Geriatric Surgery Verification
American College of Surgeons

GSV Insight: Code Status and Advance Directives – Sharp Memorial Hospital

INTRODUCTION

Michael Bencur [00:00:11] Hello and welcome to GSV Insight. Let's talk about code status and advanced directives. I am Mike Bencur the Geriatric Surgery Verification Project Manager.

Sharp Memorial Team [00:00:24] Thank you, Mike, for having us. I'd like to start off by introducing the members of our team for Generational Health here at Sharp Memorial Hospital. Dr. Diane Wintz is the trauma and Generational Health medical director. Eileen Carroll is our program coordinator. Stacy Nilsen is our clinical nurse specialist. Debbie Monaghan is our nurse practitioner and I'm a nurse manager. Thank you so much for this opportunity.

Michael Bencur [00:00:49] Thank you so much for being here. Can you please tell us a little bit more about yourselves and your hospital?

Sharp Memorial Team [00:00:55] Sure. This team has come together over quite a few years of time as we've built our geriatric focus, as well as our Generational Health Program, which is not only for surgical patients, but for all patients who come to this hospital for care, who are within the age group of 65 and older. We each bring a perspective and an area of expertise into the program, and I think part of what has made us so successful is that we allow the experts to bring their expertise forward and develop their pieces of this program. And I'll talk about that a little bit more as we go through the podcast questions. But for example, Eileen has a case management background and she was able to bring that very strongly into her advanced illness management practice as well as into the coordination of care for healthy aging and the complete development of that program. Stacy is going to complete her Ph.D. in just a couple of weeks, and she's been very focused on process improvements, looking at data and outcomes and improving our program in a direction that makes sense for our patient population. Debbie has a background in psychiatric gero-palliative medicine and has been enormously contributory in the areas of geriatrics, depression, and other psychosocial disorders, where we noted that we needed to develop pieces of the program there. So we have a whole collaboration with our mental health hospital facility, which is actually on site and on the campus. And Kelly Wright was the manager for Advanced Illness Management. She remains as such, but she's actually expanded her role in the manager position for Generational Health. So she's seeing patients who are not only ill and at end-of-life, but also those who are facing decisions related to loss of independence or those who have new onset illness or injury; and they're facing some life change that then necessitates them to understand the context of the importance of their life choices within their medical history and future.

Michael Bencur [00:03:37] Great. And can you tell us a little bit more about Sharp Memorial in general?

Sharp Memorial Team [00:03:42] Sure, this is a 350-bed staffed hospital. It is a Level II Trauma Center. We also have specialty care in cardiothoracic surgery, vascular transplants, G.I., bariatrics, and a host of other relevant specialties and super specialties of medicine. This is the metro campus. We have three other sister hospitals that serve other areas of the community. Sharpe is located in San Diego, California, and from a trauma perspective, serves a good portion of the East County, extending all the way down to the US-Mexico border and then all the way east until our county ends.

Michael Bencur [00:04:36] Great.

QUESTION #1

Michael Bencur [00:04:36] And now let's move on to our discussion. So can you give a brief history of your Generational Health Program and how you decided to apply for the GSV Program?

Sharp Memorial Team [00:04:48] Sure. I'm Diane Wintz and I will kick us off with that first question. Generational Health was developed to encompass all efforts and programs aimed to promote efficient and effective care for the adult population. A significant focus on geriatrics. This program has its origins in trauma, where the volume is about a thousand patients age 65 and older being encountered per year, many of whom need some type of surgical intervention with limited ability to provide preoperative optimization. There were several cases back in 2018 where we thought we could have done better. So at that time we gathered leaders and all of the different therapy specialties, managers of the emergency department, ICU and inpatient units, and sat around a table one day a week for eight months to design the program, which was trauma focused. The results for functional outcome and delirium mitigation were so good that we wanted to offer something similar to all geriatric admitted patients. From there, we were able to develop programmatic pieces to fit the needs of the patients. These programmatic pieces were all focused on 4M Age-Friendly care, as described by John Hartford with the Institute for Healthcare Improvement. Healthy Aging was launched to support geriatric patients with acute illness. So then we had programs for both injured and ill patients. Generational health is the umbrella for all of these programs, and it also embraces the Advanced Illness Management Department originating in 2016 and hosts a team of nurses who specialize in goals of care, advance care planning, and palliative care services. We decided to apply for Geriatric Surgery Verification to highlight and promote our programmatic partnerships across our care continuum, focusing on these specific initiatives which have all come together to give the geriatric community the best opportunity for success in our care.

QUESTION #2

Michael Bencur [00:06:56] Great. And can you describe the ACP process at your facility and how you meet the standard?

