Mobility Action Group Feedback Session
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Operator: At this time we are currently waiting for all the participants to arrive, thank you your patience and please continue to hold.

Laura Maynard: Hello everyone and welcome to the Mobility Action Group feedback session. We are very happy to have you with us today and really are looking forward to your ongoing sharing with this group. This is Laura Maynard; I am one of our facilitators today. I will be joined by Isaac Burrows from CMMI.

And let me tell you a little bit about how to participate today. As usual the slides are right there on left-hand side of your screen, closed captioning is available underneath the slides. Above the slides if you see a little raised hand function, if you want to raise your hand, there is a little person; looks like they are waving, you can click on that to raise your hand. Just under the raised hand function you can enlarge the slides by clicking on that little box that has four arrows pointing outward. If you click on that the slides become larger and if you click it again they become smaller. To see video of those that are speaking you click on the Video pod that's just to the right of the slides.

Dial-in information is under that as are the event resources, the slides from today as well as other resources that we will be referencing, are there for your download during the session. Then just underneath that is the Chat pod and we encourage you to use that widely today, to put in your comments, your thoughts, your questions and to converse with one another through chat. So, please use that pod to submit any questions or comments. And if your comments are directed to a specific individual use the (@) symbol so that we will know who that comment or question is directed towards.

Today we are going to cover after these introductions; we will be sharing the results from the feedback survey. You shared with us your feedback through a survey we have pulled that altogether and want to share it back with you a little bit. We will be talking a little bit about some data results, all of you should have received your control charts yesterday, and we will talk through how to use those a little bit. Then we will have some open sharing about what you have accomplished so far, what you have learned, any further questions you have and move on to talking about next steps announcements and reminders for the group.

So, at this time I am really honored to be able to once again introduce Dr. Sharon Inouye. She has been one of the true thought leaders behind this group, she is our mastermind so to speak and has been so valuable in the development and movement forward of this Mobility Action Group. So we are very grateful to her and her leadership in this and at this time I will turn things over to Sharon.

Dr. Sharon Inouye: Well, thank you Laura and thank you to all of you on the call. I am really delighted to be here for our feedback sessions. I was a little wistful this morning, since you know I missed you all. And I want to thank you and introduce the wonderful faculty who have been participating in this, and who have made it so incredible. Cynthia Brown is on the call today, Professor and Director of the Division of Gerontology, Geriatrics and Palliative Care in the Comprehensive Center for Healthy Aging at the University of Alabama in Birmingham, thank you

Cynthia. Susan Heisey is here, who is the Program Manager of the Hospital Elder Life Program at Inova Fairfax Hospital, thank you so much Susan.

Laura Maynard: Sharon, I am sorry to interrupt we can't hear your audio, your audio is cutout.

Dr. Sharon Inouye: Is it any better?

Laura Maynard: Yes, now you are back, thank you.

Dr. Sharon Inouye: Yes, is it any better?

Laura Maynard: Yes, now we can hear you.

Dr. Sharon Inouye: I am sorry, so did you, did I leave off at Heidi Wierman?

Laura Maynard: Actually you had said, introduced Susan and then it cut out after that.

Dr. Sharon Inouye: Okay. So I am introducing Fred Rubin, who is the Chief of Medicine at UPMC's Presbyterian Shadyside Hospital and Professor of Medicine at the University of Pittsburgh and Dr. Heidi Wierman, who is the Medical Director of Geriatric Programs at Maine Medical Center and an Assistant Clinical Professor at Tufts University. So, thank you to our incredible faculty. Thank you all, sorry about my audio.

Laura Maynard: Thank you so much, no problem at all. And let's see we will move on to, sharing some of those feedback results. So, I want to start and run briefly through the results of the survey that you have taken. You may recall that we sent a survey out. We sent this to 408 people and got 43 total responses. We sent it to everyone who had ever expressed interest in the Mobility Action Group. But those of you that have been active in the group tend to be the ones who have responded to that survey. We had it open for a couple of weeks and we have done some analysis on it. We tried to aggregate those results up to the organization level, huh, but there were a few questions that we left at the individual level rather than that. The participants who responded to the survey, 81% represented CJR participants, 17% were from BPCI Awardees and 2% were from both.

