

Moving Forward with ACE

Acute Care for the Elderly



Introduction:

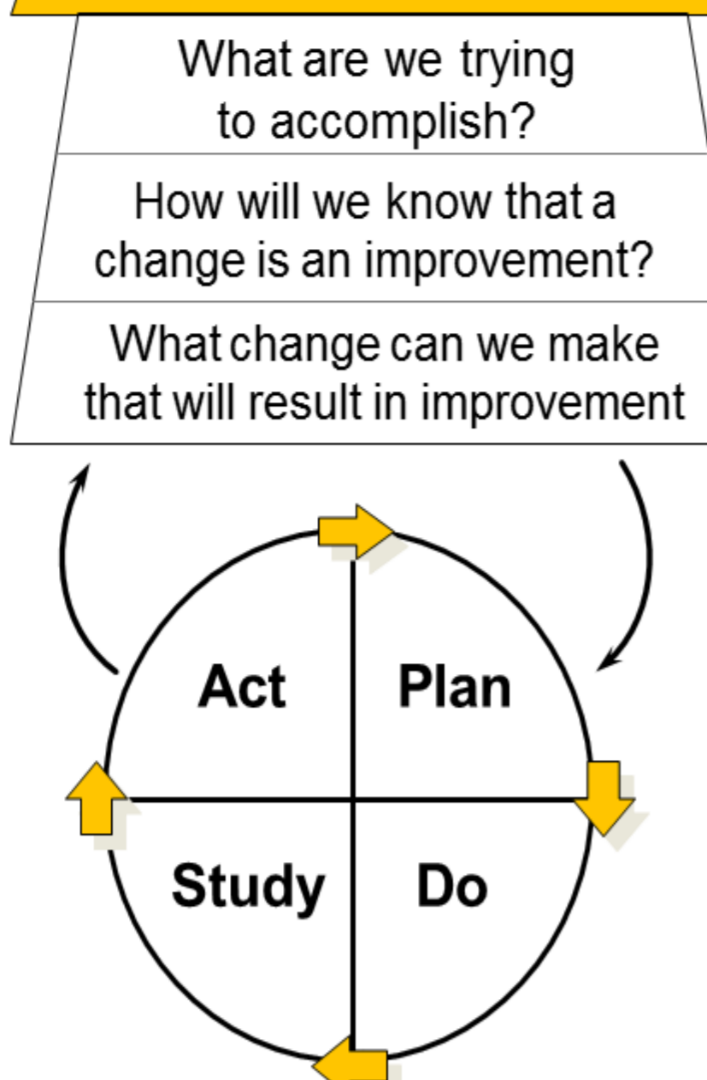
"The right patient, the right place, the right time..." are words that are often uttered in health care. Reflecting on the experiences of the previous two winters at Middlemore Hospital, our acute geriatric patients were not in the "right place" within the hospital. This vulnerable patient group was spread across general medical services with no coordinated approach to care.

Our Aim:

To improve the care for our over 85 year old acute geriatric patients by implementing an Acute Care for the Elderly (ACE) model; as evidenced by –

- Decrease in ACE- Assessment Treatment and Rehabilitation AT&R length of stay (LOS) from 25 to 20 days
- Decrease in ACE LOS from 8.5 to 7 days
- Decrease in readmission rate from 6% to 4%
- Decrease in step down of care rate from 14% to 8%

Model for Improvement



Improvement Guide, Chapter 1, 2.24 Appendix C, p. 454



The team learning about PDSA cycles at a Beyond 20,000 Days Learning Session

Method:

Using the Institute of Health Improvement's (IHI) Model for Improvement, a Model of Care (ACE), was designed and implemented within an Assessment Treatment and Rehabilitation (AT&R) ward with 13 dedicated beds.

