clinic Rehab and Sports Therapy

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

The Johns Hopkins Hospital
Baltimore, MD

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

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Is it possible that.....

Hospitals foster immobility
Immobility adversely affects patients
Those patients consume great healthcare costs

Slide 12

Does bed rest 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 wide spread 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.
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Do hospitals foster immobility?

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

- 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.

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


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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.


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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.
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
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
Cost


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Percent of Medicare and Medicaid Expenditures

<table>
<thead>
<tr>
<th>Medical Care Service</th>
<th>Medicare (Low)</th>
<th>Medicare (High)</th>
<th>Medicaid (Low)</th>
<th>Medicaid (High)</th>
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<td>Hospital care</td>
<td>45</td>
<td>55</td>
<td>50</td>
<td>60</td>
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<tr>
<td>Imaging</td>
<td>20</td>
<td>25</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Home health care</td>
<td>10</td>
<td>15</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Preventive care</td>
<td>10</td>
<td>15</td>
<td>10</td>
<td>15</td>
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<tr>
<td>Total health care</td>
<td>100</td>
<td>115</td>
<td>100</td>
<td>120</td>
</tr>
</tbody>
</table>

Health care services include those for which Medicare and Medicaid make payments, as well as other payments made to providers of services and suppliers of medical goods. Medicare and Medicaid are the two major programs of the federal government that provide health care coverage for the elderly, the poor, and the disabled. Medicare is a federal health insurance program for people who are age 65 or older, or who have certain disabilities. Medicaid is a joint federal and state program that provides health care coverage for low-income families and people with disabilities.
Failures of care delivery

- poor execution or lack of widespread adoption of best practices (e.g. sedation practices, early mobility in ICU)
- delivery failures can result in patient injuries, worse clinical outcomes, and higher costs. (e.g. hospital acquired complications)

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

Failures of care coordination

- occur when patients experience care that is disjointed (e.g. 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 (unnecessary consults)
- 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.....

Institute for Healthcare Improvement Triple Aim

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

www.ihi.org

We can’t do this alone

• The Importance of the Interprofessional Team can not be underestimated
• Role understanding and effective communication are core competencies for collaborative practice
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“The effects of a multi-disciplinary mobility initiative on liver transplant patient outcomes”
Kathleen Vass, DPT, Julie Clague, OT

Interventions:
- Nursing staff trained on: bed mobility, transfers, environmental set-up for safe mobility
- Patient education and log to track activity
- Ensure equipment availability (walkers and gait belts) on the unit

<table>
<thead>
<tr>
<th></th>
<th>Group A: Baseline (n=116)</th>
<th>Group B: Intervention (n=90)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>6.9%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>13.29 ± 8.38 days</td>
<td>10.85 ± 6.41 days (p=0.004)</td>
</tr>
<tr>
<td>% patients discharged Home</td>
<td>68.1%</td>
<td>77.4%</td>
</tr>
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</table>

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SYSTEMATIC USE OF DATA

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The ability to collect, aggregate and display data is critical in driving system change.

Use of a standardized measure

Collect uniform data upon which both clinical and operational decisions are made.
What were we looking for in a measurement tool?

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

Cleveland Clinic AMPAC 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)

Scale: 1=Unable (Total Assist)  2=A Lot (Mod/Max Assist)  3=A Little (Min Assist/CGA/Supervision)  4= None (Ind./Modified Independent)
**Slide 34**

PT 6 Clicks Data Volume – CCHS Hospitals

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Total</th>
</tr>
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<tbody>
<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>57,219</td>
<td>80,290</td>
<td>133,509</td>
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<tr>
<td>Total Visits</td>
<td>27,876</td>
<td>101,351</td>
<td>141,166</td>
<td>279,393</td>
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</tbody>
</table>

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

**Slide 36**

6 Clicks Distribution – PT / Mobility – Cleveland Clinic

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

Patients with a PT 6-Clicks Score of "24" (highest level of function), Therapist Discharge Recommendation

- 2013 - 4842 patients (8.8%) had a 6 clicks score of 24

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How does Johns Hopkins use 6 Clicks data?

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Resource Utilization:
 Physical Therapy valuations

Many independent patients who require no services upon discharge receive a PT consult

Patient requires no assistance for transfers, ambulation, and stairs
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How can rehabilitation departments create value?

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

• Be able to clearly articulate to all members of the interprofessional 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

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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

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Critical Components to Success

• Set expectations with patients and family upon admission

• Measure, Measure, Measure

• Have Fun
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“A Tale of Two Cities by Charles Dickens

“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

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From the ICU to Readmissions
THE JOHNS HOPKINS ACTIVITY AND MOBILITY PROMOTION (AMP) STORY

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CRITICAL CARE, UNMET EXPECTATIONS, AND MICHAELANGELO
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.


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

Net financial benefit $4.3 million

For details on ICU Financial Modeling see:

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“IT WAS THE BEST OF TIMES, IT WAS THE WORST OF TIMES…”

2008 Provider Expectations Survey…we all want the MICU

- Service Expectations
  - Increased therapy needed to achieve LOS targets
  - 24 hour response time
  - Up to daily therapy frequency
- Barriers to Care
  - Lack of adequate therapy staff
  - Education and Training Gap
- Poor communication and care coordination with treatment teams

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**Reality Check**

<table>
<thead>
<tr>
<th>Service Level</th>
<th>Additional Visits per month</th>
<th>Additional PTEs</th>
<th>Total Incremental Cost (Salary + Benefits)</th>
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<tbody>
<tr>
<td>Meet therapist recommended frequency</td>
<td>6,691</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>

Everyone agrees people need to move?

Does it take a therapist?

If not then who and how?

