



New York State  
Partnership  
for Patients



Get **Moving**  
Get **Healthy**  
Get **Home**



## A PROGRESSIVE MOBILITY PROGRAM TOOLKIT

A partnership of the Healthcare Association of New York State  
and the Greater New York Hospital Association

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# Introduction

The Centers for Medicare & Medicaid Services Partnership for Patients' goals under the Hospital Improvement and Innovation Network program are to reduce avoidable hospital-acquired conditions (HACs) and readmissions. The New York State Partnership for Patients (NYSPFP)—a partnership of the Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association (GNYHA)—has worked with hospitals since 2012 to achieve these goals by using multifaceted approaches to quality improvement (QI) to reduce HACs and readmissions.

Enhancing a patient's mobility can reduce length of stay, HACs,<sup>1,2</sup> and is an important tool for enhancing patient outcomes.

## What is a Progressive Mobility Program?

A progressive mobility program helps improve overall patient outcomes by focusing on patients' functional ability and overcoming barriers to progressive mobilization. Progressive mobilization begins early in a patient's hospitalization and includes documenting daily goals that are consistent with the patient's ability to move two to three times a day.

By using the tools in this toolkit, clinicians can set daily goals that are progressively more challenging to help the recovering patient avoid muscle loss. Daily goals could be as simple as having the patient sit up while a doctor listens to their breathing or walk a set number of steps around their hospital floor.

Clinicians should incorporate progressive mobility into daily workflows with the same importance as taking blood pressure readings or conducting medication reconciliation. Additionally, documenting in the electronic medical record (EMR) the patient's mobility level and efforts to mobilize is key for measuring workflow processes and outcomes. Understanding and reconciling the patient's ability to move and meet goals is also an essential part of the program.

Numerous studies support and describe the benefits of increased mobility for inpatients,<sup>3</sup> which include decreased chance of acquiring complications such as pneumonia, pressure ulcers, and falls, and a reduced length of stay. Additionally, patients who are less mobile and who have reduced function at discharge face a higher risk of readmission.<sup>4</sup>

Several hospitals and healthcare systems around the country have implemented progressive mobility programs, many of which started in the intensive care unit. These initiatives demonstrate that implementing a hospital-wide mobility program is feasible for medically vulnerable patients who have multiple comorbidities.<sup>5</sup>

1 E.H. Hoyer, Friedman, M., Laezza, A., et al., "Promoting Mobility & Reducing Length of Stay in Hospitalized General Medicine Patients: A Quality Improvement Project." *Journal of Hospital Medicine* vol. 11, no. 5 (May 2016); 341-7.

2 C.R. Teodoro, Breault, K., Garvey, C., et al., "STEP-UP: Study of the Effectiveness of a Patient Ambulation Protocol." *MEDSURG Nursing* vol. 25, no. 2 (March-April 2016); 111-116.

3 D.S. Schujmann, Lunardi, A.C., Fu, C., "Progressive Mobility Program and Technology To Increase the Level of Physical Activity and Its Benefits in Respiratory, Muscular System, and Functionality of ICU Patients." *Trials* vol. 19, no. 1 (May 2018); 274.

4 E. H. Hoyer, Needham, D.M., Miller, J., et al., "Functional Status Impairment is Associated with Unplanned Readmissions." *Archives of Physical Medical Rehabilitation* vol. 94, no. 10 (October 2013); 1951-8.

5 B.C. Pottenger, Pronovost, P.J., Kreif, J., et al., "Towards Improving Hospital Workflows: An Evaluation of Resources to Mobilize Patients." *Journal of Nursing Management* vol. 27, no. 1 (January 2019); 27-34.

This toolkit helps hospitals implement a progressive mobility program by incorporating the following into their standard workflow:

- Ambulate patients two to three times daily
- Discuss the patient's functional status during huddles, multidisciplinary rounds, and hand-offs
- Set daily mobility goals based on the patient's ability to move
- Align your hospital's mobility initiative with other harm-reduction initiatives, such as falls, pressure injuries, readmissions, venous thromboembolism, and ventilator-associated harms.<sup>6</sup>

The following sections provide tools to help hospitals implement a progressive mobility program and achieve a hospital-wide culture of activity and mobility.



### ***How to Use This Toolkit***

The NYSPFP progressive mobility program toolkit, *Get Moving, Get Healthy, Get Home*, helps hospitals plan and implement a hospital-wide progressive mobility program for inpatients. This toolkit contains resources and links to other tools and materials that can help hospitals tailor their progressive mobility program based on the facilities' needs and resources.

<sup>6</sup> L. M. Klein, Young, D., Feng, D., et al., "Increasing patient mobility through an individualized goal-centered hospital mobility program: A quasi-experimental quality improvement project." *Nursing Outlook* vol. 66, no. 3 (May–June 2018); 254–262.

# Chapter 1. Plan and Implement a Progressive Mobility Program

Planning any successful QI program requires that several key steps be taken. This chapter will discuss some of those steps. The order in which they are conducted will vary by each institution's or health system's internal culture and protocols.

## 1.1 Obtain Buy-in from Leadership & Key Stakeholders

Successful QI programs need the support of hospital or health system leadership, including the Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, and Chief Nursing Officer. The Progressive Mobility Resource List ([Appendix A](#)) includes studies that support the need for mobility programs, the benefits to patients,

and potential cost savings. Summarizing the evidence and presenting it to leadership helps make the case for a progressive mobility program.

## 1.2 Convene a Team of Stakeholders and Define Roles

Every QI program needs a dedicated team where each member has a defined role and is collectively responsible for planning the intervention, implementing it, and measuring the results. Team members should be interested in improving patient mobility and have some related expertise. For example, a progressive mobility initiative could potentially impact nursing and physical therapy, so multiple representatives from both areas

### **Tips and Considerations for Gaining Buy-In**

- Speak to colleagues who are working on core initiatives such as fall prevention and safe patient handling committees. Besides helping coordinate efforts, colleagues who have rolled out similar initiatives may have advice and suggestions on how to integrate progressive mobility into the other initiative areas.
- Use social marketing materials to promote mobility in your hospital

#### *Suggested social marketing tools for mobility promotion in your hospital:*

NYSPFP has created three videos on progressive mobility for different healthcare audiences.

