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# Mobility Action Group

## *Kickoff Event*

***April 27, 2017***
***12:00-1:00 pm EDT***

Audio available by call-back feature
*OR* by dialing (763)957-6300
Meeting ID: 647 583 166#

# Welcome

**Isaac Burrows, MPH**
Learning and Diffusion Group
Center for Medicare & Medicaid Innovation

**Laura Maynard, M.Div.**
CJR Learning System Team
The Lewin Group

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# Meeting Logistics & Norms

- All participant telephone lines are muted.
- We encourage comments and reactions via Chat and Q&A.
  - Submit any technical, webinar-related questions using Q&A.
  - Submit questions, comments or general feedback using Chat.
- Participate!
  - Chat
  - Polls
  - Post-Event Survey

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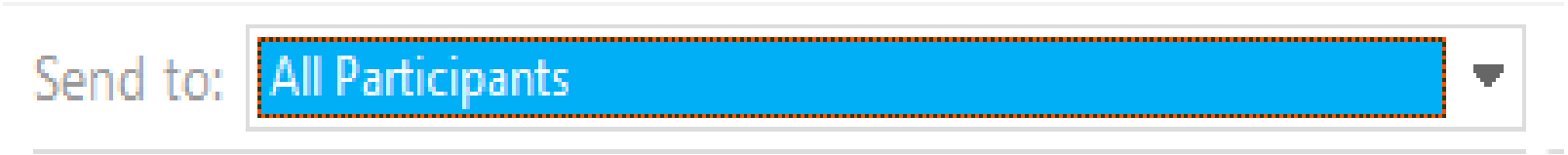
# Reminders & Resources Available

- Closed Captioning is Available – Click Here or on the link posted in Chat (may need to enter name and organization)
- Chat to "All Participants"
  - If you are experiencing technical issues, submit a question using Q&A and someone will assist you

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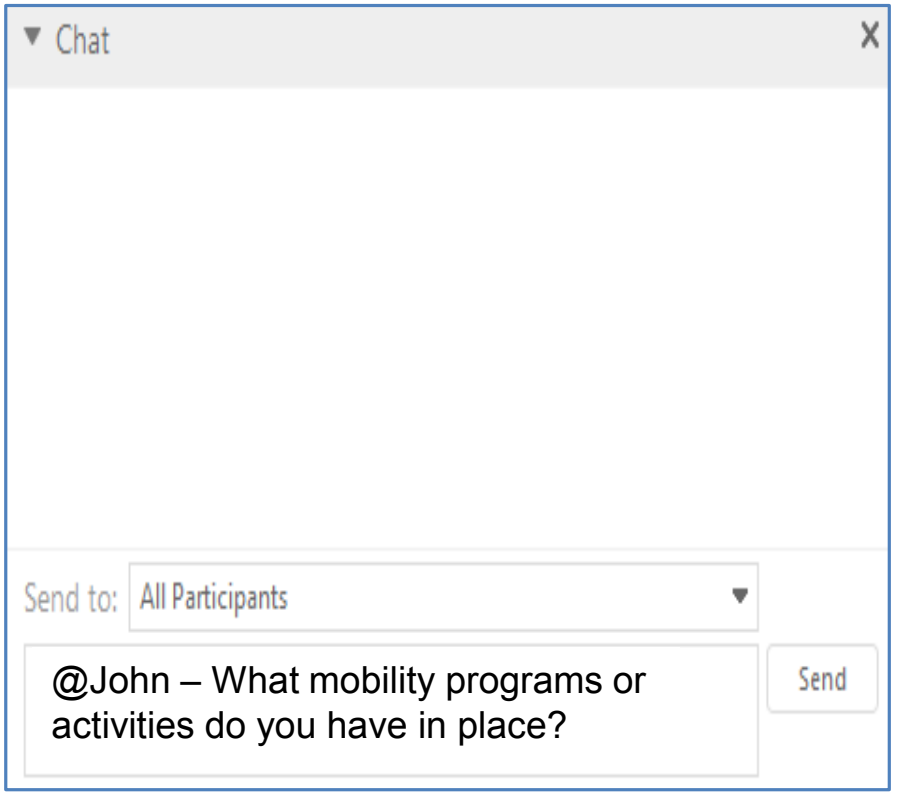
# Let's Test Out Group Chat

Please share in Chat now:

- Organization
- What you hope to learn about programs to promote early mobility

When asking/responding to a specific person, use "@" to help keep conversations clear!

