Geriatric Surgery Verification
American College of Surgeons

GSV Insight: Implementing Geriatric Vulnerability Assessments in the Elective Surgery Patient

INTRODUCTION

Michael Bencur [00:00:10] Hello and welcome to GSV Insight. Today, let's talk about implementing geriatric vulnerability assessments in the elective surgery patient. I am Michael Bencur, the Geriatric Surgery Verification Project manager. Today, Samantha Silverstein will be joining me from White Plains Hospital. Welcome, Samantha.

Speaker 2 [00:00:28] Thank you. Thank you for having me.

Michael Bencur [00:00:31] Can you tell us a little bit about yourself and your hospital?

Speaker 2 [00:00:34] Yes. So, I am a Surgical Quality Specialist at White Plains Hospital and have been working with our surgical teams for the past about 12 to 15 years and more recently became a nurse practitioner and started working in our Surgical Navigation Center. And since the standards came out through the American College of Surgeons, we've been working on looking at the Geriatric Surgery Verification standards. And I am the Geriatric Surgery Verification program coordinator. White Plains Hospital is an evolving acute care community hospital, we're a member of the Montefiore Health System and we're serving as the tertiary referral center for much of the health system. We're a 292-bed not-for-profit health care organization.

Michael Bencur [00:01:31] Great.

QUESTION #1

Michael Bencur [00:01:31] So can you describe the key steps taken to implement this standard?

Samantha Silverstein [00:01:38] Yes. So, there were a few things we set out to do initially. The first thing we did is we broke the standard down into patient pathways, focusing on looking at the elective and the non-elective pathways. And what I'm going to talk about today basically focuses on the elective pathway. We had a little more control over that patient population and so we thought it was a good place to start. We first things first gathered our interdisciplinary team and we set out to identify the screening tools that we were going to use for each of the identified vulnerabilities within the standard. Our goal was to, where possible, utilize tools we were already implementing, knowing that our nurses and other team members were already familiar with them. And of course, if they met the criteria, we wanted to keep that in place if possible. But we did end up choosing a few new tools that were different from what we had previously been using, and we had our team members there to look at it and identify which tools would be best for our screenings. In addition, you know, one of the bigger things we had to work on was deciding for the elective setting where these screening assessments would actually be completed and taking place. We knew from our previous program implementations we've worked on other programs, and centralizing a process usually makes it much easier to implement.

However, we had a few areas we had to iron out to actually make that work. We knew that having each surgeon's office perform the screening assessments would add a lot of variability to the process and it would be difficult to monitor, especially since not all of our surgeons are affiliated with our hospital and

therefore have different medical records. So, we were concerned we wouldn't be able to find what we needed, we wouldn't be aware of the screenings in advance, etc. So, we wanted to try and figure out what we could do. With that team together, we recognize that we have a Surgical Navigation Center. At the time, it wasn't mandatory for patients to attend the Surgical Navigation Center. What was being done is patients that were considered high-risk either based on their procedure or their comorbidities were coming through for a high-risk evaluation prior to their elective surgery. We also performed some full clearances for patients that needed it, but otherwise they were going to their own primary care doctors. So, when we looked at our geriatric surgery program and we identified a need for centralizing and standardizing the process, this team really stepped up. And what they did is they added to their pre-op questionnaire the age of 75 and older.

So, any patient that was 75 and older automatically was triggered as a high-risk patient. And that meant that they needed to make an appointment and come to our Surgical Navigation Center for a pre-op visit. In this way, we were able to ensure that all of our patients that were part of the GSV program went through our Surgical Navigation Center where we were going to have the assessments completed. So, in the Navigation Center, there's a nurse that performs the geriatric vulnerability screens. And so, it was the perfect opportunity to be able to implement that. So, once we identified our screening tools, where the screenings would be completed, we then wanted to find the easiest way to make sure that we were documenting our findings in the electronic medical record. At the time, we had begun to discuss with Epic some potential changes we wanted, but it was still too early in the process, and we knew that was going to be something that would take some time to actually make changes, especially as part of the health system. That's not something that was just for our hospital. But changes could impact all of the hospitals involved. So, what we wanted to do was start small and create something local.

