Frequently Asked Questions
Standard Specific

Standard 1.1: Letter of Support

Q **If I have a letter of support for other ACS Quality Programs, do I need one specific to GSV?**

A Yes, your hospital will need to submit a letter of commitment that is specific to the GSV Program. The letter of support must be signed by leadership (for example, CEO or equivalent) confirming their support for the implementation of the GSV Program. The letter must describe and demonstrate leadership support and commitment for the GSV Program at the hospital. The Letter of Support should be updated for every verification cycle. There is a template available in Module 1 of the GSV Implementation Course.
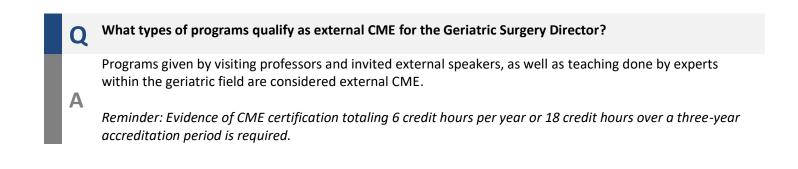

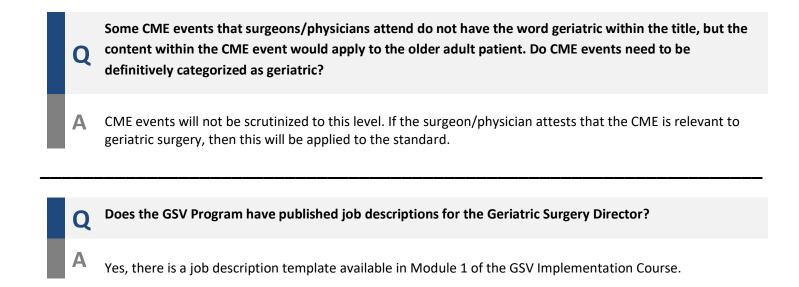## Standard 2.1: Geriatric Surgery Director

Q **Does the Geriatric Surgery Director role need to be fulfilled by a surgeon?**

A No, the role needs to be fulfilled by a physician. The official job description must reflect the responsibilities outlined in the *Optimal Resources for Geriatric Surgery* and support dedicated time and compensation commensurate with duties assigned.

Q **What is the estimated FTE required for the role of Geriatric Surgery Director?**

A There are no specific FTE requirements for the Geriatric Surgery Director, but the hospital will need to demonstrate that the work is performed effectively. The time commitment of the director must also be demonstrably adequate to the hospital's patient volume.

Q **What types of programs qualify as external CME for the Geriatric Surgery Director?**

A Programs given by visiting professors and invited external speakers, as well as teaching done by experts within the geriatric field are considered external CME.

Reminder: Evidence of CME certification totaling 6 credit hours per year or 18 credit hours over a three-year accreditation period is required.

Q Some CME events that surgeons/physicians attend do not have the word geriatric within the title, but the content within the CME event would apply to the older adult patient. Do CME events need to be definitively categorized as geriatric?

A CME events will not be scrutinized to this level. If the surgeon/physician attests that the CME is relevant to geriatric surgery, then this will be applied to the standard.

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Q Does the GSV Program have published job descriptions for the Geriatric Surgery Director?

A Yes, there is a job description template available in Module 1 of the GSV Implementation Course.

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Standard 2.2: Geriatric Surgery Coordinator

Q Who should fulfil the role of the Geriatric Surgery Coordinator?

A This role should be fulfilled with someone who is knowledgeable in program management and familiar with medical terminology. This person could be administrative, a nurse, QI personnel, or someone else. We leave this up to the discretion of the hospital to determine the best fit.

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Q Is the GSV Coordinator responsible for any data abstraction/collection?

A The GSV Coordinator is not responsible for any data abstraction/collection.

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Q Does the GSV Program have published job descriptions for the Geriatric Surgery Coordinator?

A Yes, there is a job description template available in Module 1 of the GSV Implementation Course.

