HRET HIIN Rural/CAH Affinity Group

Communicate to Ambulate
March 20, 2017
Welcome and Introductions

Marina Levin
Program Manager | HRET
Upcoming Events

HRET HIIN Data | Data Sanity: The Surprising Catalyst for Unprecedented Organizational Excellence
March 21 | 11:00 a.m. – 12:00 p.m. CT
Click to Register

HRET HIIN PFE Fellowship | Making the Connection: PFE Strategies Part 2
March 22 | 11:00 a.m. – 12:00 p.m. CT
Click to Register

HRET HIIN MDRO | The Basics
March 28 | 11:00 a.m. – 12:00 p.m. CT
Click to Register

View all upcoming events
Join the Rural/CAH LISTSERV® and enjoy benefits such as:

- Sharing of HRET HIIN resources
- Peer-to-Peer sharing of best practices and networking
- Learnings from subject matter experts
- Sharing of publically available resources

Sign up today!
# Agenda for Today

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives</th>
<th>Speakers</th>
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<tbody>
<tr>
<td>1:00pm CT</td>
<td>Welcome and Introductions</td>
<td>Marina Levin</td>
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<td>Program Manager, HRET</td>
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<tr>
<td>1:05pm CT</td>
<td>Data Updates • Baseline data sneak peek • HIIN Priorities, rural CAH cohort priorities • Review of polling results from 1/23 event</td>
<td>Paul Cholod</td>
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<td>Data Analyst, HRET</td>
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<td>1:10 pm CT</td>
<td>Critical Access Hospital Unique Needs and Strengths • How to advance the use of technology • Beyond data collection for improvement</td>
<td>Debrah Anderson</td>
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<td>Mountain Pacific QIO</td>
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<td>1:15pm CT</td>
<td>GET UP and Stay UP • Mobility as medicine: an overview of GET UP • Is fear of falling keeping us from mobilizing patients? • GET UP Must Haves</td>
<td>Jackie Conrad, RN, MBA</td>
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<td>Cynosure Improvement Advisor</td>
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<tr>
<td>1:30pm CT</td>
<td>Hospital Case Study – Face to Face and Electronic Strategies • Using triggers to automate communication. Discuss pros and cons to using triggers to automate communication • Augmenting electronic with face to face and visual. • Learn how to design workflow within EHR to promote consistency</td>
<td>Debrah Anderson</td>
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<td>Mountain Pacific QIO</td>
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<td>Kari Jo Kiff</td>
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<td>Mountainview Medical Center</td>
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<td>Reese Harper</td>
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<td>MedWorxs</td>
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<td>1:45pm CT</td>
<td>Questions from Participants</td>
<td>All</td>
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<tr>
<td>1:57pm CT</td>
<td>Bring it Home</td>
<td>Marina Levin</td>
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<td>Program Manager, HRET</td>
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Data Updates

Paul Cholod
Data Analyst | HRET
## Falls Data Updates

### Baseline Results

<table>
<thead>
<tr>
<th></th>
<th>Rate</th>
<th># Patient Days</th>
<th># Hospitals Reporting</th>
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<tbody>
<tr>
<td>All Hospitals</td>
<td>0.67</td>
<td>21,491,354</td>
<td>1,217</td>
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<tr>
<td>CAH or Rural</td>
<td>1.23</td>
<td>3,431,977</td>
<td>727</td>
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<tr>
<td>CAH only</td>
<td>1.80</td>
<td>141,868</td>
<td>73</td>
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<tr>
<td>Rural only</td>
<td>1.01</td>
<td>2,538,953</td>
<td>277</td>
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<tr>
<td>CAH and Rural</td>
<td>1.86</td>
<td>751,156</td>
<td>377</td>
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</tbody>
</table>
Debrah Anderson
Mountain Pacific QIO

Jackie Conrad, RN, MBA
Improvement Advisor
Cynosure Health

Betsy Lee, RN, MSPH
Improvement Advisor
Cynosure Health
Critical Access Hospitals Unique Needs and Strengths