Sharp Memorial Team [00:07:03] Sure. This is Debbie Monaghan. Code status is discussed and documented by the attending physician, and this is often an emergency room physician as well. If further clarification or discussion is required, the provider will ask the Advanced Illness Management team, otherwise known as AIM team, to see the patient and/or family. The nurse will meet with the patient or surrogate decision-maker to assess their understanding, arrange family meetings as needed, provide education both verbal and written materials, complete appropriate care planning documents, either a health care directive and/or a POLST form and notify the health care team of decisions and update the medical record to reflect their wishes and then document the order in our notes. And then ongoing discussions occur as needed throughout the hospitalization, and we also have an outpatient advance care planning team in the community that we can refer to so that they can follow up as needed. What's so powerful about these services is that the receipt of messaging comes from a variety of people. So both their primary provider as well as the different clinicians throughout the hospital. So the same information, but in different formats and different voices and by a variety of people, the patient and family here over and over and over again with many opportunities to ask questions and clarify.

QUESTION #3

Michael Bencur [00:08:34] That's fantastic. And who was involved in implementation? How has the team grown and what lessons have you learned during the development of this standard?

Sharp Memorial Team **[00:08:43]** You know, this is Kelly, and the beauty about this standard is that when they say it takes a village, it really takes a village. And I'm looking at my coworkers and colleagues here knowing that we're a work family. Discussing code status and addressing care planning is something that we consider as being fluid, meaning that it could be addressed on admission and change throughout the person's trajectory while they're here under our care. This means our team must be diligently conversing with all team members involved in the patient's care, and that's growing as we speak. We also do so and address this several times throughout their admission from primary care providers to the emergency room physicians, from surgeons and anesthesiologists who are attending physicians, from the operative operating room nurses to all of the floor nurses as well, the AIM team and the rest of the hospital. Case management, social work involvement as well. It truly takes a village to incorporate communication on code status of care planning. We use report sheets, handouts, banners in the chart, advanced directives, POLST forms, and these are all centered around the patient's voice and their expression of their wishes. We have learned a lot throughout this time, and we specifically learned it takes effective communication to not only ask somebody but to deliver their code status and care planning conversations and preferences. When these are established, the key is to relay without miss, to promote open dialogue, and to be open to fluidity surrounding the patient's wishes.

QUESTION #4

Michael Bencur [00:10:16] That's amazing. And can you describe how you have sustained momentum with your team and do you see new areas or opportunities to develop within this standard?

Sharp Memorial Team [00:10:29] Thanks. This is Eileen. Relationship based care places the patient at the center of all care, honoring the patient's of autonomy, decision-making is a Sharp health care value. Advanced Illness Management as a trusted partner to engage in advance care planning discussion. With the launch of a Healthy Aging team, we are assessing frailty in all older patients. Those identified with geriatric frailty symptoms are automatically consulted to Advanced Illness Management to assess for any advance care planning needs.

QUESTION #5

Michael Bencur [00:11:03] Great. And can you describe the staffing of the team who provides the ACP and describe how the program has grown over time and what metrics you use to influence additional support from administration?

Sharp Memorial Team [00:11:16] Sure. This is Debbie. So as far as the to all providers really can and should address and document goals of care in the medical record that the Advanced Illness Management team is the second most consulted team for advance care planning. The AIM department consists of 7.8 FTEs, which are one MP and a mix of RNs. The department has grown significantly since we started the ED initiative in 2016, and now at least half of our referrals are initiated in the ED. Prior to 2016, the AIM team, Advanced Illness Management was seeing approximately 600 patients annually. Now we are seeing over 4,200 per year. The metrics used to support growth for advance care planning consulting include increased efforts on education to all providers, specifically to all providers to complete ACP training annually, to increase ACP completion for sure patients over the age of 75 and to accurately document patient wishes in the medical record. But due to the time that it takes to have a thorough discussion about goals of care and advance care planning in both the primary care setting and the acute care setting, a team of skilled professionals are not only cost effective but an imperative for the metrics above. And having a dedicated team is also important for patient and provider satisfaction.

QUESTION #6

Michael Bencur [00:12:53] Very interesting. And do you have any educational resources available for your hospital staff pertaining to this standard?

Sharp Memorial Team [00:13:00] Yes, this is Stacy. We have several important and useful resources that are available to the hospital staff to support our advance care planning. So the Coalition for Compassionate Care of California provides excellent evidence-based resources for both our healthcare professionals and information for patients and their support systems. The resources available for the health care team to disseminate to patients are appropriate for all levels of the patient's health literacy, produced in appropriate languages for our population, and our culturally sensitive. Sharp healthcare has patient-centered policies and procedures related to advance care planning, which support the clinician in engaging patients in conversations of code status, non-beneficial treatment, DNAR, and allow natural death and more. Respecting the patient's decisions and creating plans of care centered on what matters most to each individual is enculturated in our nursing practice. Each new clinical nurse participates in the foundations of nursing practice orientation, introducing the Advanced Illness Management process, code status, and expectations for advance care planning. Most impactful for the professional development of our clinical nurses is the pure role modeling of our Advanced Illness Management team. Having those discussions with patients about care planning, creating those caring connections, learning how to respond to patient/family concerns, and then respecting the autonomy and choices of our patients.

