GET UP

October 10, 2017

IHAconnect.org/Quality-Patient-Safety
Indiana’s Bold Aim

To make Indiana the safest place to receive health care in the United States...

*if not the world*
Agenda

- Welcome and Introductions
- Get UP Campaign
- Guest Speaker Dr. Cynthia Brown-Cynosure
- Resources and Support
- Get Up Webinar Series
Polling Question #1

What is your role within your organization?

- Infection Preventionist
- Nursing Professional
- Laboratory Professional
- Medical Staff
- Environmental Services/Housekeeping Professional
- Other
IHA Launches UP Campaign

- Supports Hospital Improvement Innovation Network (HIIN) harm reduction efforts
- June 6 Indiana Patient Safety Summit Kick-off
- Strategic Deployment of Three Campaigns:
  - SOAP UP 3Q 2017
  - GET UP 4Q 2017
  - WAKE UP 1Q 2018
UP Campaign

**Goal:** Simplify safe care and streamline cross-cutting interventions to reduce the risk for multiple patient harms.
Early Progressive Mobility

- Falls
- Pressure Ulcer and Injury
- Delirium
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Ventilator-Associated Events (VAE)
- Venous Thrombo-Embolism (VTE)
- Readmissions

GET UP

IHAnnect.org/Quality-Patient-Safety
Did you know....

**Off Their Feet**

Some of the effects of time in the hospital

**95%-plus**

Amount of time that hospital patients spend in bed or sitting in a chair

**2 days**

Mobility of elderly patients can begin to decline this soon after they are hospitalized

*Source: Journal of the American Geriatrics Society*

THE WALL STREET JOURNAL

IHAconnect.org/Quality-Patient-Safety
Polling Question #2

From your research, what age category do most of your falls occur in?

- 18-25
- 26-45
- 46-65
- Over 65

Leaves are supposed to fall. People aren’t.
Guest Speaker
Dr. Cynthia Brown
Mobility in the Hospitalized Older Adult

Cynthia J. Brown, MD, MSPH
Professor of Medicine and Director,
Division of Gerontology, Geriatrics, and Palliative Care
Comprehensive Center for Healthy Aging
University of Alabama at Birmingham
Birmingham/Atlanta VA GRECC
The John A. Hartford Foundation
Veterans Administration (VA) Rehabilitation Research and Development
National Institutes of Health (NIH)

Financial Disclosures: None
Determining the Scope of the Problem
“Rest of injured body parts and of diseased bodies is probably the oldest and most valuable of all methods of treatment… Nevertheless we seem from time to time to forget that this therapeutic method like all others may lead to untoward results when utilized either injudiciously or excessively.”

- Dr. Tinsley Harrison, JAMA 1944
Prevalence and Outcomes of Low Mobility in Hospitalized Older Patients

Cynthia J. Brown, MD,†‡ Rebecca J. Friedkin, PhD, and Steven K. Inouye, MD, MPH,‡

OBJECTIVES: To estimate the prevalence of different levels of mobility in a hospital-based cohort, to examine the degree and type of adverse outcomes associated with low mobility levels, and to review the evidence for the mobility hierarchy and the determinants of fall and non-fall mobility in older patients. METHODS: A cross-sectional study. SETTING: An 868-bed university teaching hospital. PARTICIPANTS: Very frail, mostly hospitalized medical patients, 70 and older. MEASURES: Using a modified mobility level, scored from 0 to 12, the low mobility group was defined as having a score of 0 to 4, intermediate as a score of 5 to 8, and high as a score of 9 to 12. Outcomes were functional decline, new institutionalization, death, and death or new institutionalization. RESULTS: Low and intermediate levels of mobility were associated with 70% (95% CI: 65%–75%) study patients, respectively. Overall, 84% of 480 long-stay, 64% of shorter-stay, 47% of interinstitutional, 15% of death, and death new institutionalization was 21% of patients in the cohort. When compared with the high mobility group, frailty and institutionalization groups were associated with a 25% increase in risk of adverse outcomes. Low mobility was associated with 1.8 (95% CI: 1.5–2.3) and 1.4 (95% CI: 0.9–2.0) in the study group, respectively, and 1.8 (95% CI: 1.5–2.3) for death or new institutionalization. The intermediate mobility group had a risk ratio of 1.2 (95% CI: 0.8–1.9), 1.5 (95% CI: 0.9–2.3) for death or new institutionalization, death, and death or new institutionalization, respectively. NUMBER OF INCIDENTS: 232; 61% of patients were enrolled in the study. LIMITATIONS: This study is limited by the low mobility level, 1.4 low mobility, and the inability to track patients longitudinally, and it may be self-selected. CONCLUSIONS: Low mobility is an important outcome in hospitalized older patients, and it is an important predictor of adverse outcomes. The study demonstrates that the low and intermediate mobility levels are associated with a 25% increase in risk of adverse outcomes. This study may be viewed as a strong indicator of mortality, institutionalization, and rehospitalization. Additional references to low mobility and outcomes in hospitalized older patients may be found in Brown CJ. J Am Geriatr Soc. 2004;52(8):1263–1270.