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# Agenda

- Welcome & Logistics
- Overview of Mobility Action Group
- Overview of Clinical Framework
- Faculty Sharing Session
- Q&A
- Overview of Action Group Logistics and Measures
- Q&A
- Commitment to Action
- Announcements & Reminders

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# CMMI Mobility Initiative

- To improve function and reduce complications through enhanced mobilization of medical and surgical patients during the acute care portion of an episode of care.
- The Mobility Action Group, which targets BPCI Awardees and CJR participant hospitals, is one component of the CMMI Mobility Initiative.

# Mobility Action Group Goals

- Test or implement strategies for increasing early mobility
- Improve early mobility for patients, thereby improving quality of care and lowering costs
- Identify and leverage BPCI and CJR promising practices in early mobility, to inform the Mobility Initiative Clinical Framework

# CMMI Mobility Initiative Clinical Framework

**Strategies:**

1. Provide early mobilization with safe approaches for patients and staff
2. Assess and enhance function and mobility, and create a culture of mobility
3. Minimize immobilizing devices

# Mobility Action Group Charter and Change Package

## Contents


**Background and Rationale** ..... **3**

**Purpose** ..... **3**

**The Offer** ..... **3**

**The Commitment** ..... **6**

*Attend each Mobility Action Group session* ..... *6*

*Actively participate in Mobility Action Group discussions* ..... *6*

*Share Progress and Outcomes Associated with Your Participation in the Mobility Action Group* ..... *7*

**Next Steps** ..... **9**

**Appendix A: Increasing Mobility in Acute Care Bibliography** ..... **10**

*General Background for the CMMI Mobility Initiative:* ..... *10*

*Background on Immobility--Its Frequency and Complications:* ..... *10*

*Costs Associated with Complications of Immobility:* ..... *11*

*Examples of Successful Hospital Mobility Programs:* ..... *11*

# Faculty

Dr. Sharon Inouye, MD, MPH

Harvard Medical School, Beth Israel Deaconess Medical Center and Hebrew SeniorLife

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# The Tension Between Promoting Mobility and Preventing Falls in the Hospital

April 24, 2017

## The Tension Between Promoting Mobility and Preventing Falls in the Hospital

Matthew E. Growdon, MD, MPH[1,2]; Ronald I. Shorr, MD, MS[3]; Sharon K. Inouye, MD, MPH[4,5]

» Author Affiliations

*JAMA Intern Med.* Published online April 24, 2017.
doi:10.1001/jamainternmed.2017.0840

When older adults are hospitalized, there is an inherent tension between preventing falls and promoting mobility. In response to public and professional attention to medical errors, federal policy and, in turn, hospital culture have strongly prioritized preventing falls, with potential unintended consequences for patient mobility, functional ability, and well-being.[1] It has been known for years, however, that patient immobility in the hospital contributes to undesirable outcomes, such as increased rates of functional decline and institutionalization.

http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2621835

# CMMI Mobility Initiative Clinical Framework

| Strategy | Change Concept | Tactics |
|---|---|---|
| 1. Provide early mobilization with safe approaches for patients and staff | Train all staff in safe mobility | Training and demonstrations in safe mobility and body mechanics for nurses, aides, sitters, PT techs, volunteers, 'ambulators' |
| | | Reward/recognize front-line staff for new ideas in how to mobilize patients |
| | | Train family members in safe mobility |
| | Have appropriate assistive devices for every patient | Gait belts in every room |
| | | Walkers, canes, crutches available centrally—easy and reliable 24-hour access |
| | | Glasses, hearing aids, appropriate footwear as needed |
| | Transition Falls Team to Mobility Team | Pair mobility along with falls as critical outcomes |
| | | Always consider maintaining mobility in all corrective actions for fall prevention |
| | | Generate unit-specific (and eventually hospital-wide) reports on mobility rates and falls (with and without injury) rates |