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Standard 2.3: Geriatric Surgery Quality Committee

Q   **What are the "Case Review" requirements?**

A Complete quarterly (at minimum) retrospective case reviews to identify system-level problems specific to geriatric surgical care and define plans of action. Case reviews are usually triggered by an adverse occurrence such as mortality, early readmission, reoperation, or prolonged length of stay. Your hospital should:
- Evaluate the factors contributing to the outcome of interest for each individual case reviewed.
- Assess what could have been done differently to result in a better outcome.
- Identify system issues that might have impacted the individual case outcome and that can be addressed by the hospital to prevent similar events in the future.

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Q   **Does my hospital have to review 100% of the cases, or do we get to determine how many cases we will review?**

A Your hospital does not need to review all cases. Your hospital should collect and review data for all patients included within the scope of the GSV Program. Through your GSQC meetings your team will identify, trend, and address issues specific to geriatric surgical care at your hospital. Some metrics you may include, but are not limited to:
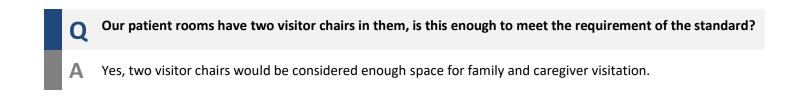- Inpatient falls
- Health care-acquired infections
- Mortality
- Rates of postoperative delirium
- Any clinically relevant data (For example, if, on case review, your hospital discovers a high readmission rate for patients discharged with the new use of a mobility aid, they may choose to measure and track these data.)

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Standard 3.1: Geriatric-Friendly Patient Rooms

Q **How does my hospital determine which elements to include in patient rooms for patient reorientation? How do we know what the reviewer will look for, and where do we document this?**
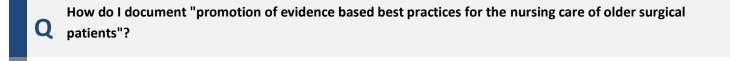
A Rooms must include elements for patient reorientation including: a large clock or other display of date, day, and time; daily planned activity goals; any anticipated medical tests or procedures; names of care team. Additionally, there must be space for family and caregiver visitation. The site reviewers will confirm facilities-based compliance measures and ensure that the appropriate infrastructure exists to provide safe care to patients during the Facility-Based Standards Compliance portion of the site visit. No documentation is needed in the EMR for this standard.

Q **Our patient rooms have two visitor chairs in them, is this enough to meet the requirement of the standard?**

A Yes, two visitor chairs would be considered enough space for family and caregiver visitation.

Standard 4.1: Geriatric Surgery Nurse Champion

Q **How many Geriatric Surgery Nurse Champions does my hospital need to have?**

A At least one Geriatric Surgery Nurse Champion (GSNC) must be identified on each surgical floor or unit taking care of older adult surgical patients in the program.

Q **What is the estimated FTE equivalent required for the role of Geriatric Surgery Nurse Champion?**

A This role is not intended to be fulfilled by a dedicated FTE.

Q **How do I document "promotion of evidence based best practices for the nursing care of older surgical patients"?**

A In the PRQ, you will be asked to describe how GSNCs are trained to promote evidence-based best practices for the nursing care of older surgical patients within their designated surgical floor(s) or unit(s). During the site visit, GSNCs will be asked to discuss their leadership roles, including promotion of evidence-based practices.

Standard 5.1: Treatment and Overall Health Goals

Q **How can my hospital demonstrate how we are assessing and documenting the treatment and overall health goals of patients?**

A Hospitals can demonstrate this standard by documenting patient-specific goals of care and the impact of treatment in the H&P template after a preoperative surgical visit or building in smart phrases that capture the shared decision-making conversation in the EMR. These are just some examples.

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Q **What if my patient doesn't want to discuss his/her treatment goals?**

A If a patient doesn't want to or is unable to discuss his or her treatment goals, this should be documented in the medical record.

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Standard 5.2: Code Status and Advance Directives

Q **What if my patient refuses to submit code status and advance directive paperwork?**

A You must document all unsuccessful attempts to establish code status and advance directives in the EMR.