So, initially we had asked prior to joining the Action Group, participant mobility programs, what level was your program? Where were you? And the majority of you were at really different stages of implementation as you can see here ranging from about 31% that hadn't really begun thinking about mobility yet, all the way up to 30% there is 33%, nearly the same number that had a mobility program already in place. And again nearly the same number that were in the early planning stages so, pretty evenly distributed at levels of implementation at the beginning.

At the time of the survey the majority of the mobility programs were considered to be pretty fully implemented but that's not a very large majority. 43% of respondents as compared to 33% who were testing parts but had not fully implemented and then a 24% group that had not implemented at this time.

About a third of the organizations thought that this Action Group was very helpful and you can see the results shown there, the range. But the majority of the people felt that the webinars, the

written materials and the opportunity to share with one another that this is something that you found to be extremely helpful and others found it somewhat helpful. Many of you believed that the Action Group was very helpful and made comments about that. We will not read all those but you can see those on the slides and see what your peers have shared; these are also available in the Event Resources pod when you look at the slides. You can see these comments of the different parts of the sessions that people felt were particularly helpful.

Interestingly, the majority of organizations believed that it's highly likely that their mobility program will continue and will move on forward. So, 54% indicated that it's highly likely that their program will continue. And there were some responses to believing that the ongoing group chat meetings, the data and resource sharing, all of these things could help with maintaining your programs over time. So when we asked, what's going to help you enhance mobility overall, overtime, chat, meetings, data sharing with one another and continuing to track things overtime.

We asked about the pacing because we were concerned as to whether this timing and having these meetings at the regularity that we did, whether this was useful for you or whether something else would have been better. And the majority felt that the timing was just right, with a few who felt that it moved a little too quickly. Same with frequency of the meetings seemed to be a pretty good fit for most of the people who participated.

We were concerned about the data collection tools and wanted some real feedback from you on that. And most of you felt that the tools were helpful overall but some felt that collecting the data was a bit time-consuming and some struggled with different components of capturing that data and tracking it.

We asked about barriers and interestingly about one-third of the participants did not experience any barriers to the Action Group. Other barriers were pretty evenly distributed including things like dates and times or feeling that the organization was more advanced or less advanced than the rest of the group, these were some of the things that were indicated as barriers but about a third of you didn't experience any barriers. And about two thirds of the organizations that responded to the survey felt that the data sharing tools were helpful.

Of those of you that did complete the data sharing tools, about half of you found them somewhat challenging, and about half didn't find them challenging at all, which is about to be, is about what we would have expected to see from that, but just interesting to see that about half of you found them somewhat challenging to use and other half did not find them so. We will be working with adjusting these tools going forward; you will hear more a little later on in this session about updating the change package, updating the tools that are available. So your feedback that you give us through this survey and in all the other ways that you shared feedback is really useful. And we will be turning that back around in terms of tools, tips and suggestions that you can continue to use going forward.

While we are talking about data and feedback and suggestions, we wanted to share a little more about the data that we shared back with you, those control charts that we sent out. So, we are going to open it up now for some discussion on that and we are going to unmute all of the phone lines for all of the participants. So if you are not speaking, please mute your own line on your end, otherwise you will be muted, please don't put us on hold, it will be lovely music but it will be distracting. You can also use the Chat pod if you would rather put your discussion points in that

way, no need to raise your hand if you want to speak just unmute your line, and speak right up. We want this to be a pretty open discussion. And we are going to frame this part of the discussion around the control charts and talk just a little bit about what are these control charts and how do we put them together so you have some context for it.

The method: we found the mean for each hospital, on each data point, we calculated the standard deviation for the data, the lower boundary line, that bottom control line, that's 3% low or 3% standard deviation, lower 3 standard deviation points lower, the other is 3 point higher. And within that is your range, up and down above your mean. So that's what we did with that and what we were hoping is that you could see rather than aggregate data, how to use your own data in a way that might be helpful, how to hone in on points where there is a lot of fluctuation, lot of difference from one week to another. Or where there is a trend up or down. When you have all those fluctuations to look at, well, what was going on at that point in time, what was different from one week to another that might have accounted for those differences.

