Alberta Health Services
Acute Care Bundle Improvement

Acute Care Bundle Improvement (ACBI) Initiative: FAQs

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What is the Acute Care Bundle Improvement (ACBI) initiative?

Alberta Health Services (AHS) developed the ACBI initiative to simplify and increase consistency in how healthcare providers deliver care to patients while in a hospital, and when transitioning between home and hospital.

ACBI is about AHS' provincial programs working with healthcare providers to make implementing best practices more manageable for providers and patients—by working better together. The anticipated result of ACBI is a standardization of best practice care delivery across all of AHS, leading to an improved patient experience.

In order to implement evidenced-based care, the tools and processes need to fit and align with daily workflow, and needs to be clear, consistent and straightforward.

What is the objective of ACBI? How does ACBI help providers?

The objective of ACBI is to make it easier for the care provider by simplifying and standardizing the admission, daily care routine, and discharge and transition steps that a care provider performs for each patient. The anticipated result is a shorter stay for patients and a better experience for patients and their families.

ACBI fosters a more collaborative approach to healthcare between acute care and primary care teams. It ensures patient information flows smoothly between those teams so primary care clinicians can contribute to their patients' care during hospital stays and follow-up is complemented with acute care strategies.

How does ACBI fit within patients' healthcare journey?

A patient's healthcare journey is an ongoing process that incorporates many touchpoints and interactions within the healthcare ecosystem – from hospital admission and discharge to community and specialty care. This journey, while managed mainly outside of a hospital setting, can be a temporary or longer-term experience that contributes to overall health and wellness.

ACBI looks at the 'path' or 'patient journey' from both the perspective of those who deliver care and those who receive care. Providers will use a consistent method to meet patient needs while in hospital which will provide patients with a better understanding of what their journey will look like from the time they are admitted and will ensure the transition back to community and primary healthcare is safe and seamless.

Why are you implementing ACBI now: what has triggered the need?

Healthcare is complex and continually evolving in response to emerging evidence.

How this evidence is implemented within a healthcare system and put into practice can be complicated – especially with many competing AHS quality improvement priorities being implemented individually and simultaneously. This has led to confusion, inefficiency, and redundancies according to front-line provider and other organizational feedback and is one of the main drivers for initiating ACBI, which aims to integrate, or 'bundle' several evidence-based projects together in a streamlined fashion.

How does ACBI improve patient and family care?

ACBI is focused on integrating collaborative care and evidence-based interventions that address the unique clinical care needs of patients through two streams:

1. A common 'foundational care bundle' based on collaborative care practices for "every patient, every time;" and
2. Condition and procedure specific 'clinical pathways' for each patient that build on the common foundation.

The ACBI initiative aims to integrate, or 'bundle' evidence based best-practice projects together making it more manageable, standardized, and consistent for providers and patients across all of AHS, leading to an improved patient experience, including:

- Less days spent in hospital.
- Fewer readmissions to the hospital after discharge.
- Safer continuity of care (transition) back to primary and community care.

Who are the key contributors to ACBI?

Strategic Clinical Networks™ (SCNs™), CoACT Collaborative Care, Seniors and Primary Care collaborated to integrate seven separate evidence-based, patient-centred provincial initiatives and clinical pathways into a streamlined bundle (one for Surgery and one for Medicine). This is called the Acute Care Bundle Improvement (or ACBI).

AHS has worked closely with patient advisors, providers, leadership, and operations in order to ensure alignment of ACBI and make it easier to integrate into day-to-day routines in a way that works for frontline staff and physicians within their local context. Ultimately, ACBI aims to improve patient, family, and provider experiences for 'every patient, every time.' When fully implemented, ACBI will be adapted locally to unique operational realities.

Will ACBI add to providers' workload?

This initiative is not new work. Each of the eight programs that comprise ACBI have been underway for many years. However, there has been limited standardization of care delivery and implementation approaches. By integrating the different programs together, ACBI eliminates redundancies and duplication of work for front-line providers.

The provincial ACBI team continues to work closely with healthcare provider teams to customize implementation to the zone, site and unit levels —based on local needs, culture, and priorities to achieve seamless healthcare delivery for Albertans.

What are the eight programs that comprise ACBI?