Key words: mobility, balance; Hospital complications; geriatrics; sarcopenia

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• 498 hospitalized medical patients, age ≥ 70 years
• Mobility scale based on nurse report:
  – degree of assistance needed
  – number of times transferred and ambulated
• Average of mobility observations for each patient, scores trichotomized
  – Low mobility: bed rest or bed to chair
  – Intermediate mobility
  – High mobility
Prevalence of Low Mobility

• Bed rest present at some point for 33% of hospitalized older patients

• 16% patients experienced low mobility throughout hospitalization
## Risk of Adverse Outcomes by Mobility Level

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Low Mobility</th>
<th>Intermediate Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any decline in ADLs</td>
<td>5.6</td>
<td>2.5</td>
</tr>
<tr>
<td>New Institutionalization at Discharge</td>
<td>6.0</td>
<td>2.9</td>
</tr>
<tr>
<td>Death</td>
<td>34.3</td>
<td>10.1</td>
</tr>
<tr>
<td>Death or New Institutionalization</td>
<td>7.2</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Adjusted for ADLs, Demographics, APACHE II, Charlson and ICU/CCU stay; Odds Ratio compared to High mobility group \((P < .006)\)
Conclusions

• Low mobility common and associated with adverse outcomes even after controlling for illness severity and comorbidities

• However, little known about barriers to mobility
Model of Potential Barriers

Patient-related factors
- Illness severity
- Comorbid conditions
- Altered mental status
- Patients symptoms

Treatment-related factors
- Hospital devices
- Admitting diagnosis
- Side effects of medications

Institution-related factors
- Staffing patterns
- Environment encourages bed rest
- Lack of ambulatory devices

Attitudinal factors
- Attitude toward mobility
- Expectation of hospital stay
- Concern about falls
• **Participants:**
  • 10 patients, age ≥ 75 years admitted to medical wards at UAB Hospital
  • Patient’s nurse & physician also recruited (n=29)

• **Questionnaire Development:**
  • Semi-structured interview guide
  • New themes incorporated into interview
  • Interviews audiotaped, transcribed and examined for common themes
"I don’t believe they are going to get me out of bed while I am here. If I said I really needed to get out of bed, they try to do what you want them to do. But evidently they don’t think it is that important."

- a Patient
“We try to encourage the doctors to order physical therapy because we don’t have time to ambulate patients in the hallway like the doctor expects.”

- a Nurse
“I think it is just that patients, when they are in the hospital, they feel they are supposed to be in bed. And they are more comfortable there and a lot of times they can see the TV better.”

- a Doctor
Implications

• Suggests modifiable and non-modifiable reasons for low mobility
• Important step in development of successful interventions to minimize low mobility
Beyond Functional Decline

1000 Subjects, stratified, random sample of Medicare beneficiaries living in 5 counties in central Alabama

Study over-sampled males, African Americans, and rural residents
Mean (standard deviation) for baseline composite life-space score among all UAB Study of Aging participants by LSA achieved without help from another person. Scores range 0-120. Bowling CB, et al. 2013
Methods

• 211 hospitalizations among 687 participants over 4 years
  • Surgical admissions = 44;
  • Non-surgical admissions = 167
• Life-Space Assessment every 6 months
• Using multilevel change model to determined trajectory of Life-Space before and after hospitalization.
Life-Space Trajectories after Hospitalization

- Surgical admissions
- Non-surgical admissions

**Graph Description:**
- **Surgical admissions** shown in green.
- **Non-surgical admissions** shown in blue.

**Axes:**
- Y-axis: Life-Space composite
- X-axis: Years after enrollment

**Legend:**
- Green line = Surgical admissions
- Blue line = Non-surgical admissions
Measurement of Hospital Mobility
Epidemic of Low Mobility

• 45 hospitalized VA medical patients, age > 65 years admitted to medical wards
  – Ambulatory 2 weeks prior to admission
  – Cognitively intact
  – English speaking
  – Monitors attached within 48 hours of admission

• Mean proportion of time spent lying, sitting, and standing/walking determined for each hour after hospital admission
Results