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Q **Are there any resources available regarding conversations about advance care planning and life-sustaining treatments?**

A Yes, there are several resources available in Module 3 of the GSV Implementation Course about advance care planning and life-sustaining treatments.

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Standard 5.3: Medical Proxy

Q **What if my patient doesn't have a medical proxy?**

A For patients without a medical proxy, there must be documentation of an effort to identify one. Educational materials must be provided to facilitate discussion between the patient and his or her surrogate about the patient's overall health and treatment goals.

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Standard 5.4: Life-Sustaining Treatment Discussion for Patients with Planned ICU Admission

Q **If my hospital utilizes MOLST/POLST forms, will this satisfy compliance?**

A Yes, MOLST/POLST forms will satisfy compliance for this standard.

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Standard 5.5: Reaffirm Surgical Decision Making

Q **What is the expected timeframe for reaffirming surgical decision making for elective surgeries?**

A The expected timeframe for reaffirming surgical decision making is any time before the surgery takes place.

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Standard 5.6: Geriatric Vulnerability Screens

Q **Are the vulnerability screens to be performed on all patients 75+ undergoing inpatient surgical admission with expected stay of 2+ days?**

A Yes, any patient in the GSV Program should have the vulnerability screens performed.

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Q **Are there specific vulnerability screens that need to be utilized to meet the requirements of the standard?**

A No, it is at your hospital's discretion to select tools that fit best within your individual workflow and can be standardized across surgical specialties involved in the implementation of the GSV Program. You might start by looking at what screening tools are already utilized at your hospital, or by the majority of surgical specialties. Several examples of screening tools can be found in Module 4 of the GSV Implementation Course. We also encourage you to listen to the _Identifying High-Risk Patients and Addressing Vulnerabilities_ webinar available on the GSV Website. For cognition screening, we also encourage you to review the _Toolkit – Diagnostic Excellence of Dementia and Cognitive Impairment in the Surgical Setting_ resource.

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Q | **Does my hospital have to use the same screening tools preoperatively and postoperatively?**

A While the program does not require the same screens to be done for Standards 5.6 and 5.16, it does require that patients are screened for impaired cognition, delirium risk, impaired functional status, impaired mobility, and malnutrition at discharge. Any identified deficits must be accompanied by plans to address them in the discharge documentation.

Q | **What are some examples of validated screening tools?**

A There are several examples in Module 4 of the GSV Implementation Course of which you can explore. Below are a few overarching screening tools:
- ACS NSQIP®/AGS Optimal Preoperative Assessment
- Edmonton Frail Scale
- Sinai Abbreviated Geriatric Evaluation

Q | **Is there a list of screening tools outside of what is listed in the standard that hospitals have used?**

A Yes, there are several examples below:
- Cognition: Six-Item Cognitive Impairment Test (6CIT), MOCA, SAGE, Edmonton Frailty w/ Mini-Cog
- Delirium: AGS Delirium Guidelines, SAGE, CAM (non-elective setting)
- Function: Katz ADLs, SAGE, FRAIL (non-elective setting)
- Mobility: "fall within 6 months" and/or use of mobility device, SAGE, TUG, FRAIL (non-elective setting)
- Nutrition: 10 lbs. weight loss in past six months / Albumin / Changes in swallowing over past 6 months, MUST, FRAIL (non-elective setting)
- Palliative Care: Lilley, et. Al Surprise Question: "Would you be surprised if the patient died within one year?", medical risk assessment (non-elective setting)

Standard 5.7: Management Plan for Patients w/ Positive Geriatric Vulnerability Screens

Q | **Are there specific management plans that need to be utilized to meet the requirements of the standard?**

A No, the management of positive screens is up to each individual hospital and will depend on available resources. Management plans should be established based on evidence-based best practices. Several examples of management plans for positive geriatric screens can be found in Module 4 of the GSV Implementation Course.