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“Culture of Mobility” Vision (January – 2009)

- Standardize therapist approach; consistency among therapists
- 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

Health Care Reform

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“In the middle of difficulty lies opportunity.”
– Albert Einstein

Medicare, Post-Hospital Syndrome, and the Louisiana Purchase

CHAPTER 2

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Identify opportunities to integrate “culture of mobility” concepts with existing hospital initiatives
The Activity and Mobility Promotion Initiative (AMP)

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

Johns Hopkins Readmissions - AMP
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.
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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

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TIMELINE – AMP Project Plan

Why is promoting activity and mobility in the hospital important?

Body Systems:
- Respiratory (hypostatic pneumonia)
- Cardiovascular (orthostatic hypotension, tachycardia)
- Musculoskeletal (atrophy and contractures)
- Integumentary (pressure ulcers)
- Urinary elimination (infection and dilution)
- Bowel elimination (constipation and diarrheal)
- Metabolic (fluid and electrolyte imbalance)
- Psychosocial (depression)
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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


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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.


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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
  - Utilization Department
  - Finance
- Support Staff
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Identify barriers to implementation

- Who is the primary provider to mobilize patients (i.e., role delineation)?
- Minimal documentation of function by MD and RN – 2 unit focused review
- Nurses (29 surveyed) first 2 Medicine Units:
  - 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.


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Nursing beliefs regarding mobility

- Time required
- Ease of admittance
- Believe it was primarily the role of PT

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Barriers to ambulation

- Patients signs and symptoms
  - Weakness, pain, fatigue
- Presence of devices
  - IV’s, catheters
- Concerns about falls
- Not enough staff to assist with out of bed activities
### Slide 70

**JHM Activity and Mobility Attitudes and Belief Survey**

**Sample questions and responses from a nursing unit**

<table>
<thead>
<tr>
<th>Statement/Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are NOT too sick to be mobilized</td>
<td>15/22 (68%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have contact training on how to safely mobilize my patients</td>
<td>16/22 (73%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do have time to mobilize my patients during my shift/week day</td>
<td>1/21 (4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse-to-patient staffing is adequate to mobilize patients on my shift/week day</td>
<td>4/22 (18%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do feel confident in my ability to mobilize my patients</td>
<td>15/22 (68%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing the frequency of mobilizing my patients 30% NOT increase my risk for injury</td>
<td>6/21 (29%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who can be mobilized usually have appropriate physician order</td>
<td>12/22 (55%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My patients are NOT resistant to being mobilized</td>
<td>7/21 (33%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believe that my patients who are mobilized at least three times daily will have better outcomes</td>
<td>20/21 (95%)</td>
<td></td>
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</tbody>
</table>

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### Slide 71

**Overcoming Barriers**

- **Engagement**:
  - Finance – therapist dedicated time to rounds
  - Administrators – Furnishings, resources.
  - Physicians – orders, walk patients or examine at bedside, 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

### Slide 72

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

- Length of Stay
- Readmissions
- Therapist Overutilization
- Fall Rates
- Hospital Acquired Complications
- Nurse and Therapist daily documentation compliance
- Call Bells
- % of patients discharged home
Assess workflow and hardware 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
- Therapist documentation
  - 6-Clicks each visit
  - 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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**Highest Level of Mobility (HLM)**

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

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**Care Coordination Functional Profile**

- Johns Hopkins - Highest Level of Mobility (Nursing)
- AM-PAC 6-Clicks
  - Mobility (PT, Nursing – 8/1/14)
  - ADL (OT, Nursing – 8/1/14)
- Diagnostic Specific Outcome Measure
- EFPT – Medication Management Risk (OT)
- Aspiration Risk (SLP – in process)
- Discharge Recommendation
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The individual patient course

Highest Level Mobility
1- Lying in bed
2 - 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)

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Enhancements to Nursing Documentation

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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
Safely Mobilizing Patients
Medical Team Training

Training Module for Nurses and PCNA's
Standardized for all nursing units
Completed by Physical Therapy staff
Both didactic and lab components

Therapist Delivery of Care Paradigm Shift

<table>
<thead>
<tr>
<th>Expectations</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>
</tr>
<tr>
<td>2. Review materials on readmissions program and rounds coverage (TL/Mgr)</td>
<td></td>
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</tr>
<tr>
<td>3. Review algorithm for provision of co-treatment (TL/Mgr)</td>
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<tr>
<td>4. Review “Discharge Planning for ACS” (CS/TC)</td>
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<tr>
<td>5. Documentation (3 samples) reflects correct leveling for patients</td>
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<tr>
<td>6. Audit (3 samples) reflects completion of activity status forms and calculators</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

- 90 second video intro “Get up and Move”
- Admitting RN scripting
  - Importance of mobility
  - Activity Status and Calendar
  - Patient and Family Choices
- Interactive tablets – provider directed

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!
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

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

In multi-variable regression analysis, patients with a 1 point increase in HLM had:
- Shorter LOS by 0.4 (95% CI 0.2-0.6, p<0.001) days
- Increased odds of discharge to home, OR 1.6, (95% CI 1.3-1.9, p<0.001)
- Fewer hospital costs by $800 (95% CI 200-1400, p=0.01)
- Patients with average 1 point higher HLM have a 10-20% decrease probability of readmission back to the hospital

Encourage creativity and fun

- Posters
- Competition
  - Provider
  - Patient
- Prizes
- Walking Trails
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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

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Take Home Points

• Activity is good, bed rest 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!!!

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Health System Rehabilitation Community
• www.apta.org/HSRC
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What’s happening at NEXT…
- Forward-thinking educational sessions
- Engaging opportunities to network with professional peers
- The prestigious Mary McMillan Lecture

Registration is open!

Questions