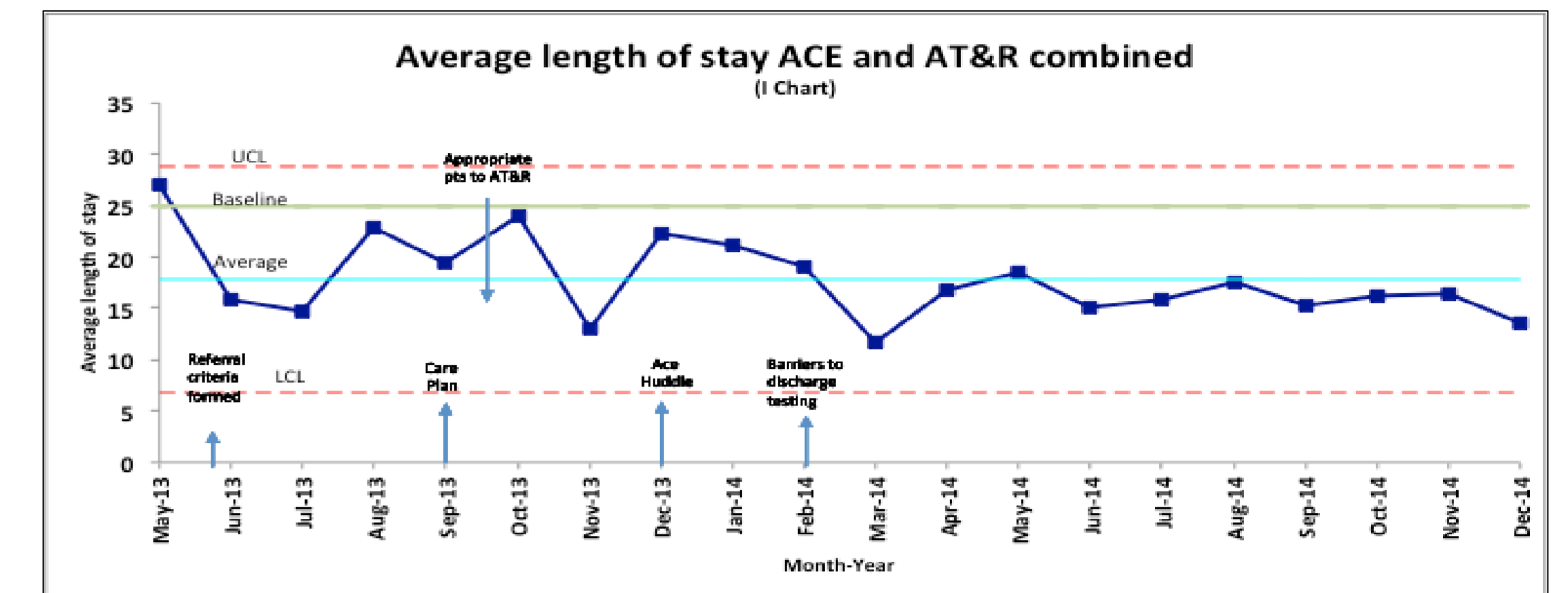
It was anticipated that the ACE model of care would –

- Provide more coordinated care to acutely unwell, non-specialised medical patients over 85 years old
- Involve earlier multidisciplinary team (MDT) interventions to reduce deterioration during the acute phase.
- Enable early discharge planning.
- Improve linkages to inpatient rehab services in AT&R.
- Coordinate patient's ongoing care with community services.

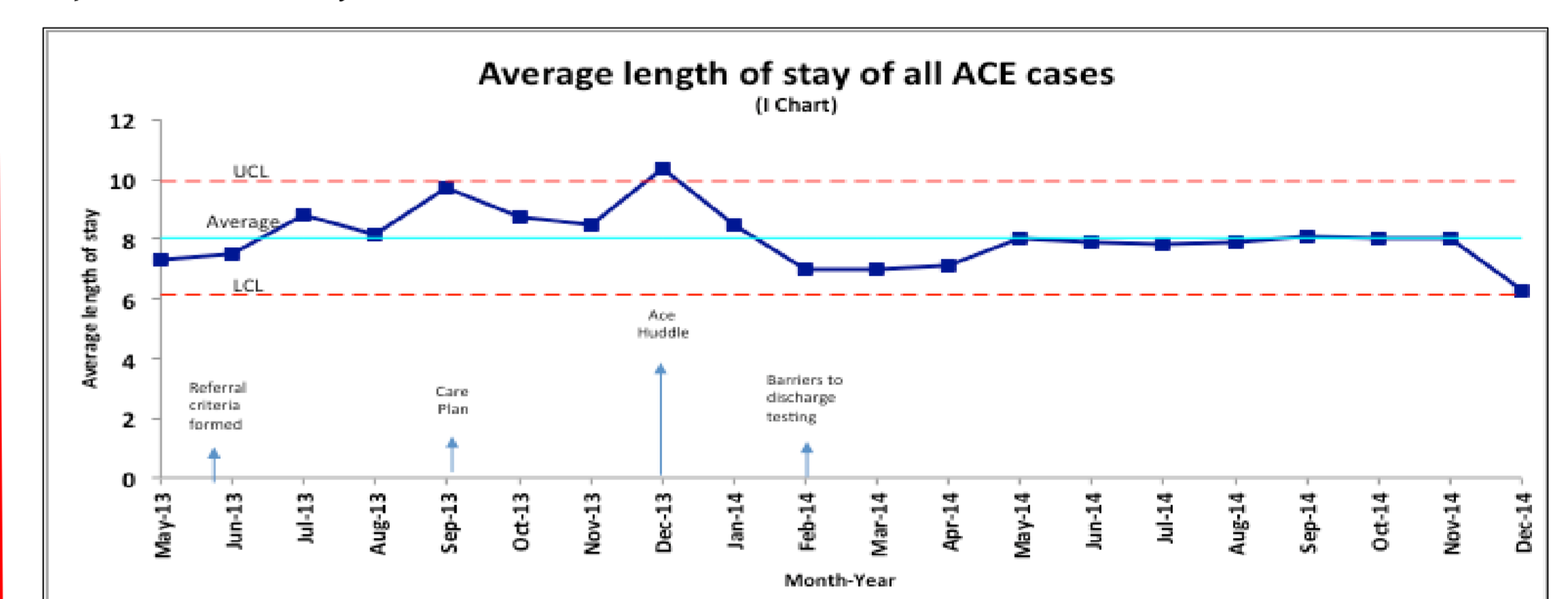
Results:

Measure	Baseline	End of 2014	Savings
Acute plus AT&R LOS	25 days	17 days	600 bed days (approx.)
Re-admission rate	6%	4.3%	10 readmissions = 50 bed days (approx.)
Acute LOS	8.6 days	7.6 days	Overall financial savings \$409,010 pa
Rate of Institutionalisation	14%	6%	

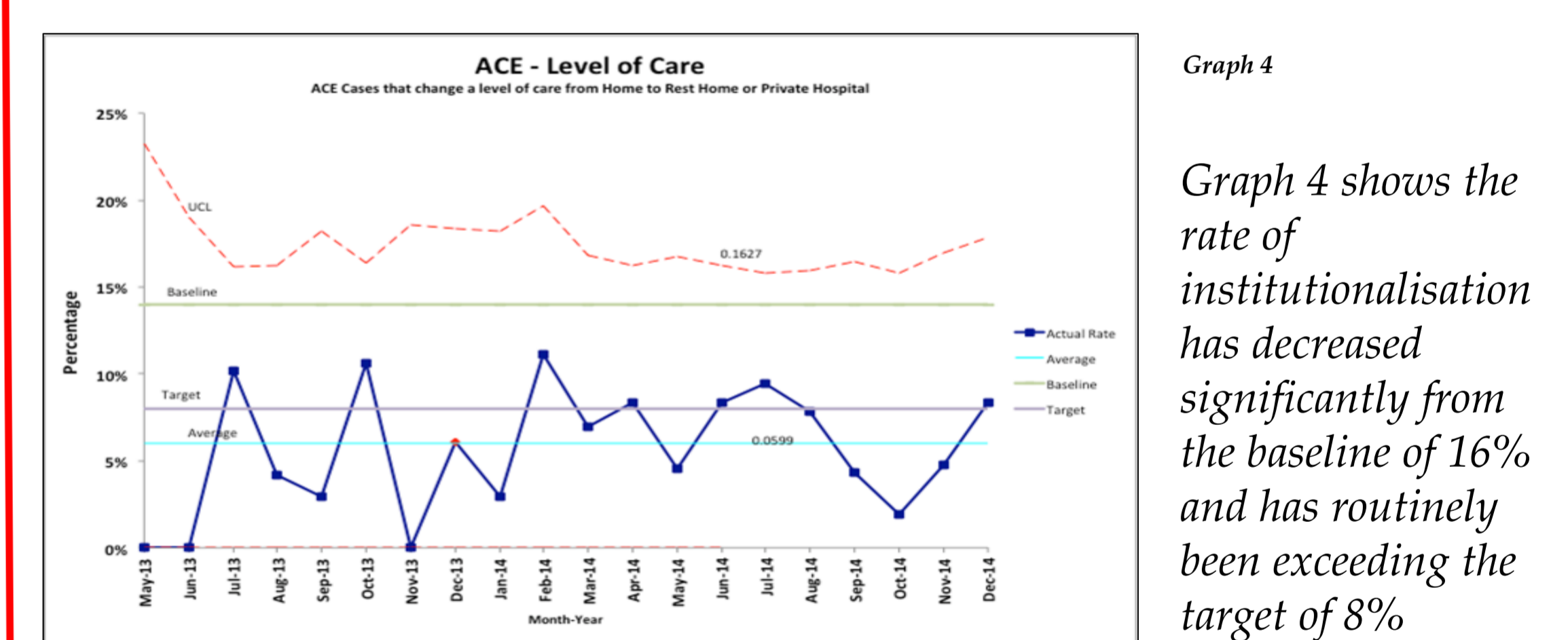
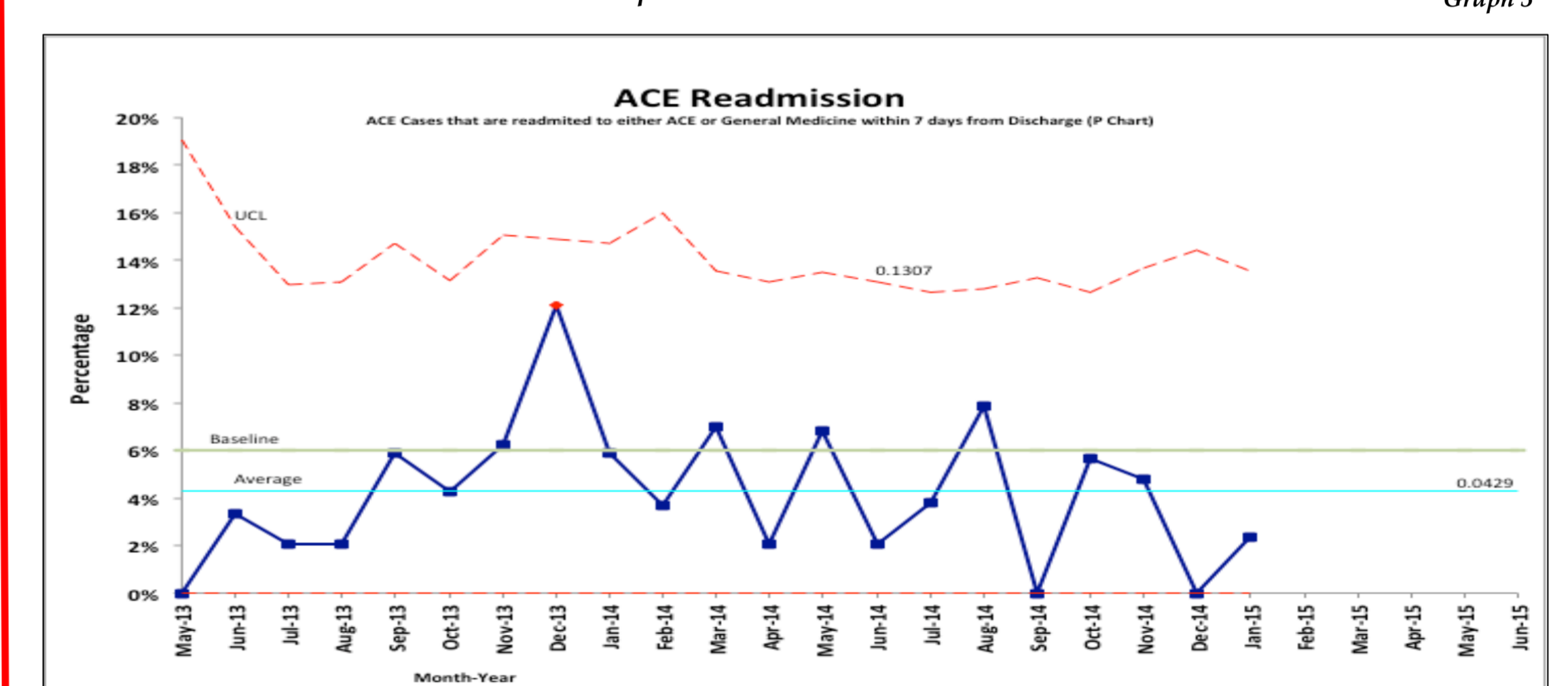
Graph 1 shows the reduction in total length of stay (LOS) for patients requiring acute and sub-acute care, who have been treated according to the ACE model as compared to the previous system.