Standard 5.8: Interdisciplinary Input or Conference for Elective, High-Risk Patients

Q **What are some examples the GSV Program can provide to obtain interdisciplinary input or setup meetings at my hospital?**

A Some examples to obtain interdisciplinary input or setup meetings at your hospital include:
- Teleconference: join meetings by phone or through online video conferencing. This will allow providers to join and have a valuable discussion without needing to be physically present in any specific location.
- Incorporated into another conference (i.e., tumor board conference), as long as the required providers are present.
- The surgeon may reach out to each required healthcare provider individually for input and document a consensus recommendation.

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Standard 5.9: Surgeon-PCP Communication for Elective, High-Risk Patients

Q **If a patient does not have a PCP or a "main doctor" and was admitted via the ER, who should the goals of care be directed to?**

A The goals of care discussion should initially be directed to the surgeon and noted in the EMR. If family members and/or caregivers are available, they should also be included in the goals of care discussion.

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Q **How should my hospital demonstrate communication with patients' PCP outside of our EMR?**

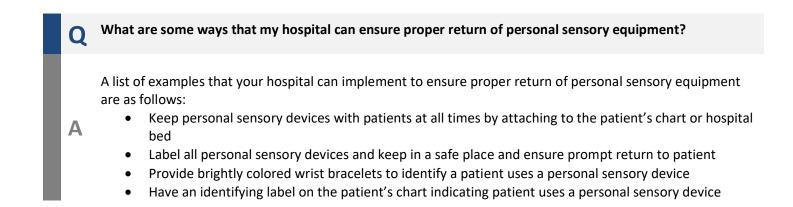**A** Communication between your hospital and the patient's PCP could be demonstrated by any of the following:
- Call the patient's PCP on the telephone and document the details of the call in EMR.
- Mail the PCP a copy of the patient's clinic note, along with details on how to contact the surgeon to ensure two-way communication.
- Print out the clinic note and give to the patient to provide to the PCP, along with details on how to contact the surgeon for two-way communication.

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Standard 5.10: Return of Personal Sensory Equipment

Q There is a system-wide policy for the return of personal belongings at my hospital. Is that sufficient to meet the requirements of the standard, or do we need a separate policy for the GSV Program?

A If a hospital's system-wide policy for return of personal belongings includes guaranteed safe storage and prompt return of personal equipment during and after surgery, this will be sufficient to meet the GSV Standard. If not, then your hospital must create a process, protocol, or policy ensuring surgical inpatients are guaranteed the safe storage and prompt return of personal equipment during and after surgery, respectively.

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Q What are some ways that my hospital can ensure proper return of personal sensory equipment?

A A list of examples that your hospital can implement to ensure proper return of personal sensory equipment are as follows:
- Keep personal sensory devices with patients at all times by attaching to the patient's chart or hospital bed
- Label all personal sensory devices and keep in a safe place and ensure prompt return to patient
- Provide brightly colored wrist bracelets to identify a patient uses a personal sensory device
- Have an identifying label on the patient's chart indicating patient uses a personal sensory device

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Standard 5.11: Inpatient Medication Management

Q We use the decision support tool in our EMR, does that meet the requirements of the standard?

A Yes, as long as there are standardized order sets/bundles/pathways to protocolize medication management for geriatric patients and a process for flagging and reviewing inappropriate medications when they are ordered.

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Standard 5.12: Opioid-Sparing, Multimodality Pain Management

Q Is there a best practice to identify and flag for potentially inappropriate medications?

A Best practices include pharmacy personnel review of patients' medication orders daily and embedded decision support tools within the EMR that provide alerts when a potentially inappropriate medication is prescribed.

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Q	**What are the surgery-specific Beers Medications and alternatives?**
A	The [American Geriatrics Society (AGS) Beers Criteria](#) outlines a comprehensive list of medications to avoid, a subset of which pertains to those commonly used in the perioperative setting (e.g., antiemetics and antihistamines).