Another possible uses to identify a meaningful up or down trend. One week or two up and down isn't really a trend, but if you have got a sustained trend either up or down that might indicate some really good process or a bit of back tracking that you would then want to look at what was happening programmatically, that might account for that and that you might be able to address.

Isaac Burrows: Yeah, that's right Laura, I think these types of charts are, folks are probably pretty familiar with them, inevitably your hospital safety office or risk management etc., they are probably many, many of these things, kind of floating around. And so you probably are used to seeing this, these types of things all the time but again we are just highlighting different ways that you can sort of use these quality improvement tools going forward and so we want to highlight some of that, kind of how, what that means to folks in particular.

Laura Maynard: Right. So I wanted to show one example and hear the story behind the example. Because each one of these charts tells a story of the unit in which this occurred. So, this is from UPMC Presbyterian Shadyside, and I am going to ask if Susan Killmeyer would be willing to speak just a little bit about explaining this chart, how this happened, what's going on, what you learned and what you can do with this type of information.

Susan Killmeyer: Hi, how are you. So this is a unit, it's a medical unit and this is 4 South. And it's a small unit, it's only 13 beds. And the unit itself, it is actually a nice way to setup units, only 13 beds and it's L-shaped. And so geographically the nursing station is set up, kind of like in the middle of that 'L'. And so there are actually three beds that have direct sides into those rooms. And so they use those three beds for the patients that are more difficult and have more medical needs. And so they place them so they are the closest to the nurse's station.

And on this particular chart that you are seeing as you can see we went well week after week, we do not use any alarms and then we had this big blip. And so this was really only one patient and this patient was a medical patient that had very poor impulse control. He would try to get on the bed on his own so they did use the bed alarm for this gentleman as that was the chair alarm when they got him up. When he was up, he would try to get up on his own so that's why they used the chair alarm for him as well. He was on the bed with system one, he could not get up his own very unsteady on his feet. So he was right there at the nurse's station, they did keep him there, but

even though he was near the nurse's station, they still felt that then needed, for safety reasons use the bed alarm and a chair alarm for him.

This unit typically does have very heavy medical patients. They try their best not to use the alarms if they don't have too or any restraints at all. We are really trying to get away from the use of any restraint, we seldom ever use a restraint. But we did pretty well here and then we had this one patient. So we wished that most of our units could be set up geographically, the way this unit is set up it's actually a newer unit. But unfortunately, we, or at older hospitals the way we are geographically set up so we just can't you know change the way how the units are laid out so if we could, I think it's an ideal way to set the unit with having the nurse's station, right there so that they can view more, more rooms have direct line of sight. Questions.

Laura Maynard: Yes. Thank you for sharing that, I would ask, I mean I think that's very clear and I think that's common for units that are doing really well with something, but you will have a patient that has a particular need. And when you are dealing with small numbers it will make your chart look like this and it's helpful just to see and hear that.

Susan Killlmeyer: Great.

Laura Maynard: Yeah, anyone else on the call have a similar situation where you have been trending along fine with pieces of your mobility program and then one or two patients had particular needs that may be made your data look different. Have others had that experience as well?

Barbara Yuhas: Hi Laura, its Barbara Yuhas --.

Laura Maynard: Wonderful.

Barbara Yuhas: Not so much that our particular patient, but the census of our patient. So our census tends to go up and down. So when you look at some of our charts, we are seeing that the amount of patients that could belong to the program, just they go up and you know it's a scattered chart there. When you look at our use of the fall alarms, the bed-exit alarms, we are actually trending down on it which I was very pleased to see. And when I plotted it against the actual amount of walks per day, there actually seems, you know you could see the walks were going up and you know towards the end the chair alarms were going down, it was really a nice segue into our mobility program.

Laura Maynard: Wonderful, thank you. Thanks for sharing that. Want to move to the next chart just for another example. This one has to do with average walks per patient. And this chart is for St. Peter's University Hospital, wondering if either Jacqueline Ciccarelli or sorry I lost her name, Patricia, either of you are on the line and would be willing to speak to this one.