NYSPFP also worked with social marketing experts to create multimedia materials that promote progressive mobilization and other efforts to change behaviors hospital wide. (See [Appendix B](#))

The videos discuss the definition of progressive mobility, its benefits, and how to implement it. Each video targets a specific audience:

- hospital leadership: <https://www.youtube.com/watch?v=9mddhKAEQTQ>
- clinicians: <https://www.youtube.com/watch?v=1xKAP4qCKVQ>
- patients: <https://www.youtube.com/watch?v=Y9vh19mOmOM>

*To maximize the benefits of the videos to promote a hospital-wide culture of mobility, consider sharing them in the following places:*

- hospital digital bulletin boards
- screensavers at hospital staff workstations
- patients' television monitors

should be involved in planning and implementation to share their expertise and knowledge of providing day-to-day patient care.

Roles should include, but not be limited to:

- Executive sponsors
- Day-to-day leaders
- Technical experts
- Clinical leaders
- Unit-based champions

Mobility subject-matter experts include:

- Physical therapists
- Physician leaders in rehabilitation
- Informaticists
- Geriatric resource nurses
- Geriatric nurse practitioners

### 1.3 Assess Organizational Readiness to Implement a Progressive Mobility Program

Organizational readiness is a change management concept that refers to staff and patient receptiveness to change and the organization's capacity to implement it. Organizational readiness may be key to determining an initiative's long term success. There are several ways to determine organizational readiness in advance.

Elicit clinical staff and physician input using:

- Focus groups
- Surveys
- Staff interviews
- Patient and family interviews

Clinicians associated with hospital-wide mobility programs are nurses, physicians, physical therapists, nursing assistants, and volunteers. Assessing their thoughts and attitudes on patient mobility will reveal barriers and beliefs that are common to staff and offer ideas about where education efforts might need to be focused.

Attitudes and beliefs that are common to a hospital's staff could include, but not be limited to, the notion that patients are too sick to be mobilized; mobilization is a task for physical therapists alone; and that nurse workloads and patient ratios make mobilization three times per day unfeasible.



#### **Considerations for Assessing Organizational Readiness**

- Survey patients and families about their attitudes toward mobility. Their views might highlight barriers that need to be addressed in the planning phases.
- Design mobility interventions that address the barriers and beliefs gleaned from the survey. Address the barriers that have the highest impact and lowest resistance.

*Example:* Staff may believe a progressive mobility program will add to their workload. One way to address this barrier is to design a program in which nursing students, clinical technicians, and volunteers are called upon to mobilize certain patients. The program could also engage a patient's family, friends, and care partners—as clinically appropriate—to help the patient mobilize.

To address the above considerations, design a survey or use one of the surveys suggested below to elicit both objective and subjective answers regarding hospital-wide mobilization of patients.

The following tools include key questions and strategies to assist staff in assessing potential challenges to implementing a progressive mobility program.



### ***Suggested Tools and Resources for Identifying Barriers and Beliefs Surrounding Mobility***

*Johns Hopkins Medicine HealthCare Solution, Patient Mobilization Attitudes and Beliefs Survey*

This survey is designed to be taken by multidisciplinary providers. Its use is critical to learning about staff opinions and perceptions regarding the mobilization of hospital patients.

[https://www.hopkinsmedicine.org/physical\\_medicine\\_rehabilitation/education\\_training/amp/](https://www.hopkinsmedicine.org/physical_medicine_rehabilitation/education_training/amp/)

**Tips:** Consider debriefing the survey results with staff. Remain positive during the discussion, and listen to staff without trying to address any of the barriers mentioned.

*Florida Hospital Association's (FHA) GET UP Campaign Implementation Self-Assessment/GET UP Planning Matrix*

The FHA self-assessment planning matrix assesses organizational readiness. It uses a concise checklist of practices that are fundamental to planning a mobility process improvement initiative.

<http://www.fha.org/files/HIIN/Get-UP-Campaign-Assessment-and-Testing-Tool.pdf>

**Tips:** Before launching a progressive mobility QI initiative, convene a team of key multidisciplinary stakeholders that includes frontline staff. Using the matrix as a guide, ask members of the team for input on potential approaches to implementing the intervention.

## **1.4 Establish Progressive Mobility Interventions**

**Intervention 1: Standardize Assessment of Patient Mobility**  
Assessing and documenting the patient's ability to move on admission and daily tracks their progress. This will also allow the implementation team to measure progress on the implementation of daily assessments and the recording of the patient's mobility goals, progress, and outcomes, which are often used as process measures in progressive mobility implementation projects.



### ***Suggested Tools and Resources for Standardizing Assessment of Patient Mobility***

*Activity Measure for Post-Acute Care (AM-PAC)*

Developed by Boston University, AM-PAC uses the World Health Organization's International Classification of Functioning, Disability and Health and can be incorporated into a facility's or health system's EMR. This tool is used to quickly assess inpatients for their level of activity and mobility. The patient's score on the assessment helps guide decisions on which patients require a physiotherapy consult. It is commonly called "six clicks" because it includes only six questions.

<https://www.mediware.com/wp-content/uploads/AM-PAC-Inpatient-Basic-Mobility-Short-Form.pdf>

**Tips:** More information on the tool's development and how to use it is available on the Boston University AM-PAC website: <http://am-pac.com/category/home/>



### **Suggested Tools and Resources for Standardizing Assessment of Patient Mobility (continued)**

#### **Get Up and Go Test**

The *Get Up and Go* test<sup>7</sup> should be conducted as part of a routine evaluation for older persons. Its purpose is to detect “fallers,” and identify those who need evaluation. It also can be used with the FHA planning matrix previously noted (see [page 5.](#))

[http://www.gericareonline.net/tools/eng/falls/attachments/Falls\\_Tool\\_2\\_Get\\_Up\\_and\\_Go\\_Test.pdf](http://www.gericareonline.net/tools/eng/falls/attachments/Falls_Tool_2_Get_Up_and_Go_Test.pdf)

#### **When should the tool be used?**

FHA recommends using the tool on admission for older patients to assess their ambulation/activity status.

**Tips:** Explaining the importance of mobility to the patient and family or care partner should be initiated at admission, with reminders and offers to assist done routinely. Additionally:

- Don't assume a frail appearance means weakness
- Plan mobility interventions early with the patient and family or care partner

#### **Banner Mobility Assessment Tool for Nurses (BMAT)**

The BMAT<sup>8</sup> is a four-step functional task list that classifies patients by level of mobility depending on tasks they can complete, such as being able to sit up and put their

legs over the bedside or stand. The tool then guides the nurse to the recommended safe patient handling mobility technology needed to safely lift, transfer, and mobilize the patient.