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Standard 5.13: Standardized Postoperative Care

Q	**What steps should a hospital take to ensure compliance with this standard when standardized management practices are already implemented?**
A	If your hospital already has a process or policy for standardized postoperative care, it should be updated to include postoperative care that addresses issues of the older surgical patient (delirium, mobility and function, and nutrition and hydration) which can greatly impact patients' outcomes.

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Standard 5.14: Interdisciplinary Care for High-Risk Patients

Q	**When a patient has a prolonged hospital stay (weeks/months) and there is little change to the geriatrics team's comments on daily rounds, is it acceptable to cut back the frequency of our rounding?**
A	The care team should continue to do their daily rounds and make note of any changes in care for all high-risk patients. Note that recommendations might not change for patients with prolonged stays and correspond with needs of the patient.

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Q	**Does the GSV Program provide any templates for how the interdisciplinary rounding can be documented for inpatients?**
A	Yes, in Module 5 of the GSV Implementation Course, there are two interdisciplinary rounding note templates that your hospital can use: • Interdisciplinary Care for High-Risk Patients - Team Rounding Note Template • Interdisciplinary Care for High-Risk Patients - Individual Note Template

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Standard 5.15: Revisiting Goals of Care for ICU Patients

Q **How can a hospital ensure compliance with the Revisiting Goals of Care for ICU Patients, specifically, what documentation is necessary when there are no changes to the code status?**

A The standard aims to emphasize the importance of goals of care discussions, noting that the formality and depth of these discussions may vary depending on the patient's clinical progression and condition.

For patients in the ICU with improved clinical progress no change, or deterioration, documentation should demonstrate:
- A discussion with patient/family surrogate has occurred regarding patients' clinical status/trajectory, even if done in daily update with family
- Note any changes (if any) in patient's POC/LOC/code status arising from these discussions.

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Standard 5.16: Assessment of Geriatric Vulnerabilities at Discharge

Q **Are there specific vulnerability screens that need to be utilized to meet the requirements of the standard?**

A No, it is at your hospital's discretion to select tools that fit best within your individual workflow and can be standardized across surgical specialties involved in the implementation of the GSV Program.

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Q **Why do we have to rescreen patients at the time of discharge?**

A It is critical to recognize if older adults have new, persistent, or worsening geriatric vulnerabilities, as any discharge without an appropriate management plan may result in impaired recovery and readmission. Patients who were not high-risk before surgery could be considered high-risk due to postoperative deconditioning after surgery.

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Q **Is there a list of screening tools outside of what is listed in the GSV Standards that hospitals have used?**

A There are several examples in Module 4 of the GSV Implementation Course in which you can explore. Below are a few overarching screening tools:
- Cognition: question to patient changes to baseline, Mini Cog
- Delirium: CAM, CAM-ICU
- Function: Katz ADLs, PT/OT plan at discharge
- Mobility: PT/OT plan at discharge
- Nutrition: nutritional needs in comparison to baseline

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Standard 5.17: Discharge Documentation and Hand-Off Communication

Q **What staff member at my hospital is responsible for the discharge note?**

A This is up to the hospital's discretion; however, some GSV sites have assigned the responsibilities of this standard to the following hospital staff:
- Surgeon or surgeon's representative
- Nursing personnel

Your hospital must develop a process to ensure a copy of the discharge summary is distributed to patients and their caregivers, PCPs, and providers assuming care where applicable. In addition, the discharge documentation must be reviewed with these individuals to set clear expectations post-hospitalization and determine how to solve problems that may arise.

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Standard 5.18: Communication with Post-Acute Care Facilities

Q **What should hospitals be utilizing to develop their list of post-acute care facilities they are associated with and their publicly reported measures?**

A We recommend hospitals visit the Medicare's Care Compare Website and utilize the filters to find nursing home's quality measures rating, short-stay quality measures, and long-stay quality measures to compare to state averages.