# CMMI Mobility Initiative Clinical Framework (cont.)

| Strategy | Change Concepts | Tactics |
|---|---|---|
| 2. Assess and enhance function and mobility, and create a culture of mobility | Assess function and mobility on admission and discharge | Standardize nursing mobility assessment on admission and discharge |
| | | Functional status assessment on admission and discharge |
| | | Assess for any evidence of acute mental status change |
| | Include mobilization plan in every patient's Care Plan | Set baseline ambulation goal, with target of 3 times a day |
| | | Limit referrals to Physical Therapy (for mobility) |
| | | Identify primary staff responsibility for mobilization |
| | Regular mobility/ambulation (with assistance as needed) | Justify all bedrest orders, and the default should be ambulation |
| | | Provide specific activity order, e.g., "ambulate with assistance, 1 lap of unit TID" |
| | | Record mobility daily, e.g., whiteboard, patient flow chart, EHR |

# CMMI Mobility Initiative Clinical Framework (cont.)

| Strategy | Change Concepts | Tactics |
|---|---|---|
| 3. Minimize immobilizing devices | Eliminate bed and chair alarms | Develop system on floor for purposeful hourly rounding (RNs and CNAs) and rapid response to call-bells |
| | | Remove bed/chair alarms from fall protocols and standing order sets |
| | | Measure usage of bed/chair alarms on floor(s ) |
| | Daily 'Patient Mobility' Scan to identify mobility barriers | Identify and reduce all tethers (urinary catheters, oxygen with short tubing, compression devices) |
| | | Verify availability of footwear and assistive devices |
| | | Confirm unobstructed walking route in patient room and hallway |
| | | Assess for other obstacles to daily mobility |

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# Sharing Successful Practices

**Fred Rubin, MD, Chief of Medicine Service**

**Susan Killmeyer, RN, Clinical Director of Ancillary Areas**

**Cynthia Conte, RN, Unit Director of Admissions Team and Resource Pool**

University of Pittsburgh Medical Center Shadyside

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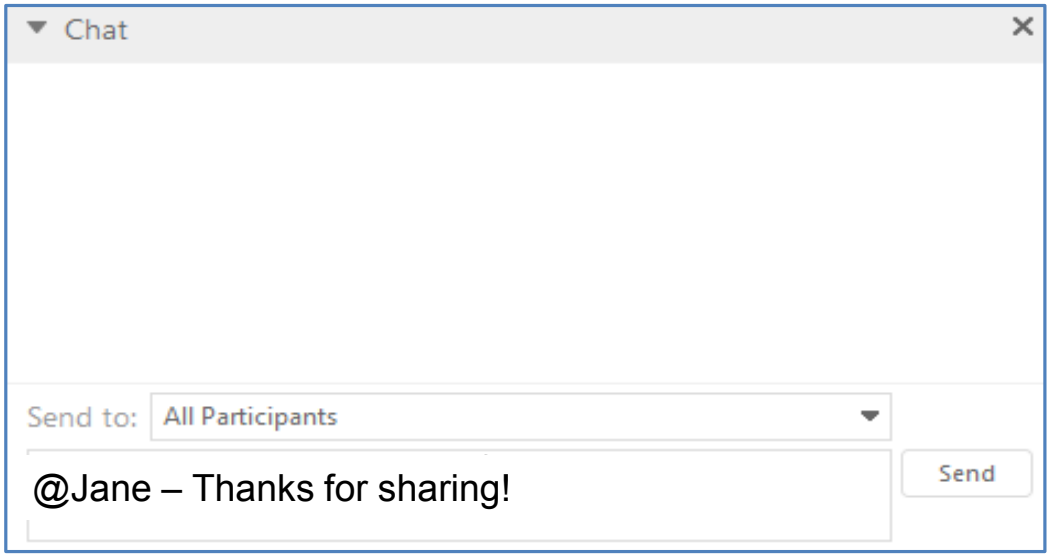
# Sharing Successful Practices

**Heidi Wierman, MD, Medical Director, Geriatric Programs**
**Molly Anderson, Manager for Geriatric Programs**

Maine Medical Center

# Questions, Reactions & Insights




- **Tell us using Chat!**
  - What questions do you have?
  - Are you using similar methods?