[https://myamericannurse.com/wp-content/uploads/2014/09/ant9-Patient-Handling-Supplement-821a\\_Implementing.pdf](https://myamericannurse.com/wp-content/uploads/2014/09/ant9-Patient-Handling-Supplement-821a_Implementing.pdf)

**Tips:** Create educational tools and tipsheets to train nurses and support staff on what technology to consider for patients at each level. Create workflow reports to help the units track a patient's progress.

Other resources that support use of the BMAT:

- <http://www.hret-hiin.org/resources/display/bmat-banner-mobility-assessment-tool-for-nurses>
- [https://www.americannursetoday.com/wp-content/uploads/2014/09/ant9-Patient-Handling-Supplement-821a\\_Implementing.pdf](https://www.americannursetoday.com/wp-content/uploads/2014/09/ant9-Patient-Handling-Supplement-821a_Implementing.pdf)
- <https://www.safety.duke.edu/ergonomics/sphm/bmat-bedside-mobility-assessment-tool>

### **Intervention 2: Incorporate Daily Mobility Goals Into Care Plan**

It is essential to set achievable daily mobility goals to assist patients to safely mobilize to the highest level of their current mobility. This also allows patients and staff to better track mobility progress and outcomes.

7 D. Podsiadlo, Richardson, S., “The timed ‘Up & Go.’ a test of basic functional mobility for frail elderly persons.” *Journal of the American Geriatrics Society* vol. 39, no. 2 (February 1991); 142-8.

8 T. Boynton, Kelly, L., Perez, A., et al., “Banner Mobility Assessment Tool for Nurses: Instrument Validation.” *American Journal of Safe Patient Handling & Moving* vol. 4, no. 3 (September 2014); 86-92.





### **Suggested Tool for Establishing Daily Mobility Goals for Patients**

#### *Johns Hopkins Medicine Highest Level of Mobility Scale (JH-HLM)*

The JH-HLM was developed based on input from multiple disciplines—including nurses, physical and occupational therapists, and physicians—for the following uses<sup>9</sup>:

- Record the mobility that a hospitalized patient actually has, not what they are capable of doing. Documentation is based on observation and should reflect the highest level of mobility (HLM) the patient performed since last documented
- Document HLM twice daily during waking hours on all patients
- Standardize the description of patient mobility across multidisciplinary providers
- Set individual patient mobility goals during hospitalization
- Create a performance measure for QI projects to promote patient mobility

[https://www.hopkinsmedicine.org/physical\\_medicine\\_rehabilitation/education\\_training/amp/toolkit.html](https://www.hopkinsmedicine.org/physical_medicine_rehabilitation/education_training/amp/toolkit.html)

## **1.5 Build Mobility Interventions Into Daily Workflow**

### **Develop a Process Map of the Desired Workflow**

A process map depicts the steps that comprise a process and highlights inefficiencies and duplication. Creating an ideal process map before beginning to implement a progressive mobility program can clarify how to include mobility assessments in the workflow.

See [Appendix C](#) for a sample idealized process map.

For help creating a process map, refer to the Institute for Healthcare Improvement guide on flowcharts (flowcharts are also known as process maps): <http://www.ihl.org/resources/Pages/Tools/Flowchart.aspx>

### **Develop Education and Training Materials for Staff**

Any educational materials for staff should include the benefits of increased mobility for patients and staff. Consider handing out the Progressive Mobility Resource List ([Appendix A](#)) to demonstrate how progressive mobility has improved patient care and outcomes.

Some best practices<sup>9</sup> to incorporate into your progressive mobility program include:

- Plan to mobilize patients two to three times daily
- Document all mobilization assessments in the patient's record daily
- Document the patient's actual mobilization in the daily record when it occurs
- Collaborate to set daily goals for a patient's mobility. Doctors and nurses can work on this with patients who have higher mobility scores; for patients who are not mobile or who have low scores, call in physical therapy staff to collaborate.

One of the implementation team's first steps in developing education and training materials should be to agree on a common definition of patient mobility and what types of movements would meet that definition.

Clinicians already have many responsibilities, so asking them to add mobility assessment and mobilization to their workload will be a big request. Explain to them how increased mobility can lighten their workload in the long run and benefit patients.

The implementation team should work with champions and other leaders to shift staff's understanding of mobility assessment and make it as routine a practice as taking a patient's blood pressure.

<sup>9</sup> Johns Hopkins Medicine Activity and Mobility Promotion (AMP), #everyBODYmoves Campaign and Resources. (2020). Retrieved from: [https://www.hopkinsmedicine.org/physical\\_medicine\\_rehabilitation/education\\_training/amp/everybodymoves/](https://www.hopkinsmedicine.org/physical_medicine_rehabilitation/education_training/amp/everybodymoves/).

In addition, the process of examining a patient's mobility scores and activities to determine the reason for any changes should become as routine a process as medication reconciliation.



### ***Other Progressive Mobility Program Toolkits***

*FHA GET UP Toolkit and Resource Guide:*

<http://www.fha.org/files/HiIN/GET-UP-Toolkit-Resource-Guide-2018.pdf>

*Johns Hopkins Medicine Activity and Mobility Promotion Program:*

[https://www.hopkinsmedicine.org/physical\\_medicine\\_rehabilitation/education\\_training/amp/index.html](https://www.hopkinsmedicine.org/physical_medicine_rehabilitation/education_training/amp/index.html)

The American Hospital Association's (AHA) *Health Research Education Trust Toolkit* provides resources for the progressive mobility program component to the AHA's Up Campaign:

<http://www.hret-hiin.org/engage/up-campaign.shtml>

## Chapter 2. Pilot a Progressive Mobility Program

The Institute for Healthcare Improvement's (IHI) Model for Improvement<sup>10</sup> recommends starting a new program by launching a pilot program in one unit or area of the hospital before launching the hospital-wide version. The small-scale start allows the implementation team to identify and fix any unanticipated problems before initiating the full rollout.

Once a unit is selected for the pilot, identify the clinicians—nurses, doctors, and physical therapists—who are assigned to the unit or who work on it frequently who could act as champions for the intervention.

### 2.1 Provide Education on Progressive Mobility

#### For Staff

Start by attending unit meetings and huddles to introduce the concept of progressive mobility and elicit staff feedback. Also attend meetings for night and weekend shifts to ensure the inclusion of all staff. Then, use staff in-services or other meetings to further discuss the assessments, goal-setting aspects, and tools that staff will use and protocols they will follow.