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Standard 6.1: Data Collection and Review

Q **Does the regulatory data (e.g., CAUTI, falls) collection and review include the hospital-wide data that is currently being collected for CMS or does it need to be stratified for only the GSV eligible patient?**

A Yes, regulatory data collection for Standard 6.1 includes the hospital-wide data being collected for CMS. However, your hospital should be able to separate and identify GSV eligible patients for the review of data to meet the standard.

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Q **How is "Postoperative Delirium" defined?**

A Delirium can be defined as an acute and fluctuating disturbance in mental status often associated with confusion, disorientation, altered levels of consciousness, inattention, and can manifest with either hyperactivity or hypoactivity. Older age is a risk factor for developing delirium after surgery which can have a significant impact on morbidity, mortality, and functional recovery. Delirium is distinct from dementia, which is a clinical syndrome marked by declining cognitive ability of sufficient severity to produce significant functional impairment. Measuring the rate of postoperative delirium is an important metric of high-quality geriatric surgical care and is required by the GSV. Review Module 2 of the GSV Implementation Course for more information.

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Q **How is "Postoperative Deconditioning" defined?**

A Deconditioning is "a complex process of physical change following a period of inactivity, bedrest or sedentary lifestyle." Deconditioning has also been defined as "declines in muscle strength, muscle mass, cognitive function, muscle protein synthesis and physical function." Deconditioning is more common in older adults and can have a marked impact on function and maintenance of independence, which are outcomes after surgery that are extremely important to many older adults. Measuring the rate of postoperative deconditioning is an important metric of high-quality geriatric surgical care and is required by the GSV. Review Module 2 of the GSV Implementation Course for more information.

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Standard 6.2: Data Feedback to Frontline Providers and Quality Infrastructure

Q **How can my hospital ensure data feedback to frontline providers and quality infrastructure is occurring appropriately?**

A Your hospital can ensure data feedback to frontline providers and quality infrastructure is occurring appropriately through any of the following means:
- Invite frontline providers and institutional leadership to participate in your hospital's GSQC meetings.
- Allot time for two-way communication and collaborative efforts, particularly during the discussion of case and data reviews.
- Engage team members during touchpoints such as Interdisciplinary Input or Conferences team rounding, or shift changes to highlight key data points. Allow time for discussion of results and patient care outcomes.
- Utilize your hospital's Geriatric Surgery Nurse Champion(s) to engage staff, ensure information is effectively communicated across shifts/schedules, and celebrate initiatives that lead to better patient outcomes.
- Empower frontline providers to identify areas for improvement and create an environment in which ideas and collaboration are encouraged.

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Standard 7.1: Geriatric Surgery QI/PI Project

Q **What are some examples of Geriatric Surgery Quality Improvement/ Process Improvement projects?**

A The annual QI/PI project must be informed by data collected and reviewed by the GSQC. This standard requires the implementation of a QI/PI project that is focused on an area of geriatric surgical care, as studies have shown that institutional QI projects can improve outcomes. Examples from hospitals in the program include:

- **Under-Recognition of Delirium in Frail Elders:** *Data informing project:* delirium was substantially underreported and underdiagnosed by staff and providers. Unrecognized delirium can greatly compound risks of delirium, including increased risk of complications and mortality in frail elders. In response to delirium complications findings, the team participated in a Delirium Steering Committee serving to develop education plans geared toward providers and the treatment teams, as well as implement proactive measures to decrease delirium.
- **Decreasing Postoperative Discharge Healthcare Utilization:** *Data informing project:* high post-discharge ED visit rate, of which half did not result in admission. Unplanned healthcare visits represent an opportunity to improve care and older adults have high rates of postoperative readmissions, and other unplanned healthcare events. Aimed to decrease preventable post-discharge healthcare utilization by improving post-discharge communication and clinical continuity through post-discharge calls from an appointed team member.

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Standard 7.2: [Optional] Geriatric Surgery ACS NSQIP Collaborative

Q **If my hospital chooses to implement this standard, how many additional variables do we need to collect?**

A If your hospital is enrolled in ACS NSQIP and you have decided to participate in the Geriatric Surgery ACS NSQIP Collaborative, you will need to collect all 14 of the GSV Variables on those cases collected within the 8-day cycle with patients 75 and older at the time of surgery.