• Mean length of stay 5.1 days
• Generated 2592 one-hour periods of data
• No patient in bed entire hospital stay
• **83% of hospital stay spent lying in bed**
• Time spent standing/walking
  – Ranged from 0.2% to 21%
  – Median time was 3% or **43 minutes/day**
Hourly Mobility Levels

Admission Day and Time

%
Conclusions

• First study to document mobility continuously over initial 7 days of hospitalization
• Found hospital patients spending at least 80% of time in bed
• On average, less than 43 minutes a day standing or walking
• Results duplicated:
  • Fisher et al. 57 minutes/day ambulatory
  • Pedersen et al. 1.1 hours/day standing/walking
Developing an Intervention
Previous Out of Bed Protocols

• Transporters used to walk patients during quiet periods, especially nights, week-ends\(^1\)
  – Pilot study, demonstrated feasibility only

• Nurse driven protocol of progressive ambulation among patients with pneumonia\(^2\)
  – No functional outcomes assessed

Nurse-driven intervention with 5 components:
1. Psychomotor skills training for nurses
2. Communication tools
3. Ambulation pathways
4. Ambulation resources
5. Ambulation culture
Results

Figure 1. (A) Ambulation frequency. (B) Ambulation distance. (C) Numeric documentation.
Feasibility of progressive sit-to-stand training among older hospitalized patients

Mette Marie Pedersen,1,2* Jette Petersen,1 Lynn Bean,3 Jonathan E. Barns,3 Lars Damkjaer,1,4 Helene-Cybele Juul-Larsen,5 Once Andersen,5 Nina Beyer5 and Thomas Bandholm1,2

1 Department of Sports Science, University of Copenhagen, Copenhagen, Denmark
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5 Department of Sports Science, University of Copenhagen, Copenhagen, Denmark

Background. In older patients, hospitalization is associated with declines in functional performance and loss of muscle strength. Loss of muscle strength and functional performance can be prevented by systematic strength training, but details are lacking in integrating the optimal exercise program and dose for older patients. Therefore, our aim was to test the feasibility of a progressive model for load sit-to-stand training among older hospitalized patients.

Methods. This is a prospective cohort study conducted on feasibility study prior to a full-scale trial. We included twenty-four older patients (68±4 years) usually admitted from their own home to the medical service of the hospital. We developed an exercise program model for load sit-to-stand, which we named STAND. The model was used as a standard to describe how to perform the load sit-to-stand exercise and to strength training exercise aimed at building a weight-bearing load of 15 kg in an optimal manner. The main inclusion criteria for a sit-to-stand exercise was an ability to perform a unaided sit-to-stand exercise. The STAND model was considered feasible if (1) 75% of the assigned patients could perform the exercise at a given level of the model; (2) 15 repetitions were achieved within a standard time of 4 s; (3) 75% of the patients attended the exercise program; (4) attendance at the hospital and two of exercise schemes (weight-loss and weight-loss) were determined as adverse events were considered.

• Developed a progression model for loaded sit-to-stand exercise

• Tested feasibility in patients ≥ 65 years and found:
  • 83% could perform in hospital
  • Progression or regression possible for all patients
  • No indication of adverse events (pain)
Methods

• 100 patients from Birmingham VAMC
  – Not delirious or demented, walking 2 weeks PTA
• Randomly assigned to Mobility Program (MP) or Usual Care (UC)
• Assessments by blinded assessors
• One month telephone follow-up
• Physicians blinded to assure no change in usual care (e.g. activity orders, PT consults)
Mobility Program (MP)
- Twice daily walks with assistance
- Provision of rolling walker, if needed & safe
- Provision of folder; document goals; track sitting, walking
- Daily motivational interviewing; focus on goals & barriers

Usual Care (UC)
- Twice daily friendly visits
- Provision of folders; document friendly messages and track visitors
Assessments and Analyses

In-Hospital
• ADL ability
• Baseline LSA
• Depression
• APACHE II
• Charlson Comorbidity
• Chart review for LOS, PT consults