#### For Patients and Care Partners

Create flyers and other materials to enlist patients, family, and care partners in the movement. Aside from mobilizing patients with higher mobility scores, patients and families or care partners may take the message of mobility's importance home and continue working on it there.

### 2.2 Observe Staff and Practice the Process

During the rollout of the pilot unit, observe staff as they conduct the assessments, implement the mobility goals, and document their efforts. Seek gaps or defects in the

process. Talk to clinicians and staff about their thoughts on the program; their feedback may help identify unique issues to resolve.

Once the pilot is up and running, you will need to measure and assess its performance. The next chapter details how to select measures and collect data for the initiative.



#### **Using PDSA to Assess Change**

You can use the Plan-Do-Study-Act (PDSA) cycle for the pilot initiative.

IHI worksheet for the PDSA:

<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>

<sup>10</sup> Institute of Healthcare Improvement, "The Life Cycle of a Quality Improvement Project." (2020.) Retrieved from: [http://app.ihl.org/LMS/Content/2ad-f747a-862f-4862-ab0c-561318f05b67/Upload/Revise/QI104\\_PDSAsComparison.pdf](http://app.ihl.org/LMS/Content/2ad-f747a-862f-4862-ab0c-561318f05b67/Upload/Revise/QI104_PDSAsComparison.pdf).



# Chapter 3. Measure Performance

The new pilot program will need process and outcome measures to assess its impact. The implementation team needs to create and establish these measures before the debut of the pilot program. The team also will need to clearly convey the measures and how to record them to clinicians and staff on the pilot unit.

## 3.1 Select and Define Measures

The implementation team should decide what needs to be measured as part of a progressive mobility program. One type of measure they could use is a process measure. Process measures track compliance with new protocols. A second type is an outcome measure, which considers the initiative's impact on patient health. Other data already being collected also could provide that information (e.g., the number of falls, length of stay on the unit, readmissions). These types of measures are proxy measures.

Another type, balancing measures, consider whether a new change is causing unintended problems elsewhere.

Standardize and define all measures and communicate them clearly to staff. Seek measures that are useful, but not necessarily perfect. Keep them simple.

### Suggested Process and Outcome Measures for a Progressive Mobility Program

- Process Measure: Percentage (%) of patients with documented daily mobility assessment and score
  - Numerator: Number of patients with a mobility assessment documented within 24 hours
  - Denominator: All patients on unit or in hospital
- Outcome Measure: Percentage (%) of patients with documented daily assessment who achieved their daily mobility goal
  - Numerator: Number of patients in a unit or hospital with documentation who meet the mobility goal corresponding to the mobility assessment score
  - Denominator: All patients in a unit or hospital with a mobility assessment documented within 24 hours

#### Tips for Data Collection

If you use an EMR to document the mobility assessment, design a process for obtaining reports on the patient assessment and mobility scores to track progress over time and to ensure mobility is assessed daily. If you're not using an EMR to document the assessment, create a tracking system and ensure a way to generate reports on the measures being tracked. Share the unit-level data with staff.



#### *Tips for Developing Project Measures*

As you develop measures, review the IHI's "Science of Improvement: Establishing Measures"

<http://www.ihl.org/resources/Pages/Howto-Improve/ScienceofImprovementEstablishingMeasures.aspx>



## Appendix A. Progressive Mobility Resource List

Creating a Culture of Mobility			
References	Summary	Findings	Comments
Creating a culture of mobility: an interdisciplinary approach for hospitalized patients. (T. Czaplinski, et al.)	This <i>Journal of Hospital Topics</i> article describes how an interdisciplinary-team approach changed an organization's culture on early patient mobility programs.	The article notes that culture change is accomplished through changes in thought practice and perception.	The program's goals were to focus physical and occupational therapy services on patients who would benefit from the skilled expertise, and to develop nursing protocols, physician order sets, expectations, and education to promote movement of all patients according to their needs and abilities.
Promoting mobility and reducing length of stay in hospitalized general medicine patients: A quality-improvement project. (E. H. Hoyer, et al.)	The team used a structured quality improvement (QI) model to determine whether a multidisciplinary mobility project would increase patient mobility and reduce hospital length of stay (LOS).	The authors found that a structured QI approach could actively prevent a decline in physical function that commonly occurs during hospitalization.	In an adult medicine population, this QI project helped improve mobility and may have contributed to a reduction in LOS.
Sustainability of a nurse-driven early progressive mobility protocol and patient clinical and psychological health outcomes in a neurological intensive care unit. (K.E. Klein, et al.)	A prospective longitudinal comparative study determined sustainable impact of an early progressive mobility protocol on mobility level and clinical outcomes.	Among 260 pre-intervention, 377 post-implementation, and 480 12-month post-implementation patients (N = 1117), walking increased post-implementation and was sustained at the eight-month assessment.	Ongoing implementation of an early mobility program in a neurological intensive care environment led to sustained improvement in patients' level of mobility, length of unit and hospital stay, depression, anxiety, and hostility levels.
Increasing patient mobility through an individualized goal-centered hospital mobility program: A quasi-experimental QI project. (L.M. Klein, et al.)	The QI mobility program on the project unit was compared to a similar control unit providing usual care. The Johns Hopkins Mobility Goal Calculator was created to guide a daily patient mobility goal based on the level of mobility impairment.	On the project unit, patient mobility increased from 5.2 to 5.8 on the Johns Hopkins Highest Level of Mobility score, mobility goal attainment went from 54.2% to 64.2%, and patients exceeding the goal went from 23.3% to 33.5%.	An individualized, nurse-directed, patient mobility program using daily mobility goals is a successful strategy to improve daily patient mobility in the hospital.

