ACUTE CARE FOR ELDERS (ACE) COLLABORATIVE BACKGROUNDER

ACE stands for: Acute Care for Elders. It is an award winning strategy developed by Mount Sinai Hospital in Toronto that has made significant improvements in care for patients, health outcomes and value-for-money. The Canadian Foundation for Healthcare Improvement (CFHI), in partnership with the Technology Evaluation in the Elderly Network (TVN), is now inviting applications to its ACE collaborative, which will spread the ACE strategy across the country and help hospitals improve the care they provide to elders.

The Need for the ACE Collaborative:

Canadian hospitals are ill-equipped to meet the needs of a rapidly aging population. While individuals 65 and older account for 16 percent of the population, they represent 42 percent of all acute care hospitalizations and 58 percent of hospital days in Canada. Equally significant is the fact that 25 percent of Canadians over 65 years and 50 percent of people over 85 years – well over one million seniors – are medically frail and represent the most significant users of acute care services.

The growing prevalence of cognitive, functional and social issues among our aging population along with a growing prevalence of frailty and multi-morbidity is challenging traditional hospital models developed to treat patients with acute issues.

In Canada, the ACE collaborative will support healthcare delivery organizations to implement proven elder-friendly care practices. Through ACE, inter-professional teams of specialist physicians – particularly geriatricians and geriatric psychiatrists – advanced practice nurses, social workers, therapists, pharmacists, dieticians and volunteers work together to provide better, more coordinated care for elderly patients.

Proven Benefits:

The ACE Medical Unit model is an acute care model created in Cleveland, Ohio in the early 1990s as a response to gaps in care for acutely ill older patients. ACE units have been shown to reduce hospital costs by 5 to 10 percent primarily by reducing patients' average length of stay. Under the ACE Strategy, Mount Sinai has become widely recognized as a leader in elder care in Canada and won numerous awards, including two Accreditation Canada Leading Practice awards. At Mount Sinai, the cost-savings realized through ACE initiatives achieved an estimated $6.7 million in net acute care savings in 2014.

Healthcare professionals that participate in the ACE collaborative will become experts in ACE-related continuous quality improvement activities; improve patient and staff experiences and satisfaction; provide more coordinated care; improve system outcomes such as the number of emergency department visits, hospitalizations and patient complications.

Healthcare organizations involved in the ACE collaborative can achieve better detection of geriatric syndromes; decreased functional decline upon discharge; fewer falls, pressure ulcers and delirium; increased patient satisfaction; decreased lengths of stay; decreased incidence of

hospital acquired delirium; increased staff satisfaction; decreased incidence of urinary catheter use; fewer readmissions; and lower hospitalization rates.

What the ACE Strategy Comprises:

The ACE Strategy involves the following:

In emergency departments:

- Tools for identifying high-risk seniors
- Advanced practices nurses who specialize in helping frail older patients
- Specialized training on common geriatric issues for healthcare providers

Within inpatient care at a hospital:

- Best practices for falls, pressure ulcers and delirium
- Specially designed wards known as ACE Medical Units, where geriatric assessments and comprehensive discharge planning take place
- Resources to build a culture of patient-centred care and give staff confidence in managing the care of older patients.
- A computer generated checklist that flags risks of decline and poor outcomes
- Provider education to reduce the use of urinary catheters

When transitioning from hospital to community-based care:

- Follow-up phone calls or transition coaches – often specially trained nurses – to help patients manage multiple prescriptions, follow post-hospital instructions
- Home visits by providers that include physicians and specially trained paramedics
- Outreach by specially trained nurses to long-term care homes
- Intensive care management for older adults who are at risk for frequent trips to the hospital