Jacqueline Ciccarelli: Yes hi this is Jacqueline Ciccarelli from St. Peters, we have had anyway, going along pretty steady with our number of walks per patient. And then we had a little, little dip, a decline in one of our weeks, week nine in particular. We found that when we would do a retrospective review and look back on it, two of the, we had a couple of patients that week, we had two patients with hyperensive issues, we also had two patients refused to be walked, and that kind of puts us in-between rock and a hard place with ambulating them. So one of our

patients who had low blood pressure needed to be transfused. So those four different patients resulted in us having low performance for that week. But we do have a really pretty robust program, we even have our volunteers trained to ambulate patients so that's helping to allow for the nurses to ambulate our CJR patients and our nursing assistance to ambulate our CJR patients that's where our volunteers are filling in the gaps on the unit. So they have a nice system up there in the orthopedic unit.

So you know we like the idea of ambulating our patients at least three times a day. The only other thing we did see, is on the day of discharge, a lot of times you will see the patients go home around noon time and they don't get the three walks in. So we are having a little bit of a concern over that too, getting their walks in. Thank you.

Laura Maynard: Thank you, thanks for sharing that.

Isaac Burrows: Yeah, and I see that Dr. Inouye actually posed, Sharon posed this question the same as I would have, I was thinking the same thing, sort of what are folks doing, you know how do you address when a patient refuses you know to get up and walk. And we have all sort of we have all experienced that, but I am curious as to what sort of different folk strategies are, some of this and I am assuming we are going to leverage some nursing strategies here, in terms of getting patients engaged, but I am curious what other folks have to say, again the folks but lines are unmuted so feel free to jump in with your thoughts on this.

Paul Krull: This is Paul Krull in Portland, Oregon at Adventist Medical Center. I, we have a nursing strategies certainly but I would say that one of the things that we work on really a lot, is the fact that we set expectations with our patients, particularly with our elective patients, obviously you know your fractures you don't have that same level of control, but we really work with them to help them understand the expectation that they are going to have to be mobile, that they have to be part of their own healing process and that you know by doing that they can help themselves. We have them, we have an agreement, you could call it where we talk about the things that we are going to do for them. And what are the things they are going to do in terms of helping themselves through the process. So we have engaged them earlier in the process, so that they understand that this is part of the process when they actually are post-operative. So that's one of the things we have done.

Laura Maynard: Excellent, thank you, thanks for sharing that. I know there has been some real interest in that idea of a patient agreement, a sort of a patient compact that they would sign. That's a good way to make the expectations very clear and to realize that they are somewhat accountable as well. I wonder if others have suggestions of how you handle it when a patient refuses the mobility. Anybody have a different suggestion, I can see people typing into chat, but I haven't seen the responses come through yet. Yeah, Julia good point, to educate patients on why this matters, why is this so important, it's a good, a refusal can be a great opportunity for education.

Yeah some great comments coming through into chat, that's good conversation. Let's raise that up a little bit, the struggle of counting walks per day. And I am going to move to the next slide which is an example of walks per day. When admission times are all over the place, sometimes late afternoon and the health condition on the day of admission might contraindicate mobility, rural counties, car ride home could be 45 minutes or more and exhausting so you don't put a lot

of activity, a lot of individual patient needs that come into the mix. So a lot of good points, Allison would you I don't know if your line is available to be unmuted, would you be willing to speak to some of those, ask some specific questions about that?

Allison Orofino: Yeah, I just, can you hear me?

Laura Maynard: Yes.

Allison Orofino: Okay, I just I found it hard to try to count the walks on day of admission and discharge because they really pull the results down in general, because of those kind of things. I mean people who come in with shortness of breath or DVT for instance they don't want you in there walking their patients quite yet till they are stabilized. And then like I said our county is pretty rural and when people get home sometimes they have to walk over uneven surfaces, gravel, driveways, long driveways. And so we aren't really aggressive on mobilizing on day of discharge, I mean once may be in the morning, but then we kind of let them just get ready to go.

Isaac Burrows: Yeah, I think that makes sense. I think one thing that's a great point Allison I think for the purposes of this group, we sort of, we made it pretty simple in terms of how we would collect the data and sort of the actual measure itself. We kind of simplify that but you are actually right, I think, yeah and I see Dr. Inouye, bringing some guys in here, down here as well. I think its right, I think you all should do what works for your program and what works out you know whether that be you know accounting for partial days or day of emission discharge etc. might make more sense. I think it's important for you all in your individual mobility programs to do what works for you, and sort of and track it and make meaningful progress, make improvement in your own way for each of your sites.