Barriers to Mobility			
References	Summary	Findings	Comments
Perceived Barriers to Mobility in a Medical ICU: The Patient Mobilization Attitudes & Beliefs Survey for the ICU. (C. M. Goodson, et al.)	The 26-item Patient Mobilization Attitudes & Beliefs Survey adapted for the ICU (PMABS-ICU) was administered online to 163 nurses, clinical technicians, respiratory therapists, attending and fellow physicians, nurse practitioners, and physician assistants in one medical ICU.	In the medical ICU, across six different clinical roles, there were relatively low perceived barriers to patient mobility, with greater work experience over the first 10 years being associated with lower perceived barriers.	As part of a structured QI project, the PMABS-ICU may be valuable in assisting to identify specific perceived barriers for consideration in designing mobility interventions for the ICU setting.
Barriers to early mobility of hospitalized general medicine patients: survey development and results. (E. H. Hoyer, et al.)	A cross-sectional self-administered survey in two different hospital settings was completed by 120 nurses and physical and occupational therapists (38 rehabilitation therapists; 82 nurses) from six general medicine units.	This novel survey identified important barriers to mobilizing medical inpatients that were similar across two hospital settings. These results can assist with the implementation of QI projects for increasing early hospital-based patient mobility.	A functional status decline commonly accompanies hospitalization, making patients vulnerable to complications. Such decline can be mitigated through hospital-based early mobility programs.
Identifying Barriers to Nurse-Facilitated Patient Mobility in the Intensive Care Unit. (D. L. Young, et al.)	An inter-professional team designed an observational process and evaluated the resulting data via qualitative content analysis.	During three four-hour observations of two nurses and one nursing technician, 194 distinct tasks were performed. The 194 observed events included 34 instances (18%) of potential mobility events that could be implemented: in bed (53%), at edge of bed (6%), and out of bed (41%).	Nurse-facilitated mobility of patients in the ICU can improve outcomes. However, a gap between research findings and implementation is part of routine clinical practice. It is often partly attributed to the barrier of lack of time.



Adverse Effects of Immobility & Bedrest			
References	Summary	Findings	Comments
Prevalence and outcomes of low mobility in hospitalized older patients. (C. Brown, et al.)	Prospective cohort study to estimate the prevalence of different levels of mobility in a hospitalized older cohort to measure the degree and rate of adverse outcomes associated with different mobility levels and to examine the physician activity orders and documented reasons for bedrest in the lowest-mobility group.	Low and intermediate levels of mobility were common, accounting for 80 (16%) and 157 (32%) study patients, respectively. Overall, any activity of daily living (ADL) decline occurred in 29%, new institutionalization in 13%, death in 7%, and death or new institutionalization in 22% of patients in this cohort.	Low mobility and bedrest are common in hospitalized older patients and are important predictors of adverse outcomes. This study demonstrated that the adverse outcomes associated with low mobility and bedrest may be viewed as iatrogenic events leading to complications such as functional decline.
The underrecognized epidemic of low mobility during hospitalization of older adults. (C. Brown, et al.)	Prospective observational cohort study to examine the proportion of time spent in three levels of mobility (lying, sitting, standing, or walking) by a cohort of hospitalized older veterans.	As measured by validated wireless accelerometers, no patient remained in bed the entire measured hospital stay, but 83% of the measured hospital stay was spent lying in bed on average.	The first study to continuously monitor mobility levels early during a hospital stay. On average, older hospitalized patients spent most of their time lying in bed despite their ability to walk independently.
Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age. (K.E. Covinsky, et al.)	Prospective observational study to describe the changes in activities of daily living (ADL) function occurring before and after hospital admission in older people hospitalized with medical illness and to assess the effect of age on loss of ADL function.	Thirty-five percent of patients declined in ADL function between baseline and discharge.	Many hospitalized older people are discharged with ADL function that is worse than their baseline function. The oldest patients are at particularly high risk of poor functional outcomes.

Measurement of Functionality			
References	Summary	Findings	Comments
Association of Wearable Activity Monitors With Assessment of Daily Ambulation and Length of Stay Among Patients Undergoing Major Surgery. (T.J Daskivich, et al.)	Prospective cohort study to define the distribution of digitally measured daily step counts after major inpatient surgical procedures to assess the accuracy of physician assessment and ordering of ambulation and to quantify the association of digitally measured step count with LOS.	Among 100 patients (53% female), the mean (SD) age was 53 (>18) years and the median LOS was four days (interquartile range, three to six days). There was a statistically significant increase in daily step count with successive postoperative days in aggregate ( $r=0.55$ ; 95% bootstrapped CI, 0.47-0.62; $P<.001$ ) and across individual operations.	Wearable activity monitors improved the accuracy of assessment of daily step count over the current standard of care, providing an opportunity to identify patients at risk for poor efficiency outcomes.
Comparison of Posthospitalization Function and Community Mobility in Hospital Mobility Program and Usual Care Patients. (C. Brown, et al.)	Single-blind randomized clinical trial to examine the effect of an in-hospital mobility program (MP) on posthospitalization function and community mobility.	Of 100 patients, eight did not complete the study (six in the MP group and two in the usual care [UC] group). Patients (mean age, 73.9 years; 97 male [97.0%]; and 19 black [19.0%]) had a median LOS of three days. No significant differences were found between groups at baseline. For all periods, groups were similar in ability to perform ADL; however, at one-month after hospitalization, the life span assessment score was significantly higher in the MP.	A simple MP intervention had no effect on ADL function. However, the MP intervention enabled patients to maintain their prehospitalization community mobility, while those in the UC group experienced clinically significant declines.
Functional status impairment is associated with unplanned readmissions. (E. H. Hoyer, et al.)	Retrospective cohort study to determine whether functional status on admission to a Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP) is associated with unplanned readmission to acute care.	Among 1515 patients, 347 were readmitted. Total readmissions were significantly associated with functional independence measure scores, with adjusted odds ratios and 95% confidence intervals.	Functional status on CIIRP admission is strongly associated with readmission to acute care. Efforts to reduce hospital readmissions should consider patient functional status as an important and potentially modifiable risk factor.
Routine Inpatient Mobility Assessment and Hospital Discharge Planning. (E. H. Hoyer, et al.)	Retrospective cohort study to examine whether the use of a mobility assessment tool in hospitalized patients with impaired mobility is associated with discharge to a post-acute facility.	Mobility scores were completed at admission and discharge for more than 95% of patients. Among 2876 patients, 716 (25%) were discharged to a facility.	Patient mobility is an indicator of health and a predictor associated with clinical outcomes. However, mobility status is not routinely measured in hospitalized patients.

