Hearts first, minds second:
Transforming practice to improve acute care of elders

Change AGEnts Initiative

The John A. Hartford Foundation's Change AGEnts Initiative was a three-year effort dedicated to improving the health of older Americans, their families, and their communities through practice change. Managed by The Gerontological Society of America, the initiative harnessed the collective strengths, resources, and expertise of the foundation's interprofessional community of scholars, clinicians, and health system leaders.

The 34 projects funded through the Action Awards grants program showcased the improvements that interprofessional teams can bring to light by implementing evidence-based programs into targeted care settings in local environments.

Every highly competent clinician wants to reach even higher goals when it comes to patient care. When disruptive change is needed to improve, though, a thoughtful and proactive plan to anticipate barriers and reluctance to change is important.

At the University of Alabama at Birmingham (UAB) Hospital, that was the approach by Kellie Flood, MD, Emily Simmons, MSN, RN-BC, CNL, and their colleagues in the Geriatrics Scholars Program. Seeking to improve the care of vulnerable older adults in the nation's third largest public hospital, Flood in 2008 spearheaded UAB's development of an Acute Care for Elders (ACE) Unit as the demonstration unit, with the long-range goal of figuring out what care older patients should receive on all 52 units of the hospital—and showing what a different the new model could make.

"In our clinical training, we always call it 'explaining the why,'" Flood said. "When you have health care providers who have been practicing in the hospital for 5, 10, 15, 20 years, many will understand immediately based on their daily experiences why change is needed. However, for some we have to move their hearts before we change their minds. In implementing the model, we spend a lot of time and effort focusing on the 'why' up front. Real-life cases, engaging them in why we need to make this change, why is this the right thing for our patients, for our families, for themselves as workers that's going to make their workflow better."

With data collection and management supported by a John A. Hartford Foundation Change AGEnts Action Award, Flood and her team have begun the process of extending this practice transformation throughout the UAB system via a unit-based care delivery redesign intervention termed "Virtual ACE." Virtual ACE focuses on using the ACE

interprofessional team model of care to target pain assessment and management, safe mobility, and delirium prevention and management on every unit in a hospital. "In our Action Award application, we said we would start by implementing Virtual ACE on two units," Flood said. "We got kind of ambitious and we did four—two trauma units, a gastrointestinal (GI) medical unit, and a GI surgical unit."

Managed by The Gerontological Society of America, the John A. Hartford Foundation Change AGEnts Initiative accelerated sustained practice change to improve the health of older Americans, their families, and communities. It did so by harnessing the collective strengths, resources, and expertise of the John A. Hartford Foundation's interprofessional community of scholars, clinicians, and health system leaders to learn from and support one another while they adopted, evaluated, and sustained changes in practice and service delivery. The Change AGEnts Action Awards grants program was designed to support Change AGEnts in implementing promising ideas in practice change.

The Situation

In the ACE unit, Flood's team learned many lessons. One was to initially focus training on the staff and providers from all disciplines who are always working on the unit, as opposed to hospitalists or residents who are frequently rotating on and off the unit every few weeks and not the consistent providers. Thus, the majority of the geriatric training targets the interprofessional care team that consists of nurses, patient care technicians, unit secretaries, pharmacists, social workers, care coordinators, physical and occupational therapists, dietitians, chaplains, and even the unit's artist in residence.

"If you're a health professional who walks onto the ACE unit, you get the training," Flood said. "Our team created nurse-driven care protocols and implemented training that touches every single provider on a unit, bringing the processes, the tools, the education, the protocols, and ways of producing large-scale culture change on a unit that had not been previously geriatric focused."

The Virtual ACE intervention calls for providers to screen all older patients using standardized tools such as baseline and current functional status (Katz Index of activities of daily living), cognition (Six Item Screen) and delirium (Nursing Delirium Screening Scale; NuDESC). Results of the screens are incorporated into nonphysician-driven geriatric care protocols for pain assessment and management (with emphasis on nonpharmacologic approaches to pain management), safe mobility, and delirium prevention and management. Change is then "hard wired" into care delivery through real-time coaching, audits, and data feedback during the post training phase.

Viewed from a proof-of-concept perspective, the model ACE unit served its purpose well. In an article published in 2013 in JAMA Internal Medicine, Flood's team reported reduced costs and lower 30-day readmissions among the patients cared for on the unit, compared with a usual-care unit elsewhere at UAB.

About the time the Change AGEnts Action Awards became available in 2014–15, Flood and her colleagues were ready to launch Virtual ACE. The curriculum was deliberate in focusing on

controlling pain, maintaining mobility, and reducing delirium, in that order. "There's a strategy for how we roll out this curriculum and the care protocols," Flood explained. "We teach pain management first because you can't mobilize patients if they're in pain. Then we teach safe mobility. We teach delirium last because patients in pain and immobile are predisposed to developing delirium."

The Expansion

Grant in hand, Flood's team developed four training modules to introduce the ACE model to the two trauma units. The effort went so well that two additional units — the GI medical and GI surgical units — were oriented to the model using a restructured, three-module effort.

Physicians became a stronger focus as the model was rolled out, Flood said. "While we didn't need the extensive training time from physicians that we did from unit staff (since the care protocols are nurse-driven) we did need their order sets to be geriatric friendly and for them to be supportive of the model," Flood explained. "When an empowered nurse comes to them and says, 'Hey, this patient's delirium screening score has increased and is now abnormal, and I've done 'A, B, and C,' what do you think about trying 'D and E,' the physicians need be supportive of that. Our physicians really like the Virtual ACE model and see the difference this type of care is making."

About that time, Virtual ACE Coach and NICHE Coordinator Shari Biswal, MSN, RN, PCCN, CNL, was added to the team, expanding their intensive coaching capabilities. She has witnessed firsthand the daily impact this type of care had on patients on the new Virtual ACE units, including the following:

- "As I was rounding on one of the GI units, several staff members immediately started talking to me using very urgent tones: 'Have you seen Mr. X? You have to go see him! We put a hearing amplifier on him, and used some of the delirium toolbox stuff, and he is so much better.' Mr. X had been a restrained, combative, and confused patient. Staff recognized his hyperactive delirium and used Virtual ACE tools to help reverse it. Staff were excited because Mr. X became an unrestrained, calm, and cooperative patient after their interventions. I was excited because they recognized his delirium and felt empowered to use their new-found skills to address and reverse it!"

- "A unit secretary on one of the trauma units reported that patients seemed to be moving around the unit a lot more and were calling for pain medications a lot less. "

- "A nurse practitioner for the trauma service talked (at length!) about how nice it was that staff were now talking to her about patient concerns and were comfortable making suggestions to her based on Virtual ACE teachings—specifically, pain management and the use of high-risk medications with older patients."

How the Change AGEnts Action Award improved outcomes

The Change AGEnts Action Awards grant enabled Flood, Simmons, and Biswal to gather data and improve management during the rollout of the Virtual ACE program. "When you're doing something in the hospital in real time, right at the bedside with an existing work force,

something that's going to have instant impact, there needs to be a funding mechanism to be able to collect data, enter data, and analyze data," Flood said. "We really need these outside sources of funding to be able to fund our research technician and a statistician to help us with the analysis." The good news is so far, even early in the Virtual ACE journey, the data demonstrate improvements in performance of geriatric screens, more patients being mobilized, and results are pointing toward reduced delirium prevalence.

The team continues to work toward the day when all the units at UAB will be set up to provide this kind of care to older adults. Flood knows it's possible by first winning over the hearts of the caring professionals who respond positively —are willing to change their practices — when they see what a difference a new approach can make.