Geriatric Surgery Verification
American College of Surgeons

GSV Insight: Vulnerability Screening for Both Elective and Urgent Patients and Contrasting the Two

INTRODUCTION

Kataryna Christensen [00:00:07] Hello, and welcome to GSV Insight: Let's Talk About Vulnerability Screening for Both Elective and Urgent Patients and Contrasting the Two. I'm Kataryna Christensen, the Geriatric Surgery Verification Project Manager. Today, Dr. Matt Schiralli will be joining me to discuss how they implemented geriatric vulnerability screens. Thank you for joining us today. Can you please tell us a little bit more about yourself and your hospitals?

Matthew Schiralli [00:00:27] Yeah, thanks, Kat. Thanks for having me, and I'm excited to take the opportunity to share our experience with other GSV hospitals. I have the privilege of leading in various ways in our health system. First of all, I have been chair of surgery for a portion of our health system that covers two of the hospitals that we've implemented GSV in. And more importantly for this talk, I get to direct the geriatric surgery program across all of our hospitals in the health system and working through our sort of campus databasing, and NSQIP Program, we have the foundation through NSQIP to run our quality programs. And so, if we take a look at the hospitals in our health system, three of the seven hospitals in our health system have worked to implement GSV Standards. We started at Unity Hospital, which is about a 250-bed hospital in a suburban, not-for-profit category. It is just outside of the city limits of Rochester and draws a population from both urban and suburban communities. Then at Clifton Springs Hospital, that's one of our smallest hospitals, a rural hospital with about functioning around 30 beds, medical surgical care, as well as a large behavioral health unit separate from that. But Clifton Springs Hospital is about 30 minutes outside of Rochester city limits. And then Newark-Wayne Community Hospital is one of our medium sized hospital, functions around 100 beds, and is again in a rural setting. Newark-Wayne and Clifton Springs together make up the eastern region for our health system and they function really in unison with each other where we transfer urgent surgical patients often over to Newark on nights and weekends and holidays, because we don't staff our ORs at Clifton all the time. That played heavily into the development of our geriatric surgery program, as the two hospitals work complementary to each other to serve the communities.

Kataryna Christensen [00:02:42] Great. Thanks so much for that wonderful introduction.

QUESTION #1

Kataryna Christensen [00:02:42] Now to dive into the questions, what were the key steps taken to implement this standard?

Matthew Schiralli [00:02:50] Well, starting at Unity Hospital, where our first program build occurred, we developed a working group around the preoperative preparation of patients. We actually developed three working groups. One was pre-op, one was intra-op, and one was post-op, and each one of those working groups met every third week. So, every week as the core team, we were hosting a meeting to work through standards. And every third week, the group around pre-op preparation of patients would meet. That gave us enough time to work with the group, talk through the standards, talk about options, and then give those leaders that were participating in the group time to go back to their frontline staff and talk about what would the impact of decisions be on those staff. Within that working group, we made it up with nursing leadership, anesthesiology leaders, surgery leaders, advanced practice providers from all

different areas related to pre-op preparation of patients, as well as multiple different types of therapists, physical therapy, occupational therapy, speech-language pathology, and brought all of those subject matter experts together to help develop our screening process. The next important step that we took in developing the screening processes was that we broke the processes into two separate processes, the first one being the elective screening process for patients who were scheduled and coming into the hospital on an elective basis. And the second one being the urgent process for those patients who were coming in with very short notice, predominantly coming in through the emergency department for urgent or emergent surgical care. Another key component of our build was to identify the location in which the screening was going to occur. Fortunately, in our health system, each of our hospitals is built out with a surgical pre-testing or pre-admission testing clinic space. And when we're talking about the elective screening process, that gave us a common touchpoint in which to perform that screening process. Our health system, like many in the country, are made up of multiple different offices, multiple different practices, some private, some owned by the hospital or by the health system, and it was difficult to imagine putting the screening process in each different location and making sure that it was working properly. And so, we took advantage of that common touch point through surgical pre-testing at Unity Hospital to make it as standard that the screening process would happen and happen in a reproducible way. For the high-risk secondary evaluation, we also had to choose a location for that, and one thing we did right away was we seized the opportunity to work heavily on preoperative preparation of patients in prehabilitation. We would actually have our high-risk evaluation done off site on a different day for anybody who had gone through the initial screening process. Turns out we were not successful in doing that, but that's one of my favorite things is to actually talk about the things in which we did not succeed because hopefully that will help other hospitals. But we learned that it was much more efficient for patients and families, as well as on the administrative side of running the program, was much more efficient to do your initial screening process in the elective world, plus your high-risk evaluation just back-to-back in the same space. So, one of the points of learning was to create a process in which we could do those in series right in the same location. That way we didn't put an extra burden on the family members to try to get their loved ones to yet another appointment. One of the other key steps for us, both for urgent and elective screening processes, was to obtain the resources from our IT professionals to build within our electronic medical record, we use EPIC at all of the Rochester Regional Health hospitals, standardize process so that we could make it very efficient for our providers to be working through a navigator that just took them from one step to the next, so that as we taught them the components, it was reinforced by an easy to use electronic medical record process.

