Early Mobility Campaigns Improve Patient Outcomes

Two AACN CSI Academy teams report success in quality improvement and cost savings with early mobility.

At a regional conference where AACN Clinical Scene Investigator (CSI) Academy participants presented their project results, teams from two Indiana hospitals reported their success in addressing early mobility.

The "Move It or Lose It!" mobility campaign at St. Vincent Indianapolis Hospital — which created a team to increase mobilization among mechanically ventilated patients who met appropriate criteria — sought to decrease ventilator days by 0.25 day and minimize the negative effects of ICU stays.

Each day, the team evaluated ventilated patients according to inclusion/exclusion criteria and discussions with bedside RNs. Mobility team members worked with patients three days a week to increase function, chart progress and initiate physical therapy. The "Move It or Lose It!" campaign achieved a significant reduction of 0.44 ventilator days, far exceeding the original goal and saving the hospital nearly $338,000 compared with the previous year.

The CSI Academy team at Indiana University (IU) Health University Hospital presented results for decreasing ICU length of stay (LOS) though increased progressive mobility.

The team knew from a six-month retrospective data collection that patients only met physician activity orders 20 percent of the time, resulting in a 5.34-day LOS in 2011 and 5.16 days in 2012.

The IU Health nurses instituted a protocol to reduce LOS, with a long-term goal of progressing 65 percent of unit patients to the next mobility level. They dramatically lowered the average ICU LOS to 4.65 days (based on 1,000 patients), resulting in a projected savings of more than $1 million.

View results of these and other CSI Academy initiatives on the CSI Academy Innovation Database, a free, evolving online library of project outcomes and documentation. Access the database at www.aacn.org/csi.

Coordinated Care Cuts Preventable Readmissions

Six out of 10 hospitals have selected a home healthcare partner to address 30-day readmission penalties.

Seven out of 10 senior hospital leaders cite partnering with home healthcare providers as a primary strategy to help reduce preventable readmissions, according to a new report, which finds that six out of 10 hospitals have selected a home healthcare partner.

"Readmission Reduction Strategies for Hospitals & Health Systems," based on a survey conducted by home healthcare provider Amedisys Inc. and HealthLeaders Media Intelligence Unit, examined how U.S. hospitals are addressing the Centers for Medicare & Medicaid Services 30-day readmission penalties.

According to the survey of 106 hospital leaders, 73 percent cited "lack of preventative care and monitoring of patients with chronic conditions as a major cause of preventable readmissions." In addition, 67 percent listed lack of coordination between hospital discharge and physician follow-up, and 57 percent noted poor accountability by those responsible for patient follow-up as major reasons behind readmissions.

"The realization is that care coordination is a problem whether or not there is a readmission penalty," Michael Fleming, chief medical officer at Amedisys, tells *Healthcare Finance News*. "Patients are sent home with no coordination for what happens to them after they are discharged. There needs to be seamless communication between what happens in the hospital and what happens after."