- CAHs have heart
  - Strong sense of community
  - Devoted and experienced staff
  - Great patient relationships
  - Volunteers
  - AND Certified EHR Technology (CEHRT)
Advancing the use of CEHRT

• Challenges for CAHs
  – Budget limitations
  – Staffing
    • No onsite IT support
    • Travelers or older clinical staff members
  – Older technology
    • Older hardware, outdated software, slow or no wireless network
  – Aging populations/patients
  – Expectations of a perfect EHR
eCQI

• Electronically enabled Clinical Quality Improvement (eCQI)
  – What we can measure, we can improve
  – Alignment for prioritization
  – Vendor communication is key
    • Combining voices can bring harmony
    • Focus on best practice and patient safety
GET UP and STAY UP

Image from: http://www.seniorexercisesonline.com
Early Progressive Mobility

Falls  PrU  Delirium  CAUTI  VAE  VTE  Readmissions

GET - UP
“New Walking Dependence” occurs in 16-59 percent in older hospitalized patients (Hirsh 1990, Lazarus 1991, Mahoney 1998)

65 percent of patients had a significant functional mobility decline by day two (Hirsh 1990)

27 percent still dependent in walking three months post discharge (Mahoney 1998)
It’s Simple

If they came in walking, keep them walking.
Progressive mobility is defined as a series of planned movements in a sequential matter beginning at a patient's current mobility status with goal of returning to his/her baseline.

(Vollman 2010)

Teaming UP To Mobilize

- PT
- CNA
- Admin
- RN
- OT
- MD
- RT
- Family
Must Do's
GET-UP MUST DO’s!

1. Walk in, walk during, walk out!

2. Belt and bolt!

3. Three laps a day keeps the nursing home at bay!
MUST DO #1
Walk In, Walk During, Walk Out!

- Determine pre admission ambulation status
- Don’t assume a frail appearance means weakness
- Use Get Up and Go test to assess ambulation skills
Get up and Go and Timed Get up

Fig. 4. The Get Up and Go test.
MUST DO #2
Belt and Go!

- Gait Belts in every room
- Safe mobilization and patient handling training for nursing staff

See CAPTURE Falls Project Website for guidance: http://www.unmc.edu/patient-safety/capturefalls/learningmodules/index.html

Gait belts are used to help control the patient’s center of balance. Gait belts are not intended to hold a patient up.
MUST DO #3
Three Laps a Day, Keeps the Nursing Home Away!
## Mobility Begins on Admission

<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Defining Characteristics</th>
<th>Intervention$^a$</th>
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</thead>
</table>
| Tier 1: Nonambulatory | Patients who • require more than a one-person assist for ambulation/transfer • are unable to maintain weight on their lower extremities • require any form of lift equipment | Active range-of-motion exercises: • ankle pumps • heel slides • hip abduction • quad sets • shoulder flexion  
Passive range-of-motion exercises: • ankle dorsiflexion • hip flexion • hip abduction • shoulder flexion  
Sit on side of bed  
Get out of bed and into a chair with appropriate equipment |
| Tier 2: Ambulatory | Patients who • are able to ambulate independently • require a one-person assist with ambulation | Ambulate with or without assistance in the hallway as tolerated  
Get out of bed and into a chair for all meals |

$^a$ To be performed three times a day (in accordance with a patient’s ability).

Wood W, et al.(2014) A Mobility Program for an Inpatient Acute Care Medical Unit.  
Tips for Promoting Mobility

• Order Modifications
  – Delete orders for:
    • Bedrest
    • Ad lib
  – Replace with specific orders
    • Times, activities, distance

• Promote Team Mobility Management
  – Delegation of patient mobility
    • Replace sitters with a mobility aide
    • Train volunteers
  – Rehab and Nursing face to face bedside handoffs
    • Document plans and progress on white boards
Question to the Participants

Where is your organization on this freedom of movement scale? Please answer within the poll.