QUESTION #2

Kataryna Christensen [00:07:06] Yeah, absolutely. And that that last step is key. And I know that a lot of hospitals have already reached out for more information on the EMR build and all the components that it's taken. So, thank you for that. Moving on to the next question. Can you describe how long it took your hospital to fully implement Standard 5.6?

Matthew Schiralli [00:07:24] Sure. It was a labor of love, a process that took a while to get going and it was partially because we didn't have any real well-defined models of other hospitals to follow ourselves after. We were part of the Beta site group, and we were certainly speaking with the other Beta sites about what was happening and what they were doing, what they were succeeding with. But for us at Unity Hospital, the approach we eventually took was to say, let's start with a definable patient population that's easy to work with. We chose elective orthopedics as our starting point. If you think about it, if you're going to have an elective total hip or total knee replacement and you're 75 and above, then you're probably a pretty healthy patient. And so that was a fairly easy group to work with. That also gave us a volume with which to work. It wasn't something that was happening once this week and then not again for two or three weeks. It gave us a steady flow of patients coming through our surgical pre-testing department, and it gave those providers and surgical pre-testing the opportunity to practice and give us feedback on the process. And so took us about three months working through the process to put elective orthopedics in place. And then

once we got that going, we felt good about it, we started to expand to the other elective surgical disciplines, and we spent about three to six months bringing in the other elective surgical disciplines into this same process. It was important to us for our staff to feel confident in the in the process and know that it didn't necessarily matter if it was a general surgery patient or a vascular patient. The screening process was the same. It was reproducible and something that they could just transfer the skills that they had learned and used in one area right on to the next. In addition to that, we did a simultaneous expansion around our urgent patient population, and this was not focused in our surgical pre-testing clinic. This was focused in the hospital utilizing our surgeons and our advanced practice providers who work within the department of surgery as they were consulting on patients to start that screening process when they did the initial consult. Whether or not a patient was going to go to the operating room right away or if a decision was going to be deferred to later, we started the screening process with that initial consultation. That was the most common, definable touchpoint. And by building out that process, it took us about, again, another three to six months to get that urgent patient population built out. So, when you look at the entire experience, probably about nine to 12 months for us to get all patients, elective and urgent, into a defined screening process.

QUESTION #3

Kataryna Christensen [00:10:10] Wow. Okay. And can you describe what resources were used and what skills were needed to put this standard in place at Unity Hospital?

