The Icelandic ACE Experience: Successes and Obstacles

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No conflict of interest
What do you know about Iceland?
Patients seeking health care service at Landspitali come from all health districts in the country.
Our nation

- **Icelandic population 338,349** (1. January 2017)
  - About 219,900 live in the capital area
  - 67 years and older: 40,832 (12.1%)

- One university hospital
- Several small hospitals, primary care, nursing homes
- Primary health care centres
- Private practices

Statistics Iceland; www.hagstofa.is
Type of organization

- Fully equipped emergency, medical and surgical hospital
- 103,500 emergency visits
- 323,000 outpatient visits
- 26,000 admissions
- 700 hospital beds
- 7.8 day average length of stay
- 15,700 surgical procedures
- 2,900 births
What is the ACE collaborative?

- **Working with:**
  - Canadian Foundation for Healthcare Improvement (http://www.cfhi-fcass.ca/Home.aspx)
  - Canadian Frailty Network (http://www.cfn-nce.ca/)
18 TEAMS ACROSS 4 PROVINCES 1 TERRITORY 1 INTERNATIONAL SITE

1. Whitehorse General Hospital

1. Geraldton District Hospital
2. Halton Healthcare
3. Hamilton Health Sciences
4. London Health Sciences Centre
5. Montfort Hospital
6. Orillia Soldiers’ Memorial Hospital
7. Queensway Carleton Hospital
8. Quinte Health Care
9. Scarborough Hospital
10. Thunder Bay Regional Health Sciences Centre
11. University Health Network
12. William Osler Health System

1. National University Hospital of Iceland

1. Horizon Health Network

1. CISSS Chaudières-Appalaches

1. Nova Scotia Health Authority - South Shore
2. Nova Scotia Health Authority - Central Zone
ACE strategy - Toronto

- **Continuity in service for the elderly**
  - Community
  - Emergency Department
  - Inpatient
  - Ambulatory
ACE strategy - Reykjavík

- Assessment clinic for the elderly
- Reorganizing the ambulatory service along with the dayhospital

- Specialized home care service to home bound older adults – pilot project

- InterRAI ED-Screener
- GEM nurses
- Education for ED-personnel

- Inpatient geriatric team
- Discharge team
- ACE-unit
Objectives

- To improve the acute care of elderly patients at LSH
- Increase ED staff education on the needs of geriatric patients.
- Reduce revisits of pt. 75 and older to the ED
- Reduce hospital admissions for the elderly
- Shorten the length of stay of patients 75 yrs and older.
- Decreased readmission rates within 30 days
- Standardise evaluation of patient needs and care pathways for those 75 years and old
Standardized screening

- Inter-RAI ED screener
- Translated in 2015
- Tested in spring 2016
- Implemented in autumn 2016
Proportion of 75 years and older screened
GEM nurses

- GEM nurses training in September 2016

- Implementation of the Inter-RAI ED screener and Contact assessment in the ED

- Started in October 2016
Elderly in ED

ED screening
All patient 75 years and older. Primer nurse at the first 2 hours in the ED

Scores 1-2

Usual ED process

Discharge home

Follow up in primary healthcare, private clinic or outpatient unit in LSH

Scores 3-4

Intervention and consulting

Discharge home

Discharge with more support like homecare or social support

Scores 5-6

Gem Nurse makes contact assessment and other instruments if needed

Cooperation/consultation with geriatric team

Patient is sick and need to be admitted. The geriatric team will get informed about the score

Geriatric servis in Landakot:
Geriatric assessment clinic
Outpatient clinic
Dayhospital
Five days rehabilitation unit
GEM nurses

- 6 days a week from 10:00 to 18:00
- See minimum 3 persons a day
- The majority discharges home or about 80%
- A lot of phone calls as follow ups
Building a bridge!
Assessment clinic for the elderly

Each patient is with each professional for about an hour. Each professional does different program. No doublework.

The elderly get lunch and a break. Meanwhile the team discusses the comprehensive assessment and conclusion.

Informing the patient and family. Coordinating with other parts of the health care system

- **3P-workshop**
  - October 2015

- **Trial spring**
  - 2016

Team meeting

Meeting with the patient and family
Family report feeling overwhelmed by persons illness

N=65
Self-reported health

N=65
10 m walking speed

Number of participants per walking speed category:
- 0.0 - 0.3 m/s: 7
- 0.3 - 0.6 m/s: 18
- 0.6 - 0.8 m/s: 32
- 0.9 - 1.25 m/s: 21

Total participants: N=78
N=76; Period Feb 2016 til May 2017.
Assessment clinic for the elderly

- Expanding the service to 2-3 times a week
- We are initiating a conversation with home-care and GP’s
Challenges

- Small group
  - Few people to do everything
- Workplan in Iceland - summer holidays
- IT takes time
The good things

- A small group
- Key members within their specialites
- Communication is easy
- Support from our leaders
- The environment is ready for changes
- Engagement from everybody
- Focus has been undisputed and clear
Welcome to visit