So, within we have Epic as our medical record. And so, what we did is we were able to create a local SmartPhrase in Epic, and we just shared it with the different providers we had in our Surgical Navigation Center. So, this is a part of our SmartPhrase that we created in Epic. This is looking at each of the assessments. So, for our functional status, we chose initially the KATZ IADLs as our functional screen. We chose the Mini-Cog for our cognition assessment and for delirium. We chose the DEAR, the Delirium Elderly At Risk. So, with each of these tools, you can see we're able to score them. And I just I went through and I scored this randomly. And then you can see at the bottom of each there is a recommendation if the scoring is positive. So, for example, in the functional status recommendation, even though this patient scored well, I've identified some of the recommendations that we make in the Surgical Navigation Center for our patients to help meet the vulnerability. And so, I have that for each assessment that we see here. And this allowed us not only to pull in the information that we got from the assessment, but also make our recommendations for the team for both the day of surgery and postoperatively as well. So, this is a continuation of our SmartPhrase. This is now the mobility assessment. And we did a nutrition assessment. And our swallowing assessment. What you don't see here is our palliative assessment for age. For age, we just use the age of the patient. But for our palliative assessment, we had gone back and forth and there were some concerns about wording. We were using the surprise question and so it's not documented here. However, we have the ability to include it.

We also have at the bottom, we've included some additional information that we use for our geriatric patients asking about if they have a health care proxy, if they have a living will, whether or not they live alone, and if they have help at home. This was additional important information that we wanted to include. So even though it's not specific vulnerability assessment, we included that information in our SmartPhrase. So, in addition, once we had all of our information together, we created our SmartPhrase. We had our Surgical Navigation Center really assist us with the process. The nurse in the Surgical Navigation Center has the vulnerability assessments completed on paper, and then those papers are given to the provider before they go in to see the patient and the provider reviews it. And then when they go in to see the patient, they perform the assessment they were already going to be creating. And then they also are discussing the vulnerabilities and then the provider is the one that actually uses the SmartPhrase

in their pre-op note. And so, they'll pull in the SmartPhrase and then they'll fill out the information based on the screenings that were complete, completed by the nurse.

QUESTION #2

Michael Bencur [00:09:25] Great. That's amazing work. How did you obtain buy-in from key participants?

Samantha Silverstein [00:09:32] I consider myself incredibly fortunate working in this hospital. I have noted support in many of the programs we have implemented. In 2019, when the Geriatric Surgery Verification standards first came out, we immediately started looking at them. We kind of got our key players together and did a gap analysis and looked at where we were at, what would be required to actually implement. But we had support from the very top from the beginning, which was really great, and that was globally for the for the whole program. Another thing that was helpful is sharing our actual data. And so, looking at our inpatient surgical population, we identified that 50% of our surgical patients were 65 and older and 50% of those were 75 and older. So, looking at these numbers and knowing that they would only grow more in the next few years, we really were able to share the impact that a program like this could have on our patient population. We participate in the National Surgical Quality Improvement Program (NSQIP) as well, and we were already able to share our data in the patients 65 and older looking at our surgical outcomes. And through other programs we'd implemented, we were able to see improvements even in our older adult population without having had specific older adult interventions in place. So, we knew that this was this program could really assist us to just take it to the next level and continue to drive improvement.

So as far as the actual wanting to go for the Geriatric Surgery Verification, we definitely had buy-in for that. When we looked at this particular standard, of course, it was our Surgical Navigation Center that really stepped up and took charge of this process. Having them involved in how we would implement and what we would do, I think was a helpful part of that. It's always helpful to get the key stakeholders involved early on in the process and get their buy-in since they really know the process best and they're the ones that are going to identify where there are barriers, why certain things will work and work. So that's always a helpful part of the process. And so, they met the challenge. They were able to make it happen. And I think, you know, again, looking at the potential impact, the program is going to have really helped with the additional buy-in because while Surgical Navigation Center played a huge role in this particular standard, we still had so many other participants involved. And so, you know, just sharing data and having them involved in the process really helped. And we were already in a state of growth with our Surgical Navigation Center and with other programs we were implementing and expanding. So, it was actually a good time for this because we just with all of the other programs growing, this was just another part of ways that we could provide exceptional care to our patients. So, it really made sense with what we were already doing. So, I share that just because I think if we share the right information and the right data, we can get the buy-in and support. And then, of course, starting small and being able to show incremental improvements helps people to come along that maybe were not as excited about it in the beginning.

QUESTION #3

Michael Bencur [00:13:28] Absolutely. Can you describe how you sustained momentum/activity with your team?

Samantha Silverstein [00:13:33] For the most part, the new processes really just became a part of standard work that was done in the Surgical Navigation Center every day. I focus on that department because, again, that's where we centralize the process for our elective patients, and it made it a bit easier when it was just how they did everything. So, each patient that came through, even if they were not part of the geriatric surgery program, had a form that they had to fill out. And so, what the team did is they