One month follow-up
• ADL ability
• Post-hospital LSA

Analyses
• Multiple imputations methods used for missing values
## Baseline Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Usual Care</th>
<th>Walking Program</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N = 100</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>73.4 ± 7.0</td>
<td>74.4 ± 6.9</td>
<td>0.48</td>
</tr>
<tr>
<td>Gender, male</td>
<td>49 (98%)</td>
<td>48 (96%)</td>
<td>0.56</td>
</tr>
<tr>
<td>Race, black</td>
<td>8 (16%)</td>
<td>11 (22%)</td>
<td>0.44</td>
</tr>
<tr>
<td>LOS, mean</td>
<td>3.6 ± 2.4</td>
<td>4.6 ± 4.0</td>
<td>0.13</td>
</tr>
<tr>
<td></td>
<td>3.0</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>GDS</td>
<td>5.0 ± 3.0</td>
<td>4.7 ± 3.2</td>
<td>0.63</td>
</tr>
<tr>
<td>Charleston Comorbidity</td>
<td>4.1 ± 2.6</td>
<td>4.4 ± 2.4</td>
<td>0.55</td>
</tr>
<tr>
<td>APACHE</td>
<td>15.3 ± 11.8</td>
<td>14.3 ± 10.6</td>
<td>0.67</td>
</tr>
<tr>
<td>PT Ordered</td>
<td>17 (34%)</td>
<td>22 (44%)</td>
<td>0.30</td>
</tr>
</tbody>
</table>
Results

• In hospital, 3 falls in 2 patients reported – all in UC group

• 8 participants did not complete study;
  2 UC and 6 MP
  – Death (n=3; 2MP, 1UC)
  – Medical complications (n=4, 4MP)
  – Patient refusal (n=1, 1UC)
## Pre-Post Hospital Function

<table>
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<th>Usual Care</th>
<th>Mobility Program</th>
<th>P value</th>
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<tbody>
<tr>
<td>Baseline ADL</td>
<td>8.7 ± 0.33</td>
<td>8.4 ± 0.27</td>
<td>0.49</td>
</tr>
<tr>
<td>Post-Hospital ADL</td>
<td>8.2 ± 0.32</td>
<td>8.2 ± 0.30</td>
<td>0.99</td>
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P-values for group differences between pre and post hospital outcomes adjusted for baseline, age, gender, race.
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<tr>
<td>Baseline LSA</td>
<td>51.5 (2.99)</td>
<td>53.9 (4.15)</td>
<td>0.46</td>
</tr>
<tr>
<td>Post-Hospital LSA</td>
<td>41.8 (3.15)</td>
<td>52.6 (4.39)</td>
<td>.02</td>
</tr>
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P-values for group differences between pre and post hospital outcomes adjusted for baseline, age, gender, race.
• Older adults spend significant proportion of hospital stay in bed.
• Many barriers to hospital mobility modifiable.
• Our small RCT demonstrates feasibility, safety and efficacy of a hospital mobility program.
• Others have shown success with sit to stand training.
• Next steps include larger trials to determine best methods for improving hospital mobility.
Mobility in the Hospitalized Older Adult

Cynthia J. Brown, MD, MSPH
Professor of Medicine and Director,
Division of Gerontology, Geriatrics, and Palliative Care
Comprehensive Center for Healthy Aging
University of Alabama at Birmingham
Birmingham/Atlanta VA GRECC
Get Up Resources
How Can IHA Help?

- What resources do you need to help with your improvement efforts?
IHA Resource Sheet

GET UP

GET UP focuses on mobilizing patients to return to function more quickly.

Keeping a patient mobile is key to helping them avoid various types of harm.

Maintaining a continued emphasis on mobility can assist in the prevention of several harm events. Including CAUTI, delirium, falls, HAPU/L, readmissions, VAE, and VTE.

There are many resources available at IHAconnect.org, including those below, to help your organization address these harm events and engage in the UP Campaign.

GET UP Resources

<table>
<thead>
<tr>
<th>Topic</th>
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<tbody>
<tr>
<td>Introduction to the UP Campaign</td>
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<td>CAUTI</td>
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<td>Late Fall Prevention Worksheet</td>
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<td>The Benefits of Promoting Mobility and Preventing Falls in the Hospital</td>
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IHAconnect.org/Quality-Patient-Safety
Teach-Back Tool

http://www.hret-hiin.org/resources/display/hret-hiin-teachback-tool-for-falls-prevention
AHRQ Toolkit

Preventing Falls in Hospitals
A Toolkit for Improving Quality of Care

https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html
Social Media Messaging

• IHA has created messaging for both general public, health care providers

• Messaging provided for formats:
  - Twitter
  - Facebook
  - LinkedIn
How are you incorporating GET UP within your organization?

http://www.hret-hiin.org/engage/up-campaign.shtml
GET UP Webinar Series

Oct. 31 - Early Progressive Mobility in the ICU
   Performance Improvement in a High Risk Unit

Nov. 14 - HAPU Prevention with Early Mobility

Dec. 12 - Multi-disciplinary Approach to Early Progressive Mobility
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