1. **Collaborative Care** is a healthcare approach in which interprofessional teams work together, in partnership with patients and families, to achieve optimal health outcomes. A few examples of Collaborative Care practices include Care Hubs, Rapid Rounds and Comfort Rounds. CoACT - Information for patients and families (ahs.ca) Co-ACT - Information for physicians (Insite) *(link requires AHS login)*

2. **Pressure Injury Prevention for Adult Patients in Hospital**: One in 6 patients in Alberta hospitals has a pressure injury, despite 90% of patients being screened for risk of pressure injury. Pressure injury prevention is a required organization practice by Accreditation Canada and hospital acquired pressure injuries are considered a source of hospital harm by the Canadian Patient Safety Institute (CPSI). We are supporting sites / units in an evidence-based implementation of SSKIN+, an acronym that describes the interrelated interventions or strategies to prevent pressure injuries in hospital.

3. **The National Surgical Quality Improvement Program (NSQIP)** is an international outcomes-based, risk-adjusted surgical quality tool, while Enhanced Recovery After Surgery (ERAS) is a pathway based surgical standardization tool. These evidence-based programs work together with a goal of measuring and improving the quality of surgical care, patient outcomes, and surgical experience.

4. **Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD) Clinical Pathways** promote evidence-based patient care through use of Care Paths within Connect Care. Care Paths are the advanced electronic form serving as a clinical decision support tool allowing: an integrated multidisciplinary approach through shared coordination of a patient's health care goals across all settings, aid in clinical workflow with simple intuitive supports accessed by Best Practice Advisories (BPAs), and consolidated Care Links in one place for easy access including admission order sets, daily assessments, labs, and discharge planning/transition to community.

5. **Elder Friendly Care (EFC)** addresses factors that increase risk for vulnerable older adults in acute care. This includes the hospital environment/routines and is informed by the patient's personal profile of vulnerabilities or 'frailty'. EFC uses preventive care strategies to decrease adverse experiences in hospital (such as falls and delirium), and poor outcomes after discharge (such as hospital-acquired disability, increased care needs including facility care, and increased risk of death).

6. **The Home to Hospital to Home Transitions Guideline** is a unique, province-wide initiative that merges acute, primary and community care under one guideline that outlines the supports Albertans need to safely transition from their communities to hospitals and then back home again. Transitions are a critical point in the patient journey and represent times when patients are most at risk and vulnerable. When care transitions are not well managed, this can lead to negative outcomes for patients, families, and caregivers as well as undue burden on the healthcare system.

7. **Cirrhosis Care** – The Cirrhosis Care initiative aims to improve the quality of care for patients with cirrhosis in Alberta. This initiative includes a standardized cirrhosis order set available through Connect Care, a focus on improving knowledge for patients and families through enhanced educational resources, and comprehensive reference materials for healthcare providers online at www.cirrhosiscare.ca.

How is ACBI being implemented provincially?

ACBI is being implemented in a phased approach (initially) at the 14 highest-volume adult acute care facilities in Alberta where it will have the biggest impact.

ACBI has been identified as an organizational priority and has been included in annual zone operational plans to strengthen accountabilities. It is also being aligned to other provincial and zonal priorities such as Connect Care; AHS Review (Sustainability Program Office) ALOS/ELOS and ALC improvement; Patient Movement; Know Your Data (physician audit and feedback structures for General Internal Medicine Physicians and Hospitalists); and Enhancing Care in the Community.

Timelines

ACBI implementation sequencing and timelines have been developed to align with Connect Care implementation and to allow for sharing across sites. Three implementation streams have been identified:

1. Sites that have already launched Connect Care.
2. Sites that are launching Connect Care within 3-6 months.
3. Sites that that are over six months away from Connect Care launch.

Some Zones have requested a broader zone-wide approach for ACBI implementation and the provincial support teams are exploring ways to support this.

Implementation at the zone level

A tailored implementation approach will be aligned to the unique context of each site, in partnership with site operations, and will include:

- The provincial support team working closely with zone and site leadership to support the front-line teams in their implementation.
- Delivering quality improvement training.

- Promoting an understanding of data and using it to drive quality.
- Dividing the ACBI work into manageable pieces based on admission, daily care and patient transitions.
- Arranging for information sharing and learning among sites and units.
- Identifying zone and site support resources and infrastructure.
- Working with site multidisciplinary teams, including primary care and physicians, for locally driven implementation and sustainability.
- Supporting front-line teams so that providing evidence-based care is easy thing to do.
- Working with physician champions at each site to foster clinician engagement.
- Implementing physician-level data sharing and supportive quality improvement infrastructure linked to ACBI through the Know Your Data initiative.

Education & training

The provincial support team will provide targeted education and training and has access to subject matter experts from all eight programs comprising ACBI. Educational tools and resources will be developed to support site staff and physicians using evidence-based principles from quality improvement, change management and implementation science. Education will be designed to be efficient in terms of time commitment required, offered just-in-time to maximize uptake, and certain items will be accessible through online options.