Virtual ACE:
Working Towards an Age Friendly Culture One Unit at Time

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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 hard-wire 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 hard-wire 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
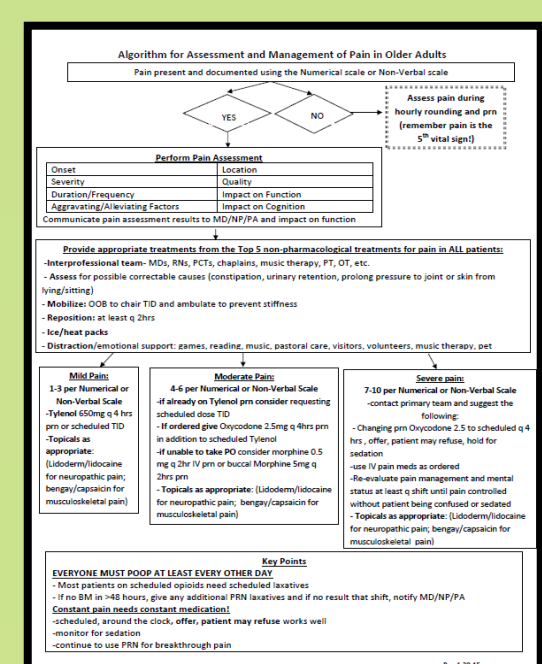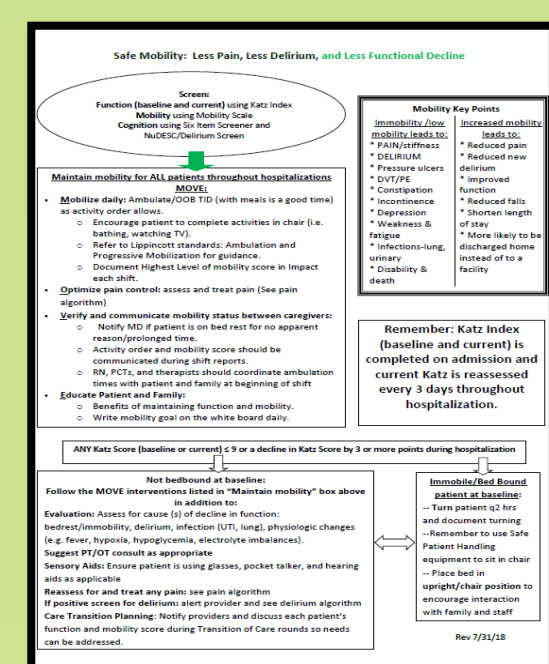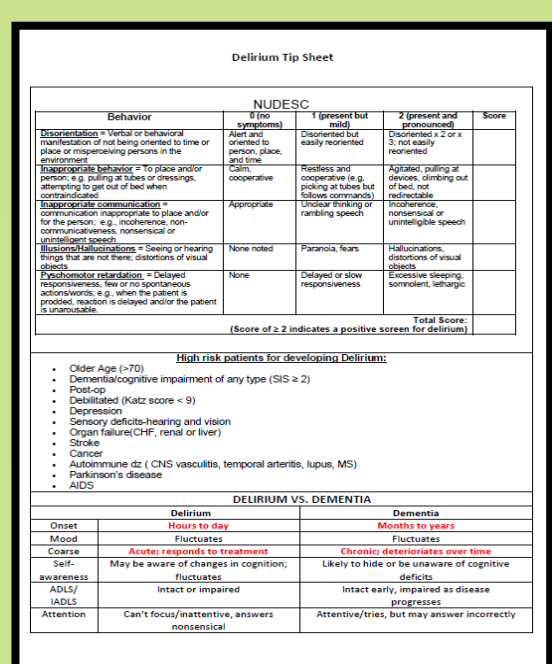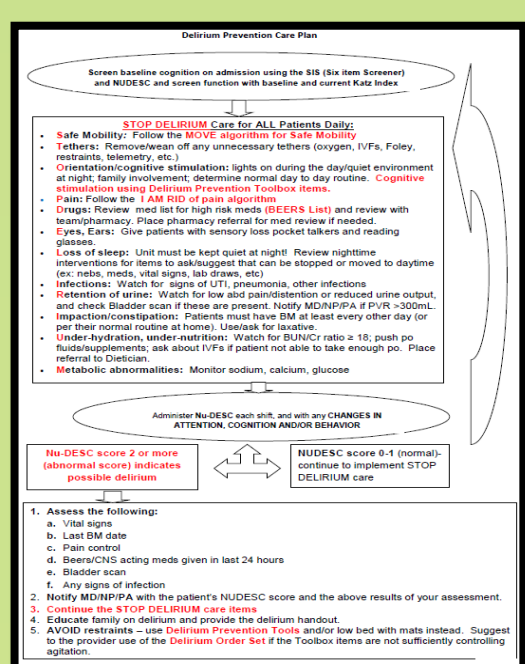