Laura Maynard: Thank you. Does anyone else in looking at your control charts, and considering how they look similar or different to the ones that we are highlighting today. Do you have questions or comments or things that you have learned from us? I know Barbara mentioned having compared a couple of the charts to one another to see how the story fits together.

Dr. Sharon Inouye: So this is Sharon, can I add a comment here? I just wanted to say that we are hoping that the use of these flow charts and you know showing you your data and kind of the stories that they tell. We are hoping that you will use these really to track your own progress and to feedback to your site, and find way to improve your program, you know whether there is opportunities for retraining staff or may be thinking of other ways to engage patients, re-education and so forth. That's what I hope that we are modeling here and trying to show you some of the stories and some of the messages that we get from them.

Laura Maynard: Wonderful. We also had some other discussion questions that we wanted to open up for everyone to feel comfortable, just sharing about, particularly in terms of what have you accomplished in the last couple of months, and what have you learned from that. And any questions you might have for your peers that are in this group or strategies and tools you can share. This being our last kind of regular session together as we give you this feedback, this is your opportunity to ask each other questions. So feel free to put that out there and as far as what you have accomplished, I am already seeing in chat where Hazen has typed in, they have seen a decrease in the use of bed and chair alarms and an increase in overall number of walks in their unit. So a nice combination of good outcomes that have happened. Anyone that's on the phone

willing to talk about some accomplishments you have had over the last couple of months and/or things that you have learnt?

Barbara Yuhas: Laura, it's Barbara Yuhas, I believe that most of us have learned in my team that it is a team effort, it's not just one person, it's not just one specialty that is focusing in on the patient but it's bringing in the team the physicians, the nurses, physical therapy anybody, even the family to really encourage our patients to get up to be mobile, to really benefit them going back home and setting a goal for them you know letting them know that what's their goal, what's their purpose, where do they want to see themselves post discharged, do they see themselves in an acute rehab or do they see themselves going home with assistance at home. And that's really our goal is to get them back home.

Laura Maynard: Great point, thank you.

Susan Heisey: Here at Inova, this is Susan Heisey, we have used the family brochure that has been very helpful in engaging families to support their loved ones, while they are in the hospital. And that opens up the discussion that includes the patient who can also, be an active part of their recovery also.

Laura Maynard: Great, thank you. Anyone else?

Susan Heisey: This is Susan again, one of the things that we noticed as we are moving forward with our mobility program, is that we are seeing definitely an increase in patients being mobilized and also increase the steps. What we found is that they seem to sometimes not always go from the 6 to 7. And it seems like what we are noticing is that it's may be due to lack of staffing sometimes, where patients aren't always walked quite as often. So it's something that we are beginning to address now in the program.

Laura Maynard: Right, thank you. Just wondering too, I know we have Paul from Adventist on the line, and you had shared a little bit earlier. But I know that your program is pretty fully developed, your mobility program is pretty far along. And as you can see here many of these folks are either in beginning stages or just moving at intermediate stages with their mobility programs. Would you be able to share some tips or suggestions for them in terms of maintaining a mobility program, keeping it going over the longer haul since you all have been able to do that at Adventist?

Paul Krull: Sure, we have, really focused in making sure that our OT and PT in-patient teams are heavily involved in the process. We have two classes that we offer each day that the patients attend, and they have to navigate there obviously with assistance. And making sure that that they are able to get there, they bring their chair with them, and or we bring their chair with them, I should say. And that doesn't count the additional walks that they take on their own, with either family members that we have worked with or with PT or an OT. So, we really make certain that within a few hours of them, of the patient getting on the floor that we have got them mobilizing. Our goal is, a number of steps before they discharge and in many cases they get two or three four or five times the goals that we have.

I think something that's really important as your program progresses is that mobility is about individualization, for the patients you know you might have a wide ranging set of patients and

needs. And so making certain that you are setting the goals individually for them, I think that's really what makes the program successful and making certain that the patient understands that, as well as the family members.