## Safe Patient Handling

References	Summary	Findings	Comments
Safe patient handling and movement: a literature review. (J. Mayeda-Letourneau)	A critical review of the safe patient handling literature was conducted to study the impact of a safe patient handling and movement (SPHM) program on healthcare worker injuries, job satisfaction, and associated costs.	A SPHM program decreases overall work injury costs and improves healthcare worker job satisfaction.	Reduced work injuries, decreased injury costs, improved patient outcomes validated in research, and employees feeling their employer's support all contribute to a program that moves an organization toward a culture of safety.
Prevention of disabling back injuries in nurses by the use of mechanical patient lift systems. (R. F. Edlich, et al.)	This review in the <i>Journal of Long Term Effects of Medical Implants</i> describes strategies to prevent occupational back pain in nurses (OBPN).	OBPN is a major source of morbidity in the healthcare environment. According to the National Institute for Occupational Safety and Health, occupational back injury is the second leading occupational injury in the United States.	Patient handling is a well-documented way to safely use assistive equipment and devices to eliminate hazards that invite serious back injuries in nurses.
Zero lift programs in small rural hospitals in Washington state: reducing back injuries among health care workers. (W. Charney, et al.)	This pre-test-post-test descriptive study compared patient-handling injury data prior to program implementation with those after program implementation.	Patient-handling injury claims decreased by 43% in participating hospitals from 2000 to 2004 (i.e., from 3.51 to 2.23). The time lost frequency rate decreased by 50% (i.e., from 1.91 to 1.03).	In Washington state, health-care workers have the highest rate of compensable back injuries. Zero lift was defined as replacing manual lifting, transferring, and re-positioning of patients with mechanical lifting or use of other patient assist devices.

Resourcing Mobility Programs			
References	Summary	Findings	Comments
Towards improving hospital workflows: An evaluation of resources to mobilize patients. (B.C. Pottenger, et al.)	A prospective time and motion study was conducted to characterize resources to safely mobilize different types of patients.	In 212 total mobility sessions, the median time-to-mobilize and time-to-document were 7.75 and 1.27 minutes, respectively. Additional staff support was required for 87% and 92% of patients with medium and high-mobility limitations, respectively.	The study characterized the three primary resource inputs—time, staff assistance, and assistive devices—needed to engineer mobility workflows. The information may help to ensure that nurses receive appropriate support to integrate regular mobility activities into their patient care workflows.
Choosing Wisely Together: Physical and Occupational Therapy Consultation for Acute Neurology Inpatients. (J.C. Probasco, et al.)	A multidisciplinary team on the general and cerebrovascular neurology acute inpatient services mapped the rehabilitation consultation process. Multiple interventions included modifications to multidisciplinary rounds, discussion of patient rehabilitation needs, and physician education on appropriate rehab consults.	The rate for initial rehabilitation consults for patients with no limitations in mobility or activity during the six-month baseline period was 12%, which fell to 7% and 10% during the six-month intervention and sustain periods, respectively.	A multifaceted intervention led to improved use of acute inpatient rehabilitation consultation while increasing the frequency of rehabilitation treatment for patients with the highest functional impairment.
Inpatient Mobility Technicians: One Step Forward? (D.L. Young, et al.)	This <i>Journal of Hospital Medicine</i> editorial notes that a single blind randomized pilot trial by Rothberg, et al., where the authors confirmed previously known findings that inpatient mobility, which was assessed in this study by accelerometers, predicts post-hospital patient disposition.	One-hundred-two inpatients aged 60 years and older were randomly assigned to one of two groups: intervention (ambulation protocol) or usual care. Patients in the intervention group took significantly more steps on average compared with those receiving usual care (994 versus 668).	This study highlights the feasibility of using trained mobility technicians rather than more expensive providers (e.g., physical therapists, occupational therapists, or nurses) to enhance inpatient ambulation.

## Prevention of Hospital Acquired Conditions & Mobility

References	Summary	Findings	Comments
6-PACK programme to decrease fall injuries in acute hospitals. (A.L. Barker, et al.)	A cluster randomized controlled trial to evaluate the effect of a nurse-led six-PACK program on falls and fall injuries in acute wards. The trial sought to increase the frequency with which the six-PACK interventions were used on the premise that increased use decreased falls and associated harm.	The trial was successful at increasing use of the six-PACK interventions, with a high proportion of patients receiving interventions within the first day of their ward admission. However, the interventions had no effect on falls or fall injuries compared with usual care.	The six-PACK program is a nurse-led, multifactorial falls prevention program for acute care hospitals. It includes a nine-item fall risk tool and six interventions, including ones to improve safety of mobility, as impaired mobility is a common fall risk factor.
Validation of the mobility subscale of the Braden Scale for predicting pressure sore risk. (G.C. Powers, et al.)	A study to establish the convergent construct validity of the mobility subscale of the Braden Scale Movement as recorded by a Motionlogger Actigraph, a wristwatch-sized accelerometer and micro-processor that measures physical movement (activity) continuously.	Convergent construct validity for the Braden mobility subscale was supported. The mean activity for each of the four subscale score groups was plotted, producing a histogram in which higher scores were associated with greater activity.	The Braden Scale for Predicting Pressure Sore Risk has been tested extensively for reliability and validity, but the validity of each subscale has not been evaluated. Because subscale scores guide patient care decisions, validity is an important issue.
The Tension Between Promoting Mobility and Preventing Falls in the Hospital. (M.E. Growdon, et al.)	The authors of this <i>JAMA Internal Medicine</i> article conducted a systematic review of literature that supports their view that promoting mobility in the hospital may actually help to prevent injurious falls, thus calling into question the practice of immobilizing patients for the sake of fall prevention.	The strongest evidence comes from the Hospital Elder Life Program (HELP), which enhances mobility while decreasing falls. HELP, which one author (of the article) helped to design, is a multicomponent program to prevent delirium, a leading risk factor for hospital falls.	While hospital falls can lead to harm, treating them as “never events” has led to over-implementation of measures with little efficacy for falls, yet profound contribution to immobility.
Early Mobility in the Hospital: Lessons Learned from the STRIDE Program. (S.N. Hastings, et al.)	This <i>Geriatrics</i> paper describes how STRIDE (assisted early mobility for hospitalized older veterans), a supervised walking program, works and how it is being shared with other hospitals via Replicating Effective Programs framework.	While hazards of immobility during hospitalization have been long-known, sustained solutions to the problem have been elusive. STRIDE offers a promising approach for hospitals to support increased mobility in their patients.	Several studies demonstrate that inpatient walking programs can mitigate negative outcomes, yet hospital mobility programs are not widely available in US hospitals.

