Background

- Acute Care for Elders (ACE) Units have demonstrated improved clinical outcomes and reduced costs of care. However, many older patients are admitted to non-ACE units.
- Similar to other organizations, our large academic medical facility is challenged with how to best hardwire ACE unit best practices across the organization.
- Booth et al (2018) demonstrated the feasibility of implementing a “Virtual ACE” model of care to address this gap.
- The model supports unit-based, interprofessional teams to become ACE-like and Age Friendly by focusing training on the following areas:
  - Pain assessment and management (Medication)
  - Functional decline & Mobility
  - Delirium prevention and management (Mentation)
  - Care transitions (What Matters)

Project Aim

- Integrate the ACE model of care on one unit over 24 months

Strategy for Change

- Utilize iterative Plan Do Study Act (PDSA) cycles to work with stakeholders to hardwire geriatric best practices.
- Meet with Unit Leadership for engagement
  - Establish goals and metrics
  - Identify champions from each discipline
- Frames to maximize engagement with stakeholders:
  - Frame as care for vulnerable patients – making geriatric care just routine care
  - Frame as leverage points for safe and timely discharges
- “ACE Tracker” Report:
  - For use by the interprofessional team at the point of care to manage processes of care and facilitate safe, patient centered care transitions
  - Training, assessment of cognition, delirium, functional status, medications (What Matters)

- Train staff in assessment and management of specific geriatric syndromes
  - Provide “pathways” for front-line staff to manage geriatric syndromes

Changes Made

- Initial training for Virtual ACE interprofessional unit-based team included assessment of cognition, delirium, functional status, mobility (including gait belt training), and pain.
  - Emphasis for this phase was on the importance of screening and using pathways to manage geriatric syndromes.
- Subsequent changes included adding the following:
  - Transition of care rounds
  - Mobility scale documentation in EHR
  - Mobility tech pilot
  - Virtual ACE “refresher” class
  - Shift huddles with staff 2-3x/week
  - Mobility goals tool for patient white boards
  - Volunteer walking protocol
  - Additional care transition coaching for staff

Outcomes

Mobility: Walking in the Room

- In the past 24 hours, have you walked in the room?

Mentation

- % pre intervention to 43%
- % post intervention to 8%
- % intervention overall

Other Outcomes

- Improved staff completion of screens for cognitive impairment, function, and delirium
- Decreased percentage of patients with BEERS meds ordered and administered
- Delirium results showed a decreased percentage of patients with positive delirium screens
  - Decreased from 10% pre-intervention to 5% post-intervention overall
  - Decreased from 18% pre-intervention to 8% post-intervention in medical patients
- Mobility: Walking in the hall
  - Increased from 27% pre-intervention to 43% post-intervention

Lessons Learned & Next Steps

- From previous implementations of Virtual ACE, we learned that mobility is one of the most difficult processes to improve, hence the increased focus on mobility for these iterations.
- Unit Nursing leadership & Unit Champions are essential to sustain improvement.
- Introduction of the Mobility Tech as a part of the care team shows promising results.
- We are seeking funding to expand the pilot of the mobility tech role.
- Addressing “What Matters” is another area for improvement within our organization.

References


Booth et al (2018) demonstrated the feasibility of implementing a “Virtual ACE” model of care to address this gap.