We have been able to be very successful with techniques like that. And just simply making certain that the patient understands from the very beginning that mobilization is their expectation, they may not have been able to do it, prior to the surgery, but that's where we are going and we are going to make our way through that. And that they may have pain currently but that is more joint pain specifically and the pain they are going to have later is going to be more surgical pain perhaps. And so that they need to work their way through it and it's different pain and that it will go away. So just kind of really setting the expectations upfront, I think those are key elements.

Laura Maynard: Thank you. Thanks so much for sharing that, that's really, really significant. And I do see continuing chat happening, people are continuing to converse with one another. As they do that we are also going to begin to shift now. Please continue chatting into the comments. And if you have questions or comments as we go forward and begin to talk about the change package, please feel free to go ahead and type those comments on in. But at this point we are going to begin talking just a little bit about some updates that we are making and what you can look forward to, in the change package. So I will turn it over to Isaac for that.

Isaac Burrows: Yeah, thanks Laura. So as you know, as part of this group we sort of started out and early on we provided you all with this change package and toolkit of what we thought were things that would be useful for you, for you all as you kind of went through this work. And as we have kind of gone through the process over this past summer of you all sharing, a lot of people providing additional resources and thoughts and ideas, we have really taken the opportunity to then really take your feedback, and incorporate, and updated the revised change package. That we are still actively working on, to be quite honest.

So we think we will have it ready to go out in a few weeks, but, we wanted to highlight a couple of things that we, couple of big things that we think that will be useful going forward. And we think this will be resource for you in the future as well as we plan on highlighting this broadly, even outside of this group and outside of CMS. So if we can go to the next slide.

One highlight here again and it's sort of it, this is where we changing slightly that the table of contents here. I think that what you will see is that there is actually a mobility of roadmap, and we can go to the next slide. So we made an attempt in that if you all remember back in the change package, there was a framework that we think have changed concepts and changed tactics that we think are useful as you are standing on mobility program. And what we are try to do is in conjunction with that, create a sort of sequencing of what we think based-off of your feedback, is the process for standing this up.

Now you will notice that this roadmap so to speak is in a circle, most roads don't go in the circle, although I do get stuck in roundabouts. But the idea here of being in the circle, is that you would continue to iterate down this, correct, you would potentially launch this and in one unit, then you would move on to another unit or you will try to provide the units and you test this on etc. And so this is sort of iterative quality improvement, kind of way doing this. And with that, I am going to actually pass it over to Sharon to talk about some of the toolkit aspects as well.

Dr. Sharon Inouye: Great. Can you hear me okay? Yes?

Isaac Burrows: Yes.

Dr. Sharon Inouye: Okay. I am sorry about my audio today. So, and thank you again Isaac, and we are working very hard right now to update the toolkit and incorporate the very important resources that you all have shared with us. They are going to make this so much stronger. And if you remember the earlier toolkit it had a lot of blanks in it and we are trying to fill in a lot of those blanks for you. Here is the table of contents for our new toolkit. This is going to change slightly moving forward as we continue to add more things, but we wanted to show you this to give you an idea.

So they are going to be protocols from the Hospital Elder Life Program, all pertinent to mobility, including some adaptions that have been shared from the site. We are also going to have a much more robust resource for various types of mobility assessments, including starting from very low-levels of mobility, all the way up to very high-levels of mobility, to help you with just those and target people for their appropriate mobility levels.

In addition, there is additional process and outcome with measures. Most of those you have already seen from the course your measurement stirring this Action Group. We are going to bolster this with some additional references, those are not yet on here, including the purposeful or intentional grounding that is being done at some sites, as they follow prevention strategy to be used in lieu of bed and chair alarms that will be added in here. There are patient targeted materials such as examples the patient and family brochures, that the sites have shared, patient flyers, patient goal sign, etc. that might be helpful or give you ideas for materials to be used at your site, even posters that you might be able to use on your floors. And then there will be spotlights from the sites who have agreed to share their knowledge and information with you in response to targeted questions and surveys.