Prevention of Hospital Acquired Conditions & Mobility			
References	Summary	Findings	Comments
STEP-UP: Study of the Effectiveness of a Patient Ambulation Protocol. (C.R. Teodoro, et al.)	Pre-test/post-test randomized controlled trial was used to compare a planned ambulation program (STEP-UP: brief ambulation educational videotape, posting of daily ambulation goals, ambulation reminders) to usual care.	The sample included 48 patients (n=22 ambulation program [AP]; n=26 usual care [UC]). No differences were found between the two groups for age, sex, reason for admission, and/or pre-test amount of ambulation ( $p>0.05$ ). The amount of ambulation for the AP group increased from pre-test values, while the amount of ambulation for the UC group decreased from pre-test values.	A pragmatic ambulation program that could be incorporated easily into clinicians' practice routines significantly improved ambulation in hospitalized patients, helping them STEP-UP during hospitalization.

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# Appendix B. Social Marketing Shareables

## What are Social Marketing Shareables?

Social marketing shareables are videos, images, and text that help hospitals educate patients, staff, and the community about your organization's progressive mobility program via platforms such as Twitter, Instagram, Facebook, LinkedIn, hospital-specific homepages, and discussion forums.

## How are Shareables Used?

### Video

You can embed a link to a video on your hospital's homepage or other educational platform and share via social media as desired.

### Images

NYSPPF encourages hospitals to use these images on any social media or internal educational platform. You can modify the images by inserting your hospital logo, if desired.

### Text

NYSPPF text details the benefits of progressive mobility; your hospital's public relations or education teams can copy and paste it into any social media platform. Also provided are suggested hashtags for use on social media.

## NYSPPF Shareables

### Video

- Leadership facing:  
<https://www.youtube.com/watch?v=9mddhKAEQTQ>
- Clinician facing:  
<https://www.youtube.com/watch?v=1xKAP4qCKVQ>
- Patient facing:  
<https://www.youtube.com/watch?v=Y9vh19mOmOM>

### Images: Screensaver



### Images: Infographics and Social Media Posts

All infographics are 1200 x 628 pixels, an ideal size for most social media platforms. Two versions of each are available: one with only the NYSPPF logo and a second with space for your hospital's logo. Text to accompany each graphic, and a copy of the related graphic is available on [page 24–25](#) (numbered accordingly).

To access native files, please visit: <https://www.nysppf.org/Members/Initiatives/SafetyAcrossBoard/Progressive-Mobility/ToolsandResources.aspx>

### Text

Key messages for staff:

- Patients spend on average 83% of their hospital stay in bed—and that's way too much! Mobility offers patients their best chance to stay independent and avoid a nursing home stay or hospital readmission, research says, and stimulates greater patient satisfaction and a better hospital experience.
- Patient mobility is not a job for just one discipline; it's a joint effort! Involve the whole care team in efforts to help patients get moving, get healthy, and get home!
- When patients get up and move, many harmful hospital-acquired conditions can be reduced, research says. Learn more about [your hospital's] progressive mobility initiative at [insert web address].

Text (<280 characters)	Graphic
<p><b>#1</b> FYI: The sooner a hospital patient is mobilized, the better their outcomes, studies say. #mobilitymatters</p>	 <p><b>PROGRESSIVE MOBILITY IMPROVES</b></p> <ul style="list-style-type: none"> <li>Functional Independence</li> <li>Sleep Quality</li> <li>Muscle Strength</li> <li>Likelihood of Discharge Home</li> <li>Recovery Time</li> <li>Quality of Life</li> </ul> <p>New York State Partnership for Patients   <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>
<p><b>#2</b> FYI: While everyone wants to prevent falls, patient immobility can be harmful! #mobilitymatters</p>	 <p><b>PROGRESSIVE MOBILITY REDUCES</b></p> <ul style="list-style-type: none"> <li>Time on Ventilator</li> <li>Hospital LOS</li> <li>Pressure Ulcers</li> <li>Readmission and Death</li> <li>Cost of Care</li> <li>Staff Injury</li> </ul> <p>New York State Partnership for Patients   <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>
<p><b>#3</b> Finding time to get patients up and moving can be a challenge. Coordinate with the whole care team to lighten the load in more ways than one! #mobilitymatters</p>	 <p><b>THE BENEFITS OF CARE COORDINATION</b></p> <ul style="list-style-type: none"> <li>» Improved communication</li> <li>» Safer patient care handling</li> <li>» Easier transitions of care</li> </ul> <p>New York State Partnership for Patients   <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>
<p><b>#4</b> Set and share daily mobility goals with patients and families to get moving, get healthy, get home, and stay home! #mobilitymatters</p>	 <p>Patient: <b>SMITH, BILL</b></p> <p>Daily mobility goals: <b>WALK 10 STEPS</b></p> <p>Notes: <b>ALLERGIES: PENICILIN + PEANUT PRODUCTS</b></p> <p>Date: <b>01/19</b>      Mon. Tues. Wed. Thurs. (Fri) Sat. Sun.</p> <p>Nurse: <b>AMY HAWKINS</b></p> <p>Doctor: <b>DR FULLER</b></p> <p>Phone: <b>238</b> Room: <b>12 A</b></p> <p>New York State Partnership for Patients   <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>
<p><b>#5</b> Help your hospital establish a culture of mobility. #mobilitymatters</p>	 <p>Research shows that <b>MOVING</b> as much as possible <b>HELPS YOU</b> get better faster.</p> <p>New York State Partnership for Patients   <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>

Text (<280 characters)	Graphic
<p><b>#6</b> FYI: Investing in a mobility program is good for patients and reduces hospital costs! #mobilitymatters</p>	<p><b>HOW MUCH DOES PATIENT IMMOBILITY COST?</b></p> <ul style="list-style-type: none"> <li><b>Hospital Acquired Infections</b> 45,814 additional cost on average per infection</li> <li><b>Ventilator Acquired Pneumonia</b> 39,828 additional cost incurred per patient</li> <li><b>Readmissions</b> 11,200 average cost per readmission</li> </ul> <p>New York State Partnership for Patients Learn more about it at <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>
<p><b>#7</b> FYI: Spending too much time in bed can impact your health, safety, and long-term wellbeing. #mobilitymatters</p>	<p>Hospital patients spend over <b>83%</b> of their time <b>IN BED.</b></p> <p>New York State Partnership for Patients Learn more about it at <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>
<p><b>#8</b> FYI: Hospital patients spend more than 83% of their time in bed. #mobilitymatters</p>	<p><b>Patient Immobility can be harmful.</b></p> <p>It can cause:</p> <ul style="list-style-type: none"> <li>» Pressure Injuries</li> <li>» Ventilator-acquired pneumonia</li> <li>» Delirium</li> <li>» Functional Decline</li> <li>» Nursing home stay</li> </ul> <p>New York State Partnership for Patients Learn more about it at <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>
<p><b>#9</b> Follow (YOUR HOSPITAL) progressive mobility initiative at <a href="http://www.NYSPFP.org">www.NYSPFP.org</a>. #mobilitymatters</p>	<p><b>Get Moving Get Healthy Get Home</b></p> <p>New York State Partnership for Patients Learn more about it at <a href="http://www.nyspfp.org">www.nyspfp.org</a></p>