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Q **In order to collect the GSV Variables, does my hospital have to participate in the GSV Program or can we just participate in NSQIP?**

A The GSV Variables are only available to participants of NSQIP that are also enrolled in the GSV Program (Level 1 or Level 2 Verification) and are abstracting cases for *Standard 7.2 [Optional] Geriatric Surgery ACS NSQIP Collaborative.*

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Q What is NSQIP?

A The ACS National Surgical Quality Improvement Program (NSQIP) is a nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care. The program helps hospitals track surgical complications and analyze validated data. Additionally, blinded, risk-adjusted data is shared with other ACS NSQIP hospitals, allowing participants to nationally benchmark their postoperative outcomes such as mortality and complication rates.

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Q What are the benefits to participating in the Geriatric Surgery ACS NSQIP Collaborative?

A Hospitals will be able to collect data on variables such as Evidence of Advance Care Planning, Fall Risk on Discharge, and Functional Health Status 30 to 90 Days Postoperatively, which will be available for review in the registry's benchmarking reports. Data are also available as a research file to members of the Geriatric Surgery ACS NSQIP Collaborative who are interested in analyzing the data and contributing to the collective knowledge base on geriatric surgical outcomes.

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Standard 8.1: Geriatric Surgery Community Outreach Project

Q What are some examples of Geriatric Surgery Community Outreach Projects?

A Community outreach projects for the GSV Program should focus on awareness, education, or prevention. Engaging the community through outreach strengthens local ties, fosters health literacy for patients and caregivers, and improves health outcomes. Examples from hospitals in the program include:
- **Falls Prevention Class**: In-person community class directed toward the older adult community in a low-income senior housing facility. Purpose of class: to promote awareness of common contributors to falls, how to recover from a fall, strategies to minimize potential falls, and activities that promote balance.
- **Virtual Educational Session:** Virtual session at an acute care facility/rehab center to share important information to consider prior to having surgery. Goals of session: Gain understanding on why this topic is important for seniors, understanding what shared decision-making means, and understanding what a designated decision maker or medical proxy is and why it is important to have one.
- **Nutrition for Older Adults:** Session about the importance of nutrition optimization in the older adult population and provide education to the older adults in the community about how to help optimize nutrition within their environment to help maintain strength and function.

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Q Does the Community Outreach Project have to be completed at the time of application?

A No, it does not need to be completed in time of the application/PRQ submission; however, in the PRQ submission, you must detail when you anticipate the project will occur so that the site reviewers can tailor any questions they have about it based on where it is projected to be on the project timeline. For example, if you can provide the context, purpose, and aims of the project, the education you anticipate providing on the topic, and the expected date/location of the project, this would be sufficient for the site reviewers to assess standard compliance.

Standard 8.2: Geriatric Education of Surgeons and APP's

Q What percentage of surgeons from the institution need to have completed specific geriatric training? How many hours of training?

A All surgeons performing surgeries on patients in GSV (in other words, surgeons in those specialties implementing the program) should have the required education. For example, if you're implementing GSV in your Ortho department, then all ortho surgeons performing surgery on patients 75 and older should complete education that ensures basic geriatric concepts (eliciting goals, screening and managements plans for vulnerabilities).

Standard 8.3: Geriatric Education of Nurses

Q What are the educational curriculum requirements for Nurses?

A Educational curriculum requirements must cover the following areas:
- Eliciting patients' goals to ensure surgical care is concordant with patients' wishes
- Screening for high-risk geriatric vulnerabilities in cognition, mobility/function, and nutrition/hydration
- Management strategies of high-risk geriatric vulnerabilities in cognition, mobility/function, and nutrition/hydration

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Standard 9.1: [Optional] Advancement of Knowledge in Geriatric Surgical Care

Q Why should my hospital participate in the standard?

A Participating in this standard allows your hospital to showcase the projects, studies, and lessons learned at your hospital.