So please continue to share, we would love to incorporate your materials into the toolkit. This version of the toolkit will only be shared with the participants in this Action Group and so that everything that you share will be shared within the group. We are developing a publically facing version of this toolkit that will be completely de-identified. And so there will be no materials that will identify sites or individuals that eventually we hope to share with the public, that will be much further down the line, but it's a way that we are hoping this Mobility Action Group will continue to have impact and help patients in the hospital, and you know really embody the contributions that this important group has made because you are now all faculty, in this initiative. And we are hoping that you know many hospitals can go on and learn from what you have done and what you shared. So thank you so much and this again as Isaac said, we are hoping to complete in the next few weeks to share out with all of you. So please pay attention to your e-mail and to the ILS Connect site because everything will be posted there.

Isaac Burrows: Yeah, great.

Dr. Sharon Inouye: Thank you.

Isaac Burrows: Thanks Sharon. And we want to pause here for a quick discussion, if folks have any sort of, I want to make sure we get time because and get your feedback on the change

package in and of itself. If there are things, what would you add, again the phone lines that are unmuted, what would you add, if there are things that you feel like that were most helpful, you know what would you be willing to provide to the groups, is there anything else that you have, you know especially, I think one of the things we were looking for especially if you have sort of a mobility tech aide kind of job description I think that was one thing that the group is looking for, if someone has that and we would be willing to share that or an agreement that we mentioned earlier, I think it was Paul that talked about having that sort of, that patient agreement, if anyone is willing to share those types of things that will be great.

Paul Krull: This is Paul. I am happy to share the agreement.

Isaac Burrows: Oh great. Thanks Paul. Anyone else? Any feedback on the toolkit, the change package, the conceptual framework for this work?

Laura Maynard: I was wondering if anybody had a job description for a mobility technician or a mobility aide that they could share. I know several of you are using that role and that I think that might be something very helpful for the group.

Susan Killmeyer: Hi, this is Susan from Shadyside, UPMC.

Isaac Burrows: Hey go ahead.

Susan Killmeyer: Hi, we used the mobility aide, sometimes we have three, and we have had them for several years. And they start you know one is on one side of hospital and one is on the other side of the hospital and they start early in the morning around 7 o'clock. And they just start trying to get people up for meals, and they go from one unit to the next, then they engage the other PCPs or the nursing assistants on the unit. And then once people are up for meals and they start their regular walks with patients.

Dr. Sharon Inouye: Hey Susan, do you have a job description for that role or could you get one for us?

Susan Killmeyer: We really don't have a job description. It's more or less what they also do in between that, you know they do regular PCP work if the patient would need to be cleaned up or you know anything that a regular PCP would do, that would jump right ahead it and do that. But you know I can just basically talk to you off-line about you know what they actually do. We never really wrote a job description for them, I guess it's something we should probably think about. But they actually, I am telling you what, they absolutely love what they do. And when you talk to them they talk with so much passion about how good they feel when they leave here every single day knowing that they did something that really mattered for patients.

If they, I mean they never call off, they never take a sick day, patients asks for them by name, you know they will say, the gentleman's name or Jane and Louis and they will say, is Louis here today? I am waiting for him to come and walk me, I don't want to walk with anybody else, I am waiting for him for my walk. I mean that's pretty amazing what these two guys these two guys have done.

Occasionally we have somebody else that can also fill in that position, with our census is higher and they take one day off during the week and then you know they kind of rotate the weekends.

And so we are actually trying to look to see if we can get somebody to work on the weekends, on the odd shift because we know that you know our physical therapy department, we don't have enough you know therapist, we only have so many FTEs, and that's one area we think that we could lease up our PCPs that help add with walks during the weekend time. So we are looking at adding them possibly on the weekends, on the evening shifts. So we know that that is a possible need and we are looking and doing that as well.

Isaac Burrows: That's great.

Dr. Sharon Inouye: Fantastic. Thank you for sharing that Susan.

Isaac Burrows: Yeah, absolutely. Did want to jump on, and while we are, or sort of getting information on this. And just kind of let you know that we are developing a contact list for everyone who is kind of been actively participating in the group. We want you all that going forward as we think about how we are going to move forward, we want you to have the ability to continue to chat with each other outside of this, and collaborate, and share ideas, even though that the official initiative, is per say, you know coming to a close, this work will continue and you all sort of have the ability to sort of utilize each other as resource.