- Train staff in assessment and management of specific geriatric syndromes
  - Provide "pathways" for front-line staff to manage geriatric syndromes

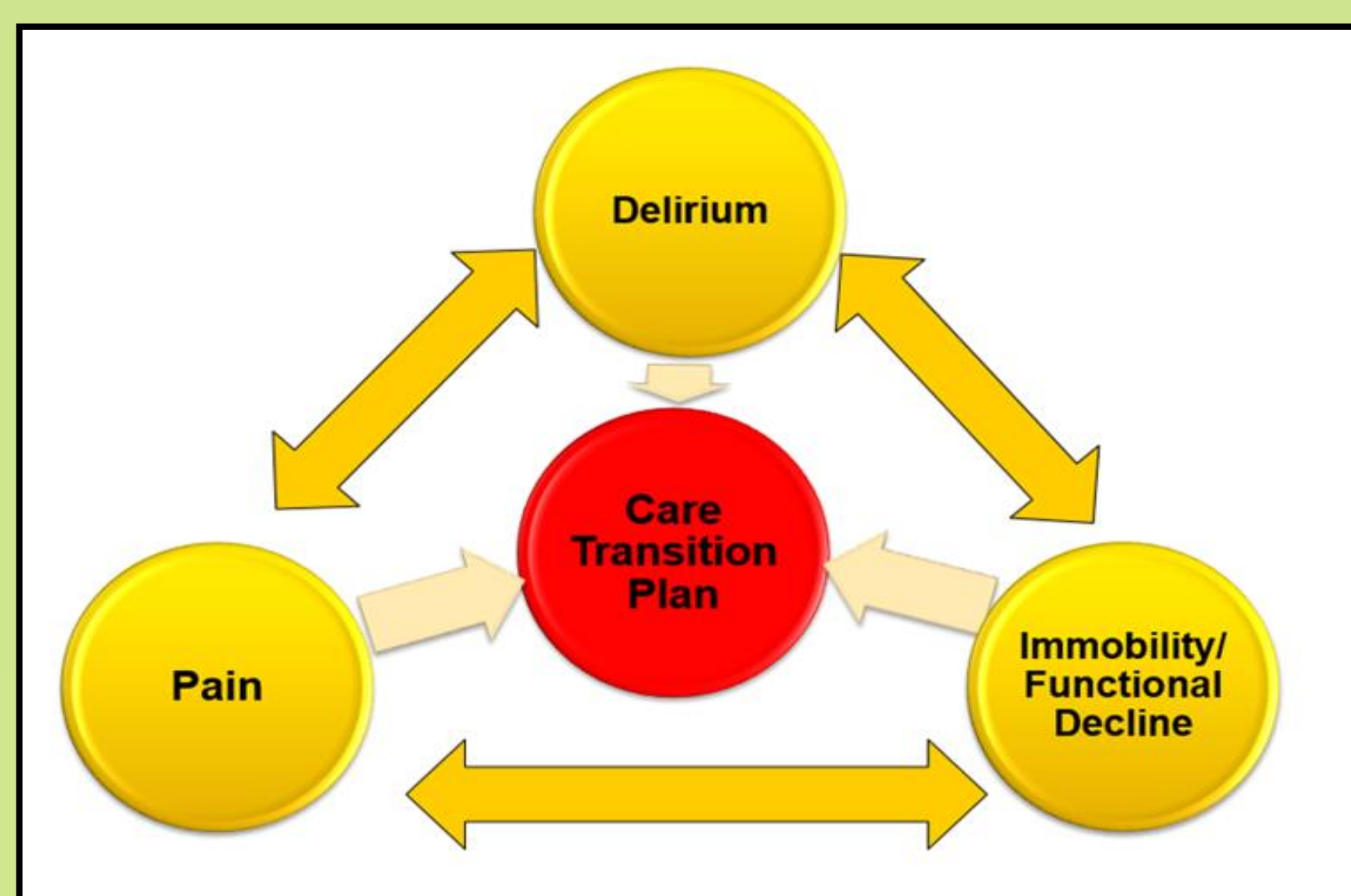| **Mentation** Delirium Six Item Screener	**Medications** BEERS & Antipsychotic medications	**Mobility** Mobility Scale KATZ function	**What Matters** Advanced Directives Care Transitions