created packets and if the patient was under 65, they got one packet. If they were over 65, they got another packet. In that packet for the patients 65 and older included the vulnerability assessments. Some of the information was filled out by the patient and then verified with our team and the others. For example, the Mini-Cog has to be implemented by a nurse doing the three word recall and having the patient draw the clock. But we just created that as part of the work that was already being done. So, it took a little extra time, but for the most part it was able to just be easily incorporated. And then in addition, in preparing for our weekly interdisciplinary GSV vulnerability reviews for our elective patients, so we have a weekly huddle where we're looking ahead at the following week and reviewing all patients that are having inpatient surgery and any patient that is identified as vulnerable, having a positive screen for one or more of the vulnerabilities, they're reviewed and we discuss their comorbidities, we discuss their vulnerabilities and identify the recommendations that were made by the Surgical Navigation Center provider. And so, in doing that, we were really able to identify if any patients had been missed. And I was able to communicate that back to the Surgical Navigation Center and get them scheduled. And so just having that checks and balances really helped with continuing the momentum and keeping the process going. But I think, like I said from the beginning, it's just that we had to make it a part of our everyday process, things that we were already doing for every patient. And this was just an add on, a little extra thing. In that way, it was part of our routine.

QUESTION #4

Michael Bencur [00:15:53] That's great. Were there any barriers or setbacks that occurred while trying to implement the standard? And if so, what were the solutions to those barriers?

Samantha Silverstein [00:16:01] Yeah, I think any time we implement something new, there's always going to be a barrier or a setback or just growing pains as we implement programs. And so there weren't too many major ones for this particular standard. And again, in our elective setting, we were able to really standardize the process. I think what we realized as we were going through it is that we wanted to make sure that what we were doing in the elective setting, we were then going to be able to do the same assessments in the non-elective settings pre-operatively. And so, well, I wouldn't necessarily call it a barrier, but some things that we had to do is we've since the implementation of our SmartPhrases, we have been working with the Epic team and our, our IT teams who have been incredibly helpful in changing some of the assessments that we're doing so that we can create it standardized for both patient workflows, just so that we can make sure that when we're assessing them prior to discharge that we now have the same tools that we're using. So that was one of the things that we just had to go back to the drawing board a little bit and identify some changes that we were going to make to the process.

But overall, the workflow for the most part went pretty smoothly. And as I shared, we do some checks and balances to make sure that we haven't missed any patients. I did also was saying before that we are now screening patients 65 and older. So another change we made was that initially we were just using those 75 and older, but recently we've been, as we've been looking at our older adult population and looking at some other programs we're implementing throughout the hospital, having to do with older adults, we wanted to make sure that we were able to be consistent in messaging with all of our staff members, and so we wanted to use the age 65 and older, which is used for the NICHE Program we're involved in, as well as for the 4Ms Program that we're working to implement. So that was another change that we made, and it was just part of an iteration of the process. And so again, we just went back to the team and identified what we wanted to do and what the changes were and why and identified a way to find a way to meet that need. So, one of the things that the Surgical Navigation Center does is there is a questionnaire so all patients, once they're scheduled for surgery, get a phone call by that team. And in that way, we're able to risk assess the patients and identify those that are high-risk because those that are high-risk, regardless of if they're in the geriatric program or not, do need to come through the Surgical Navigation Center for that high-risk assessment. And so, what we did is we added to the questionnaire, we changed it to 65 and older, and we had that changed. If they're 65 and older and

they're having inpatient surgery, that would automatically score high-risk on the questionnaire, and they would come in. And so, we had to change a little bit of our workflow that was going to increase our patient load in the Surgical Navigation Center. So, we had to make sure that we were able to appropriately address that because that definitely took some work with our teams. But we were able to predict how many patients, how many additional patients it would be and identified a plan, went to the interdisciplinary group and discussed it with everyone and it made sense to move forward with it again and staying consistent with our other programs throughout the hospital. And so, again, they really were able to implement it and just identify where we still needed to do little tweaks to make sure we could meet the needs of the larger population that we included.

So overall, I think, you know, they were able to do a lot from changing the questionnaire to creating the SmartPhrase to make sure we could get documentation. We even went through different iterations of the SmartPhrase we added in the recommendations because we identified that initially we were doing the vulnerability assessment but then didn't have any way to share what should be done about those vulnerabilities. So, you know, just again, it was it was trial and error and going back to the drawing board and then presenting the group with the recommended solution, and if we got the approval, we would move ahead and make those changes and implement it and see how that went. So, you know, overall, with that process, we were able to be successful with the standard and very consistent with being able to implement it. So, we were pleased with that.

CLOSING REMARKS

Michael Bencur [00:20:53] That's really great to hear. Well, thank you so much, Samantha, for joining us today and sharing your experience implementing this standard.

Samantha Silverstein [00:21:00] Thank you so much for having me and for allowing us to share our work and sharing everyone else's work as well. It's been a great experience to learn from others.

Michael Bencur [00:21:10] I hope you all learned as much as I have today. If you would like to share your GSV implementation strategies, please don't hesitate to reach out to me at mbencur@facs.org.