Matthew Schiralli [00:10:18] Sure. We relied heavily on the work of others, to be honest with you. We looked for verified screens, standard screens that had been published, and we tried to take as many of those and put them in to our workflows as possible. The SAGE screen, the Sinai Abbreviated Geriatric Evaluation, from Mark Katlic and JoAnn Coleman was it was an immediate go to. As we were starting to develop our program, Mark and JoAnn helped us in the beginning with ideas, and that SAGE screen became something that was really useful backbone to the elective screening process. We didn't think it was it was appropriate in the urgent world, doing a timed walk and a Mini-Cog in the urgent world didn't work out quite as well. But in that elective process, the SAGE screen was our backbone and we built off of that to include, over the course of time, the DRAT for delirium screening, the EAT-10 for Dysphagia screening, the MNA for nutritional screening, and a palliative care screening that our local palliative care teams brought to us. We put all of this together to create the elective screening process, and honestly, we've tweaked it over time. We started with a different nutritional screen, worked with that for a while, and then our nutritionists came to us, our dietitians came to us and said, look, that's really not the best one to use after we've used it for a while, let's switch it over. And so, we had to be willing to try something, see how it went, and then change if needed. The other big resource we touched on before, but for us it was a huge resource, was our electronic medical record and our IT professionals who went through the EPIC build for us to really make this a workflow that was not clunky, and it was very efficient. And then the third major resource we used, we used a lot of time from healthcare professionals. It was a very willing medical staff and group of healthcare professionals who recognized the need in the elderly population and how we knew we could do better. We just needed to bring the group together and bring all of our expertise to the table to develop a process by which we could efficiently screen patients so that we could then know who to focus mitigation techniques on.

QUESTION #4

Kataryna Christensen [00:12:48] Wonderful. And do you have any educational resources available for your hospital staff pertaining to this standard?

Matthew Schiralli [00:12:56] Absolutely. Over the course of time we've been developing educational resources. We have our entire electronic medical record build is supported by an extensive document that shows each one of the healthcare professionals what their role in the program is and what their role in the

screening process is. We have gone to our surgical pre-testing and pre-admission testing clinic spaces and taught new skills to those providers who picked it up right away and ran with it and helped develop a cognitive evaluation screen that never existed before in those spaces, and delirium screening that never existed there. We've gone on to teach the nurses about using Mini-Cog assessments in the hospital, I know that's not exactly the risk screening process, but as we're getting ready to transition patients out of the hospital, there's another risk screening process that occurs in GSV Standards. And so, we taught the nurses and provided manuals for their med rooms and pocket cards for the nurses and again, EMR resources for them to work off of. And so, we have multiple different resources that we've brought to different areas of health professionals to support this process.

QUESTION #5

Kataryna Christensen [00:14:18] Great. And lastly, what are some tips for other hospitals who are struggling to implement this standard?

Matthew Schiralli [00:14:25] I think with any major change management process, you have to just pick something and start with it. And that's my biggest tip. You know, not rocket science, just my opinion is pick the screening process. Because once you put the screening process in place in your hospital, it functions as the foundation for everything else to happen. If you have a well-developed screening process that is easy to use, then folks will be able to work patients through in a scalable way and then actually identify those patients who are at higher risk so that you can then start dedicating some of your more expensive, costly resources toward those higher risk patients. I think we all have to be willing to fail. That was one of the things that that we did well right from the get-go. We said we don't know exactly what we're going to do, but we're going to start with something. We're going to work with it for a while, and then we're going to reevaluate. And if it doesn't work well, we're going to change it because the population needs this, our community needs this, and we just need to be dedicated to the process of implementation of a new process and then a reevaluation of it. Then the third thing I think is keep your screening process basic and broad. Try to capture as many of these patients in the high-risk as possible, because what we found was that it felt like we were capturing a lot of patients in the high-risk until we did their high-risk screening and then realized how much compensated cognitive dysfunction exists in this patient population, that unless you have a really broad screening process, you're not necessarily going to pick up on their frailties of the population, and then you won't, you'll miss your opportunity to try to intervene.

CLOSING REMARKS

Kataryna Christensen [00:16:16] So first, I want to congratulate you on all of your hard work. You have done a tremendous job, you and your team, at all three of these hospitals. And it's just been very, very exciting to work with you. So, thank you again so much for joining us today and sharing your experience implementing Standard 5.6.

Matthew Schiralli [00:16:36] Wonderful. Thanks, Kat, for inviting me to share some of our experience. And as always, we're very open to sharing our experience on an individual basis with other hospitals. And so, reach out, my email is on the screen. Feel free to send me an email and will, along with my team, respond and share our experiences with you.

Kataryna Christensen [00:16:56] Great. I hope you all have 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 kchristensen@facs.org.