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# Prework

- Survey
  - Complete by no later than Thursday, May 4, 2017
  - If you do not have the survey link, please email mobility@lewin.com
- Team
- Tactics to Test
  - Please type into the chat panel the tactics you have chosen to test initially

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# Measurement

- Goals of measurement:
  - Monitor your own progress
  - For CMMI to identify where additional assistance might be needed
- Two types of measures to track and submit on a monthly basis:
  - Standardized: walks (two walk measures), bed-chair alarms, implementation progress, and organizational readiness (total of five measures)
  - Non-standardized: physical restraints, falls, functional status, and staff injuries (one measure for each)

# Standardized Measures

| | Sunday, April 23, 2017 | Monday, April 24, 2017 | Tuesday, April 25, 2017 | Wednesday, April 26, 2017 | Thursday, April 27, 2017 | Friday, April 28, 2017 | Saturday, April 29, 2017 | Weekly summary |
|---|---|---|---|---|---|---|---|---|
| Eligible (1) patients present at the beginning of the day shift in the test unit | 12 | 15 | 16 | 13 | 11 | 16 | 13 | 96 |
| Number of patients who walked at least three times on that day (2) | 3 | 2 | 2 | 5 | 4 | 3 | 6 | 25 |
| Total number of walks in the unit that day (3) | 14 | 16 | 18 | 15 | 11 | 15 | 15 | 104 |
| Number of patients with a bed or chair alarm | 3 | 3 | 5 | 4 | 3 | 2 | 3 | 23 |
| Proportion with at least three walks, % | 25% | 13% | 13% | 38% | 36% | 19% | 46% | 26% |
| Walk per patient day | 1.17 | 1.07 | 1.13 | 1.15 | 1.00 | 0.94 | 1.15 | 1.08 |
| Proportion with a bed or chair alarm, % | 25% | 20% | 31% | 31% | 27% | 13% | 23% | 24% |

(1) For definition of eligible patients, see the Instructions tab

(2) Include patients admitted that day and not present at the beginning of the day shift (proportion could therefore be more than 100%) / Definition of one "walk": every time the patient left his/her room by foot; do not include walks to the bathroom or around patient own room.

(3) If a patient took more than one walk in a day, count all walks that day for all patients (including patients admitted that day and not present at the beginning of the day shift)

README | Identification | Trends | **Sample Week (do not use)** | Late Apr | Week 1 (Apr 30) | Week 2 | Week 3 | Week 4 | Late May | Week 5 ...

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# Standardized Measures (cont.)