1 2 3 4 5 6 7 8 9 10

Mobility Restriction
- Bed Alarms prevent freedom of movement
- No access to walker, cane

Some Mobility
- Physical Therapy treats in-patients
- Patients allowed to ambulate
- No ambulation program for those needing assist

Free to Move Safely
- Patient mobility is assessed on admission
- Independent ambulation is encouraged for those who can
- Support is provided for those needing assistance
Resources to Support Mobility

- **Capture Falls Toolkit for Critical Access Hospitals**
  - Interprofessional approach to fall injury prevention, with emphasis on safe mobility. Includes mobility training videos, use of gait belt, how to support a fall and many other tools.

- **Hospital Elder Life Program (HELP)**
  - Targets hospitalized patients over 70, focusing on improving care for elders. One innovation as part of their program is using trained volunteers to ambulate patients

- **Fall Prevention Tips for Hospital Patients and Families**
  - One page fall safety information sheet for patients and families

- **Sample Med Surg Mobility Protocol**
  - One page fall safety information sheet for patients and families
Hospital Case Study

Mountainview Medical Center

White Sulphur Springs, Montana
- 25 Bed Critical Access Hospital
- 16-18 Intermediate/Long Term
- Skilled and Acute
- PT Dept.- Inpatient and Outpatient

Kari Jo Kiff, RN
Director of Nursing
What we have done:

• Falls Committee

• Multidisciplinary strategies
  – PT Evaluations, Medication Review

• Communication enhancements
  – Electronic, Traditional, NEW

• Data Collection
  – Electronic reporting system
Multifaceted Communication

Electronic
- Admission Assessment
  - Fall Risk
  - Interventions in place
- Post Fall Assessment
  - Orders triggered
    - PT Evaluation
    - Pharm Med Review
    - Additional interventions
- Auto Email notification
  - CEO, DON, PT, Risk Mgr

Traditional
- Centralized Fall Board
- White Boards
- Care Plan, Kardex

NEW
- Staff-wide yearly education
  “Facility wide Program”
- Post Fall Huddle
Centralized Fall Board
• Results of Testing
• Challenges Encountered
• Next Steps
Communication Strategies and Challenges

Patient White Boards
- Results of Testing
- Challenges Encountered
- Next Steps
Designing Workflow in EHR

• EHR can improve efficiency in two ways
  – Bedside workflow and documentation
    • Triggers linked to events
      – Admission & Post Fall Assessment Triggers
      – Automated email notifications
  – Data collection – outcome and process measures
    • Outcome measure – Fall with injury
    • Process Measures
      – Post Fall Huddle Completion
    • Data elements collected for trending
      – injury level, time of day, interventions in place
Designing Workflow

• How to work with a vendor to get workflows that will improve efficiency
  – Consolidate/ become one voice
    • United workgroups with the same project goals
  – Bedside workflow and documentation
    • Portable Workstations on Wheels / Touchscreen capabilities
      – Are the staff using it? If not, find out WHY not.
        » Computer literacy, awareness of the functions, perceptions/ misconceptions
  • Shift Reports can communicate vital information
    – Fall status, ambulatory goals, Physical Therapy orders
Designing Workflow

– Data collection – outcome and process measures
  • Start the workflow from the point of Admit
    – Patient Flags (follow the patient from visit to visit)
    – Incorporate fall status in admission assessments
      » Trigger orders, additional forms, or initiate specific ambulatory programs
  • Electronic Orders – Find out who can add/edit and what the capabilities are
    – Trigger associated orders (i.e. Physical Therapy, Restorative Programs), Protocols, Initiate Care Plans
    – Orders can trigger additional events that tie into the rest of the workflow
    – Reporting requirements
Questions / Discussion
Thank You!

Find more information on our website: www.hret-hiin.org

Questions or Comments: HIIN@aha.org