OPEN DISCUSSION

Michael Bencur [00:14:20] Wonderful. Well, you've obviously done great work and that really shows through your team and the members that are gathered here today. Is there anything else that you'd like to share about the standard and your efforts?

Sharp Memorial Team [00:14:33] Yeah, I think the group should address and we'll just sort of open this forum up a little bit. But we should address two different situations that we come across frequently. One is the patient who had a relatively independent lifestyle before coming to the hospital and has a surgical problem where and we believe that although surgery carries risks, they will benefit from that procedure; versus the patient who comes into this hospital who is frail or demonstrates other vulnerabilities and they have a surgical problem, but surgery is not expected to lead to a successful, functional, or rehabable issue. And I just kind of wanted to go around the table and hear everybody's approach, how do they approach the surgical team and how do they approach the patient in those situations. I can start. Recently had a 91-year-old patient who was independent at home, 100% independent at home, came in with a large bowel obstruction, probably cancerous. And essentially the options were to do surgery or to put him on comfort care. And the family chose to try to do surgery. During the first night, he became delirious and I met with the family and have long discussions about the options, but also just kind of talking about delirium and how that could impact his recovery and made some decisions that, you know, post-op he would be do-not-attempt-resuscitation. And the family had a very clear understanding of what his wishes were previously and what the risks were. Unfortunately, he did end up dying post-op, but it was a very smooth, peaceful transition for him and the family under those circumstances. Yes, so we often see both of these scenarios in our day-to-day practice. What's important in my role is to have that conversation as early as possible, get to know the person just like I would my own family member, try to understand what their baseline status is, coordinate with the entire interdisciplinary team that I think will be needed throughout the whole hospitalization. Due to the limitation of our nursing scope, we often, and I say "we" as in all the Advanced Illness Management nurses, turn to the provider, the attending, the surgeon, the consulting physician, whatever the disease process may be we collaborate with all parties involved to really understand what their philosophy and what their offerings are for for each type of patient. It's very important to get their perspective and to be on the same page when we're having a goals of care conversation with the patient and their loved ones involved. We try to go over what their baseline wishes would be and then the implications of each direction that we're offering here at the hospital and the main focus being on short-term goals, what we're capable of providing here

within the walls of our facility as well as long-term goals, which are goals outside of our facility: what life will look like when you leave us, who will we coordinate with for your care to make sure that you have the best outcome possible? And by best outcome, we're very clear that it is centered around the patient. What is their expectation and how do we meet those expectations as clearly as possible? As AIM nurse, I kind of consider myself as ultimately the patient advocate, the truth teller. I am the middle person. There's the physician who definitely has the options and opportunities to share with the patient, but I also have to realize that figuring out what the patient wants isn't always exactly what the family wants, and being able to be able to provide them with that opportunity of endless time, if you will, of the opportunity to have more meetings if necessary. Often patients don't know in the emergency department what exactly that they want, and maybe there's a great way that we can help them, But is that really going to impact their quality of life? Is this going to give them that opportunity to truly have their what they really want? And I find that our department is extremely successful in being able to really offer the patient the opportunity to feel that they are valued with the appropriate information so that they can make the true decision regarding what they want for their health care. I so appreciate all of that, because as a surgeon, I find that some of the hardest cases that I manage are the ones where I know I have a surgical solution that I could offer, but that it's ultimately going to take that patient out of the home forever, or it's going to obligate that patient to long-term artificial feeding or long-term machine dependance. And in the big scheme of what's important in life, is that really what the patient wants? So I use this team quite often in my own practice that the collaboration is enormously, enormously supportive to patients, but it's also supportive to providers because this is a team that tells me as a surgeon that it's okay, the patient doesn't want you to do that operation or it's okay, the patient understands that if you do this operation that the outcome may not be successful, but they still want you to try. And it's that external validation that I need as a surgeon to go forward and feel confident about what I'm offering.

CLOSING REMARKS

Michael Bencur [00:21:07] Great. Thank you very much.

Sharp Memorial Team [00:21:09] Thank you for having us and giving us this opportunity to tell our story.

Michael Bencur [00:21:14] You're very welcome. And for those of you watching, Dr. Wintz's e-mail is up on the screen. If anyone would like to reach out with further questions. And thank you again for joining us. I hope you have 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. Thank you.