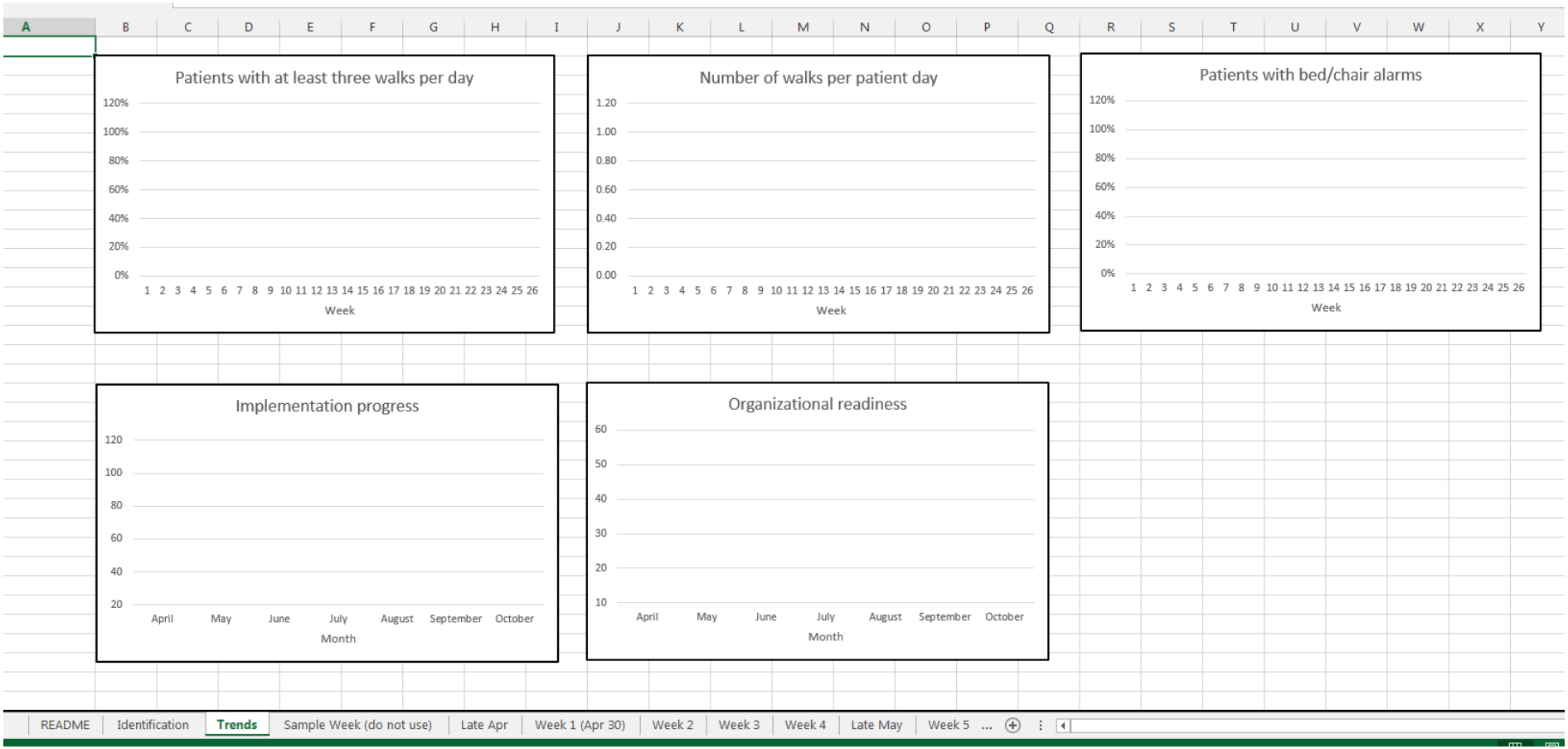
**Monthly Measure: Action Items Implementation Progress**

Please characterize your plans and progress related to the action items in the Mobility Initiative Clinical Framework and Toolkit.

*Note: 1 = Not considering this implementation strategy; 2 = Considering this implementation strategy, but have not pursued it yet; 3 = Implementation strategy is in the planning stages; 4 = Implemented this strategy, but experiencing challenges; 5 = Implemented this strategy and it is working well.*

| Strategy | Change Concept | Action Item | Implementation Progress |
|---|---|---|---|
| **1 - Provide early mobilization with safe approaches for patients and staff** | Train all staff in safe mobility | Training and demonstrations in safe mobility and body mechanics for nurses, aides, sitters, PT techs, volunteers, 'ambulators' | |
| | | Reward/recognize front-line staff for new ideas in how to mobilize patients | |
| | | Train family members in safe mobility | |
| | Have appropriate assistive devices for every patient | Gait belts in every room | |
| | | Walkers, canes, crutches available centrally—easy and reliable 24 hour access | |
| | | Glasses, hearing aids, appropriate footwear as needed | |
| | Transition Falls Team to Mobility Team | Pair mobility along with falls as critical outcomes | |
| | | Always consider maintaining mobility in all corrective actions for fall prevention | |
| | | Generate unit-specific (and eventually hospital-wide) reports on mobility rates and falls (with and without injury) rates | |
| **2- Assess and enhance function and mobility, and create a culture of mobility** | Assess function and mobility on admission and discharge | Standardize nursing mobility assessment on admission and discharge | |
| | | Functional status assessment on admission and discharge | |
| | | Assess for any evidence of acute mental status change | |
| | Include mobilization plan in every patient's Care Plan | Set baseline ambulation goal, with target of 3 times a day | |
| | | Limit referrals to Physical Therapy (for mobility) | |
| | | Identify primary staff responsibility for mobilization | |
| | Regular mobility/ambulation (with assistance as needed) | Justify all bedrest orders, and the default should be ambulation | |
| | | Provide specific activity order, e.g., "ambulate with assistance, 1 lap of unit TID" | |
| | | Record mobility daily, e.g., whiteboard, patient flow chart, EHR | |
| | Eliminate bed and chair alarms | Develop system on floor for purposeful hourly rounding (RNs and CNAs) and rapid response to call-bells | |
| | | Remove bed/chair alarms from fall protocols and standing order sets | |