Graph 2 shows the average length of stay (LOS) for the acute episode of care under the ACE Model. Of note is the marked reduction in the LOS following the implementation of the ACE Huddle.



Graph 3 shows (with the exception of one month) that the readmission rate of this population has been consistently under the baseline of 6%. The 7 Day readmission rate was used to compare to baseline data.



Graph 4 shows the rate of institutionalisation has decreased significantly from the baseline of 16% and has routinely been exceeding the target of 8%

Change Tested	Outcome
Referral criteria/process: Develop a tool to enable selection of appropriate patients to ACE model of care and predict those who are at risk of stepping down level of care or who may require an AT&R admission.	<ul style="list-style-type: none"> ✓ Initial creation of the Screening Tool using expert opinion to develop categories and scoring system ✓ Criteria and scoring system tested in ACE patients ✓ Refined and modified tool - from 12 down to 6 categories; 1,3, 6 score ✓ Predictability of Screening Tool tested – defined scoring bands (21 and over = high needs; 15-20 = grey zone; <15 = return home) ✓ 3rd party user testing successful
Patient Journey: Improving patient referral from Emergency Care (EC)	<ul style="list-style-type: none"> ✓ Improved afterhours admission and referrals process- <ul style="list-style-type: none"> – ACE patients during the day can be referred straight to team on the ward from EC if criteria met – ACE patients after hours only coming through one pathway (medical) instead of several pathways
Inpatient Care: Admission Planner/screening tool	<ul style="list-style-type: none"> ✓ Functioning multidisciplinary team (MDT) screening tool is in place ✓ All patients fully screened within 24 hours by MDT ✓ Completion rates over 90% ✓ Implemented and in monitoring phase
Inpatient Care: ACE Care Plan	<ul style="list-style-type: none"> ✓ Development of a multidisciplinary Intervention Care Plan to work with the Admission Planner/Screeener ✗ Multidisciplinary Care Plan abandoned ✓ Nursing Care Plan for ACE patients in development ✓ Care Plan only updated if interventions change ✓ Care Plan is proving useful during ACE Huddles
Inpatient Care: Weekend Physiotherapy Assessment	<ul style="list-style-type: none"> ✓ Easy identification of ACE patients requiring Weekend Physiotherapy Assessment ✓ ACE patients who require Weekend Physiotherapy Assessment are receiving it
Inpatient Care: MDT ACE Huddle	<ul style="list-style-type: none"> ✓ Members of the MDT meet Mon/Wed/Fri at 1130am to discuss ACE patients, set Goal Discharge Dates (GDD) & to identify Barriers for Discharge ✓ ACE Huddle Checklist developed to ensure huddle is efficient

Discussion:

A key change idea was MDT ACE Huddle which appears to have had the biggest impact upon reducing the average LOS of ACE patients.

- Key groups of patients who have benefited from the ACE model are –
- Those that would require rehabilitation - these patients are now staying up to 1 week less in hospital.
 - Those at risk of institutional placement - these patients are now more likely to return home.

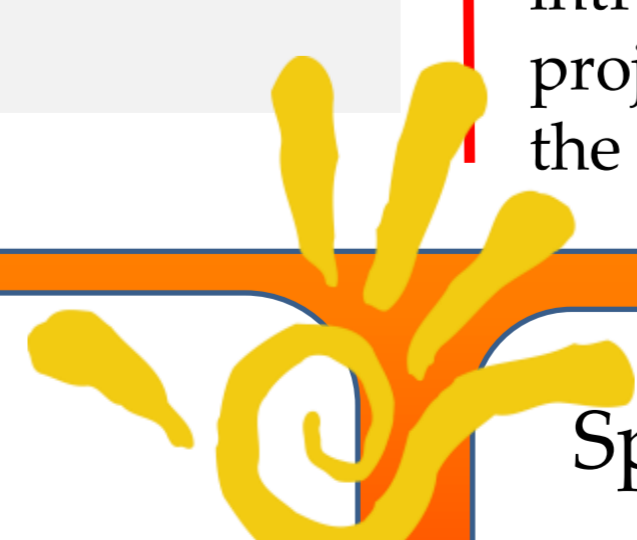
The evidence and outcomes for the pilot phase of the ACE project demonstrate good clinical outcomes for the patient and good financial and operational outcomes for CMDHB. The ACE model of care that was introduced was well supported and evidenced in the research and the project demonstrated that those positive outcomes could be replicated in the CMDHB environment.

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