So if you don't want your contact info, as part of this group, and we are talking about e-mail address, we are not talking about phone numbers. If you want to opt out, please send an email to mobility@lewin.com. My sense is most people will not want to opt out, but if you do want to opt out, by all means you have the ability and we will compile the list of folk's contact info and we will send it around. Again, just happy to see you all have that resource going forward.

We are obviously not, we are not to shut down the ILS Connect site, you still have the ability to login and go on and post and that kind of stuff as well. But as an additional resource, we wanted you all to have kind of each other's contact info. And with that, I think we can move on, Dr. Inouye, I think Sharon you have some sort of kind of thoughts on some next steps.

Dr. Sharon Inouye: Great, can you hear me?

Isaac Burrows: Yes.

Dr. Sharon Inouye: Okay terrific. So I just wanted to close with just telling everyone how heartened I am to see what we all have been to accomplish together and just to express my gratitude to the incredible site, and to the faculty, and to our CMMI team. I think all of the programs have advanced and many programs are fully implemented and functioning successfully now. I did want to call your attention that our Mobility Action Group, which featured in the Wall Street Journal article for those of you who may not know, and the link is right here on your screen next to Event Resources, there is one called Weblinks. And if you scroll down there you will see the Wall Street Journal article, where they mentioned our Mobility Action Group. So we are so excited that, to let you know we have made into the national news. It is the big thing we are doing, it is a big deal we really are you know changing care at the bedside.

But I think we all know we still have ways to go and this is the process of continuous improvement, to get all the programs fully implemented, to continue so that all the sites can reach their goals, and to spread it so more hospitals have programs like this. So it's extremely important to sustain

your work that you started and please don't lose your momentum. And we want to offer you some strategies to help keep this going. So, please continue to share with each other. We would encourage you not to opt out of the contact list. But of course you can opt out if you would like. But if you do share, you will have that information and please stay in touch with each other. You can communicate certainly via email and phone. We also have the ILS Connect site that will remain active.

Another way you can gain support is through the Hospital Elder Life Program or HELP. And you received an email this week about how to join in and how to register for that program. You can join the Google group there which is very active. Many of the faculty on this initiative are members of the HELP program and so they would be there and available to help you, so please sign up and register, it is free of charge if you are interested.

As you know the new toolkit will be available in just a few weeks, and that will have new resources to help you. We also wanted to thank you for sharing your learning and for helping us, think about other ways to continue to disseminate the work.

And so just in closing, it's been such an honor and pleasure to work with all of you. It's just been so inspirational, all of you striving to improve healthcare at your sites, improve quality of life for your patients and really also to be involved in the initiative, which we hope we can turn into something that will be lasting and that will have a broader impact on the field through the toolkit, through your efforts of continuing to disseminate it, and spread the word at your sites, and at other sites. And we hope you will do that, continue to spread the word of what you have done, and what the Action Group has done, and sharing your learnings.

So please keep it going. You have really shined a light on your corner of the world. And we hope to keep that light spreading to illuminate our healthcare in our country and throughout the world. So, thank you so much for what you have done. We are just starting so this is the starting point so keep going. Thank you so, so much.

Isaac Burrows: Great. Thanks Sharon. Just as, and to really kind of leverage the work that you all have been doing, we are actually working on a much wider, broader event, to kind of highlight the work that of this group, of what folks are doing. Again, we were planning this event to encompass, sort of all CMMI models. So we have very large audience, and again highlighting the work that you all have done and using what you have done as a platform to kind of even, to spread this work even further.

So more to come on this, we have a possibility of a webinar upcoming, we don't have official details to share, sorry, but we are working on it. And once we do, we will stay tune, we will make sure that you get that information out. And with that, I am actually going to turn it back over to Laura for the final steps.

Laura Maynard: Thank you. So just a few quick announcements and reminders, please do take a few minutes to respond to the post-event survey that's going to be popping up for you, and that will also be emailed to you. It's not too late to submit your September data; if you are interested in doing that we will receive it at any point. The date was September 25th, but even at this point if you have additional data that you would like to share, and have included in the mix. We will be glad to include it for you. And if you have any questions about any of this, the mobility mailbox

will remain open and available. So please send any questions or comments to mobility@lewin.com. Thank you all very much for your participation and thanks for sharing in this session today.