# Standardized Measures (cont.)

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# Non-Standardized Measures


**III. Falls Domain**

**Measure Title or NQF #:**

**Measure Description (for non-NQF measures only):**

**Numerator (for non-NQF measures only):**

**Denominator (for non-NQF measures only):**

**Timing:**

**Data Aggregation:**

| Examples of Existing Falls Measures | | | |
|---|---|---|---|
| **Measure Title** | **Measure Description** | **Measure Numerator** | **Measure Denominator** |
| **Patient Fall Rate NQF #0141 American Nurses Association** | All documented falls, with or without injury, experienced by patients on eligible unit types in a calendar quarter. Reported as Total Falls per 1,000 Patient Days and Unassisted Falls per 1000 Patient Days. (Total number of falls / Patient days) X 1000 | Total number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by hospital unit during the calendar month X 1000. | Patient days by hospital unit during the calendar month. Included Populations: • Inpatients, short stay patients, observation patients, and same day surgery patients who receive care on eligible inpatient units for all or part of a day. • Adult critical care, step-down, medical, surgical, medical-surgical combined, critical access, and adult rehabilitation units. • Patients of any age on an eligible reporting unit are included in the patient day count. |
| **Falls with Injury NQF #0202 American Nurses Association** | All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 | Total number of patient falls of injury level minor or greater (whether or not assisted by a staff member) by eligible hospital unit during the calendar month X 1000. Included Populations: • Falls with Fall Injury Level of "minor" or greater, including assisted and repeat falls with an injury level of minor or greater • Patient injury falls occurring while on an eligible reporting unit | Patient days by Type of Unit during the calendar month. Included Populations: • Inpatients, short stay patients, observation patients, and same day surgery patients who receive care on eligible inpatient units for all or part of a day. • Adult critical care, step-down, medical, surgical, medical-surgical combined, critical access and adult rehabilitation inpatient units. • Patients of any age on an eligible reporting unit are included in the patient day count. |

# Continue Discussion on ILS Connect

- You will be added to your own private group on ILS Connect called “Mobility Action Group”
- To post a comment or share a resource:
  - Go to the “Groups” tab on ILS Connect
  - Click on “Mobility Action Group”
  - Post your comment in the group
- Or, just respond to others

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# Continuing Education Credits

The Centers for Medicare & Medicaid Services (CMS) is evaluating this activity for continuing education (CE) credit. The number of credits awarded will be calculated following the activity based on the actual learning time. Final CE information on the amount of credit will be available to participants within the Learning Management and Product Ordering System (LM/POS) after the live activity.