Delirium Prevention Pathway   Mobility Pathway   Pain Pathway


References

Booth, K. A., Simmons, E. E., Viles, A. F., Gray, W. A., Kennedy, K. R., Biswal, S. H., . . . Flood, K. L. (2018). Improving Geriatric Care Processes on Two Medical-Surgical Acute Care Units: A Pilot Study. J Healthc Qual. doi: 10.1097/jhq.0000000000000140

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
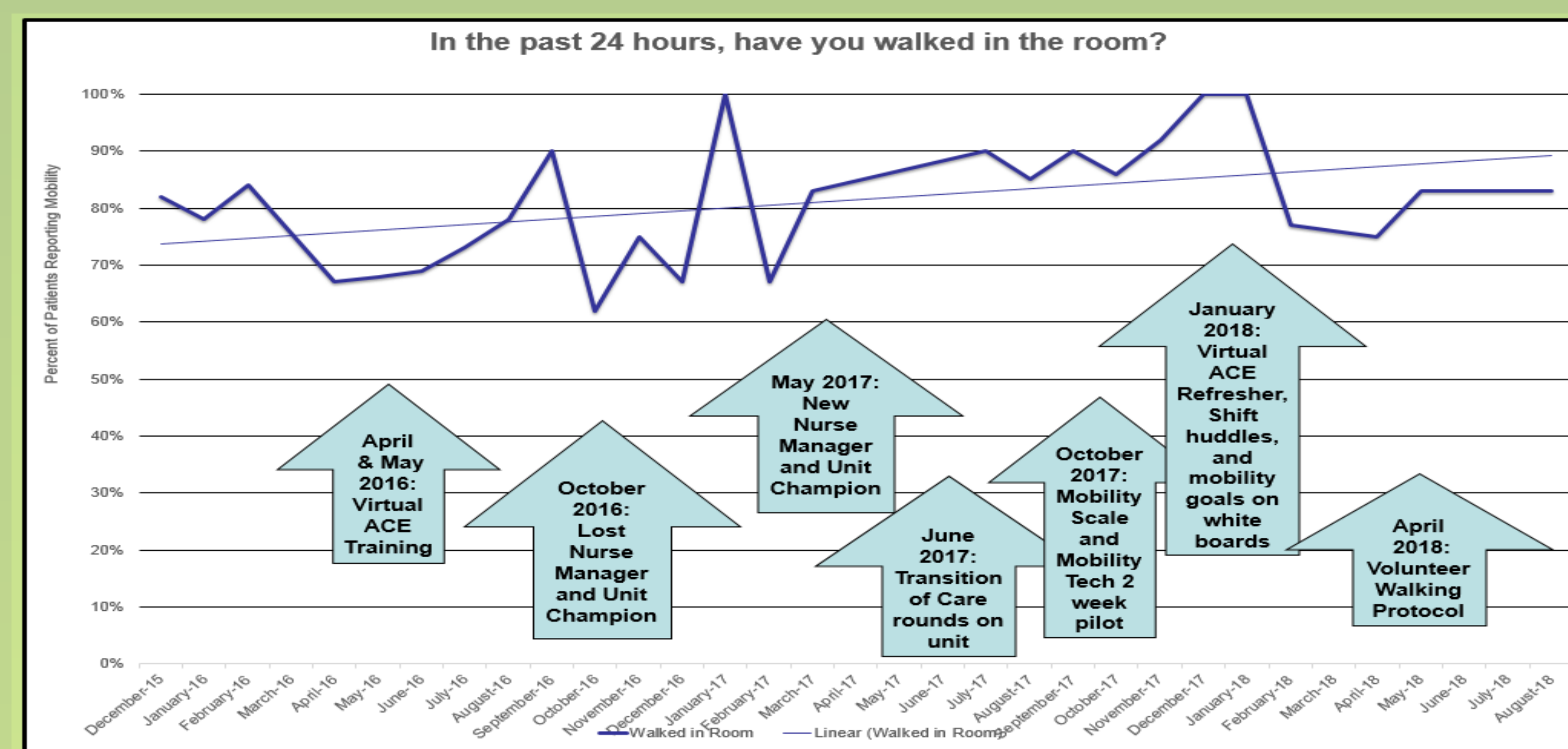
Mentation
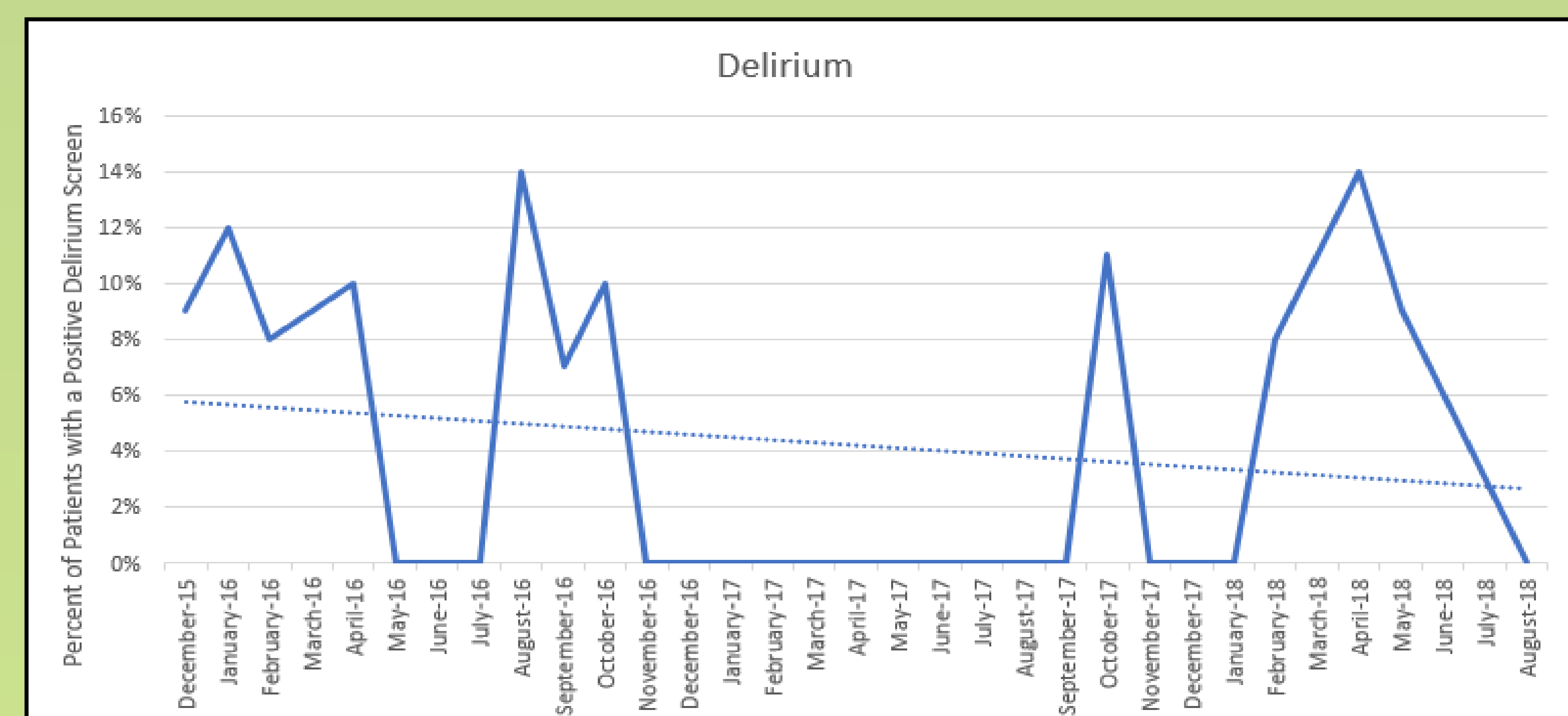
Other Outcomes

- 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.