Key messages for patients:

- Hospital patients who spend too much time in bed risk loss of their strength, flexibility, and functions. By moving as much as possible, patients can preserve their independence, get better faster, and home sooner!
- Moving as much as possible during a hospital stay offers patients their best chance for an easy discharge and also preserves their independence. Discuss your movement goals with your care team to get healthy, get home, and stay home!
- Fears about pain, falling, and lack of privacy can cause hospital patients to feel uneasy about getting

up and moving. Your care team will help you meet your mobility goals while keeping you safe and comfortable.

E-mail messaging for staff:

- Hospital patients spend 83% of their stay in bed on average—way too much time! Confining patients to bed can increase risk of pressure injuries, delirium, functional decline, ventilator-acquired pneumonia, and other serious conditions, research shows. Mobility, however, offers patients their best chance to stay independent and avoid a nursing home stay or readmission, and that leads to increased patient satisfaction and a better hospital experience. And while finding the time to get patients up and moving can be a challenge, coordinating with the whole care team can lighten the load in more ways than one! Learn more about [your hospital's] progressive mobility initiative at [insert web address].

# Appendix C. NYSPFP Daily Mobility Workflow Process Map

## Suggested Assessment Tools:

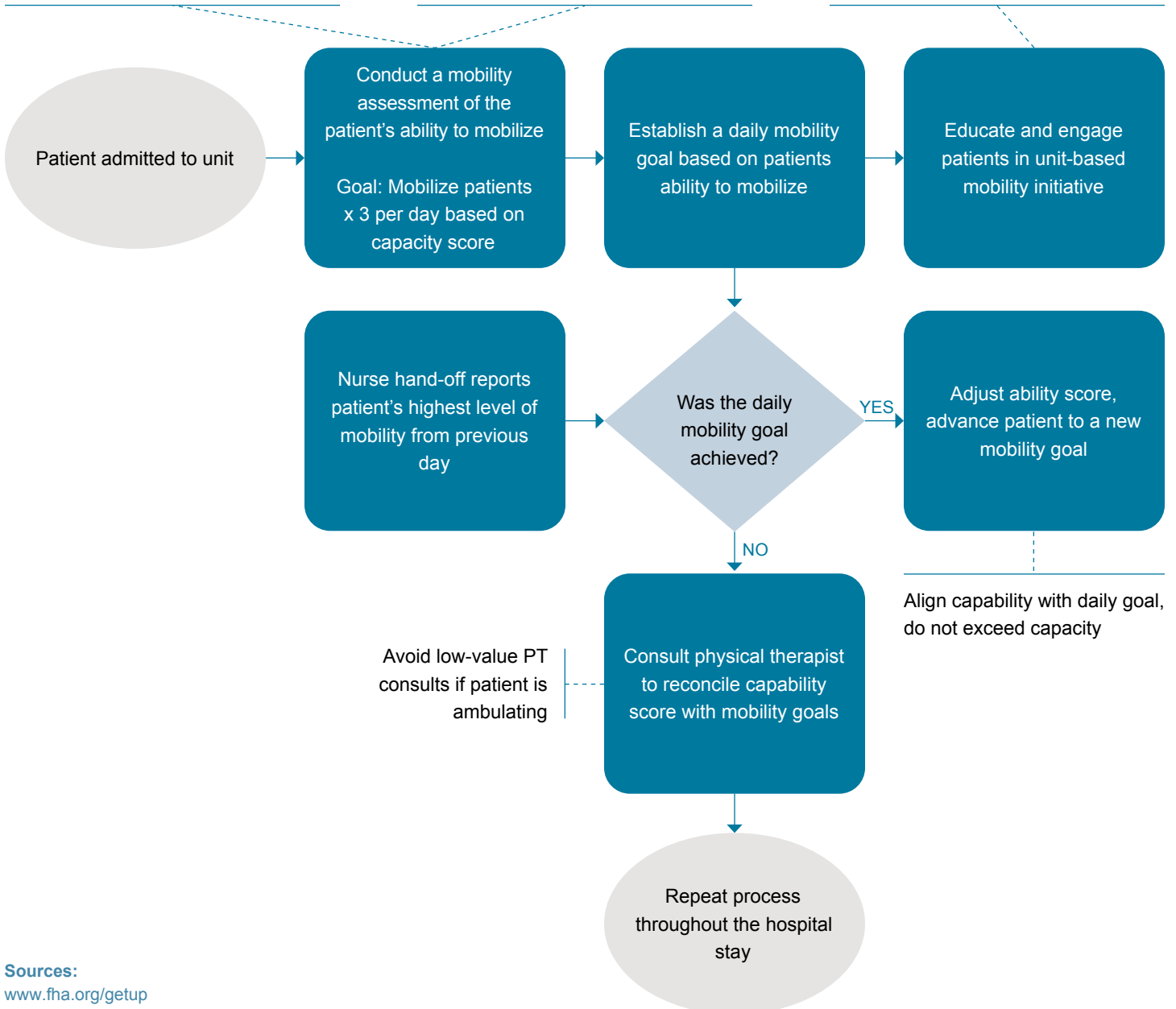
- Boston University AM-PAC/
- JH-HLM, Hopkins AMP toolkit
- Florida Hospital Association “Get Up” toolkit
- Banner Mobility Assessment for Nurses

Document assessment score; document daily goal in EMR & white board

## Process Step:

Unit mobility champion (e.g., RN Charge Nurse) runs report of daily mobility scores on all patients; supports staff in advancing patient mobility goals

Develop a mobility plan with the patient



## Sources:

- [www.fha.org/getup](http://www.fha.org/getup)
- [www.hopkinsmedicine.org/pmr/amp](http://www.hopkinsmedicine.org/pmr/amp)
- [www.hopkinsmedicine.org](http://www.hopkinsmedicine.org)
- [www.fha.org/news/latest/show-details/End-PJ-Paralysis/364](http://www.fha.org/news/latest/show-details/End-PJ-Paralysis/364)





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