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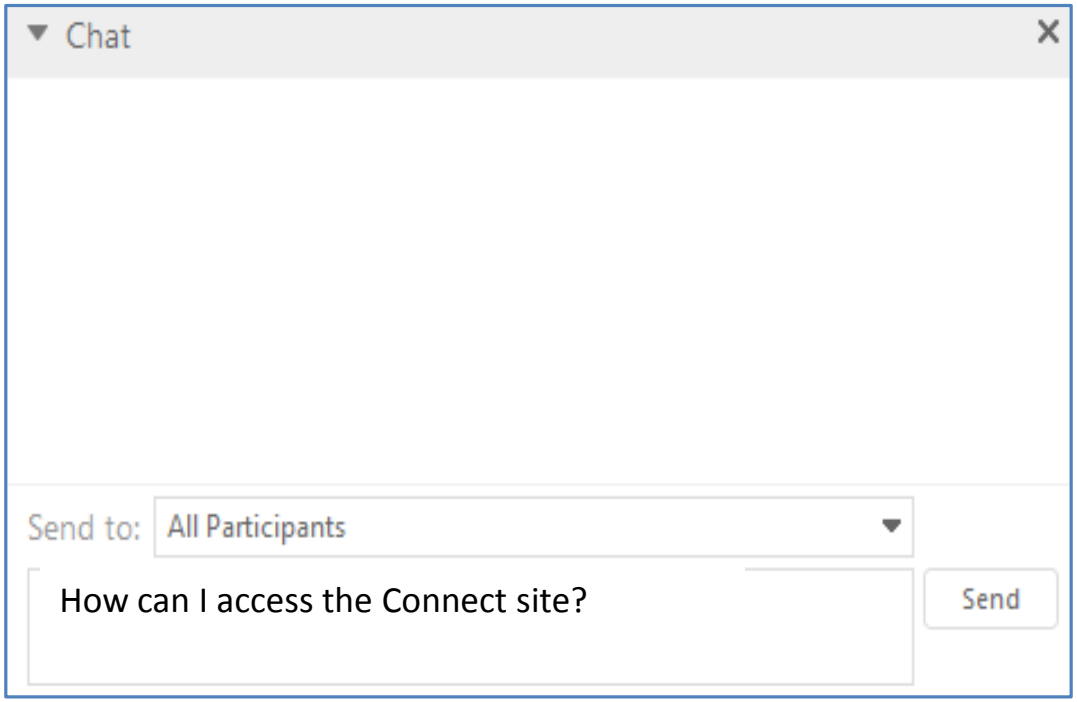
# Q&A




Please submit your questions into the chat panel

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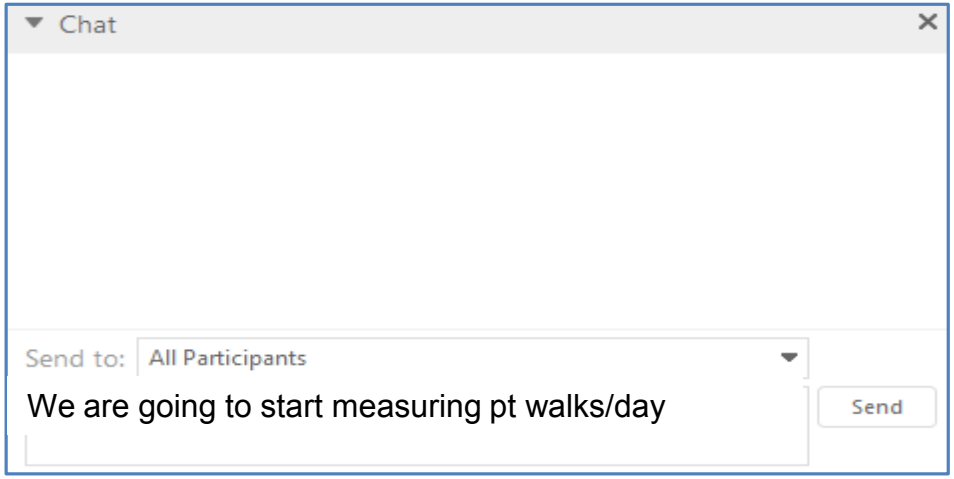
# Commitment to Action

- What are you going to test or implement in the next two weeks? Share in Chat now!




- For the next Mobility Action Group session, be prepared to share:
  - Current work in mobility
  - New work to try in mobility

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# Poll

**Would you like to share more about a strategy or tactic you are using to increase mobility during the next session on May 10?**

- Yes
- No
- Maybe

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# Announcements & Reminders

# Upcoming Mobility Action Group Sessions

| | |
|---|---|
| **Mobility Action Group Session Two** | **May 10, 2017<br>12-1 pm EDT** |
| **Mobility Action Group Session Three** | **May 25, 2017<br>12-1 pm EDT** |
| **Mobility Action Group Session Four** | **June 8, 2017<br>12-1 pm EDT** |

If you have any questions, send an email to Mobility@Lewin.com

*Please take a few minutes to respond to the Post-Event Survey*

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