Commission on Cancer State Chair Town Hall

April 9, 2025

Commission on Cancer
American College of Surgeons

CoC State Chair Town Hall

Maria Castaldi, MD, FACS
Chair
Committee on Cancer Liaison

Quan Ly, MD, FACS
Vice-Chair
Committee on Cancer Liaison

ACS CoC Commission on Cancer
American College of Surgeons

Welcome to New CoC State Chair

Kelly Hewitt, MD, FACS

Utah CoC State Chair

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CoC Update

- Monthly CLP and Accreditation Site Visit List
- Post-Town Hall Communications
- 2025 CoC Research Paper Competition
- Call for Nominations for the 2025 CLP Awards
- Upcoming Meetings:
  - Quality and Safety Conference: July 17-20 in San Diego, CA
  - State Chair Town Hall: July 30
  - CLP Meeting: September 10
  - ACS Clinical Congress 2025: October 4-7 in Chicago, IL
    - CoC Fall Meetings: October 4 (tentative)

ACS Geriatric Surgery Verification (GSV) Program

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Manager, Geriatric Surgery Verification Program

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The GSV Program

As the fastest-growing segment of the U.S. population, older adults bring a complexity in physiological and social issues that challenge our current health-care system's perioperative care model. To address this challenge, the ACS developed the Geriatric Surgery Verification (GSV) Program.

The program includes evidence-based standards that specifically address and optimize the surgical care of patients.

GOALS OF THE PROGRAM

1

Systematically improve surgical care and outcomes for older adults by promoting patient- and family-centered care

2

Encourage interdisciplinary input and collaboration to facilitate implementation of evidence-based practices

3

Concisely address the most important aspects of geriatric surgical care within the four-part ACS framework for quality improvement

ACS 4-Part Quality Model

ACS Quality Programs were developed by applying the **ACS "4-part model"** used across surgery to achieve high quality care.

Standards

ACS sets the standards to establish a baseline for high-quality patient care

Right Infrastructure

Because quality programs provide infrastructure to support the standards

Rigorous Data

Collect and analyze the right data to inform improvement efforts

Verification

Surgical peers verify that processes and practices are in place to meet standards

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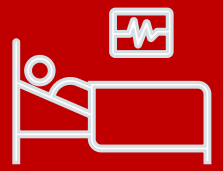
Why Your Hospital Should Participate in GSV:

- The population in the United States is expanding and aging.
- In the last decade, older adults reached **55.8 million people** or 16.8% of the total population.
- Older adults have substantially more chronic conditions, require more care, have increased complexities, and have higher healthcare utilization.
- Older adults have **worse outcomes** – many of which are likely **preventable** with better care.

Fast Facts: Care for Older Adults

$164 B

estimated annual cost of delirium in the U.S.



40%

of inpatient surgery patients are older adults

$13,800

The average cost of a readmission for patients 65+

This is typically 5% higher than the cost of the initial hospital visit.

(Barrett et al.)

5.2 Days

The average LOS for patients 45-84 years of age

(Weiss et al.)

Overview Timeline

How do we attain high-quality care for older adults?

- Work began in 2012
- The ACS received a grant in 2016 through the JAHF
- The GSV Program launched in 2019
- Pandemic 2020 - elective surgeries were stopped

- Brainstorming sessions with GSV Committee(s)
- How to make the program more feasible for hospitals

- The care of older adults became a priority for the Department of Health and Human Services
- CMS identified measure gaps
- Two attestation-based measures were submitted by the ACS in 2022
- CMS Age Friendly Hospital Measure approved in August 2023

The CMS Age Friendly Hospital Measure

The Age Friendly Hospital Measure assesses hospital commitment to improving care for patients 65 years or older receiving services in the hospital, Operating Room, or Emergency Department.

- **Mandatory**: Hospitals participating in CMS Inpatient Quality Reporting (IQR) Program will have to comply with it.
- **Period**: Hospitals must attest to the entire measure for the 2025 calendar year, January 1, 2025 through December 31, 2025.
    - Submission of **attestations** will be on an annual basis, through CMS web portal.

We recognized that Surgery is often one of the most difficult areas in the hospital to implement change, so the GSV Team launched a new level of the program which directly aligns with this measure.

The new GSV Level will help your hospitals meet every requirement in the measure.

Hospitals Face Potential Penalties for Noncompliance

- All hospitals that don't meet participation requirements **could face significant financial penalties.**

- Depending on the size of your hospital, failure to comply with the measure could result in losing as much as $3 million.

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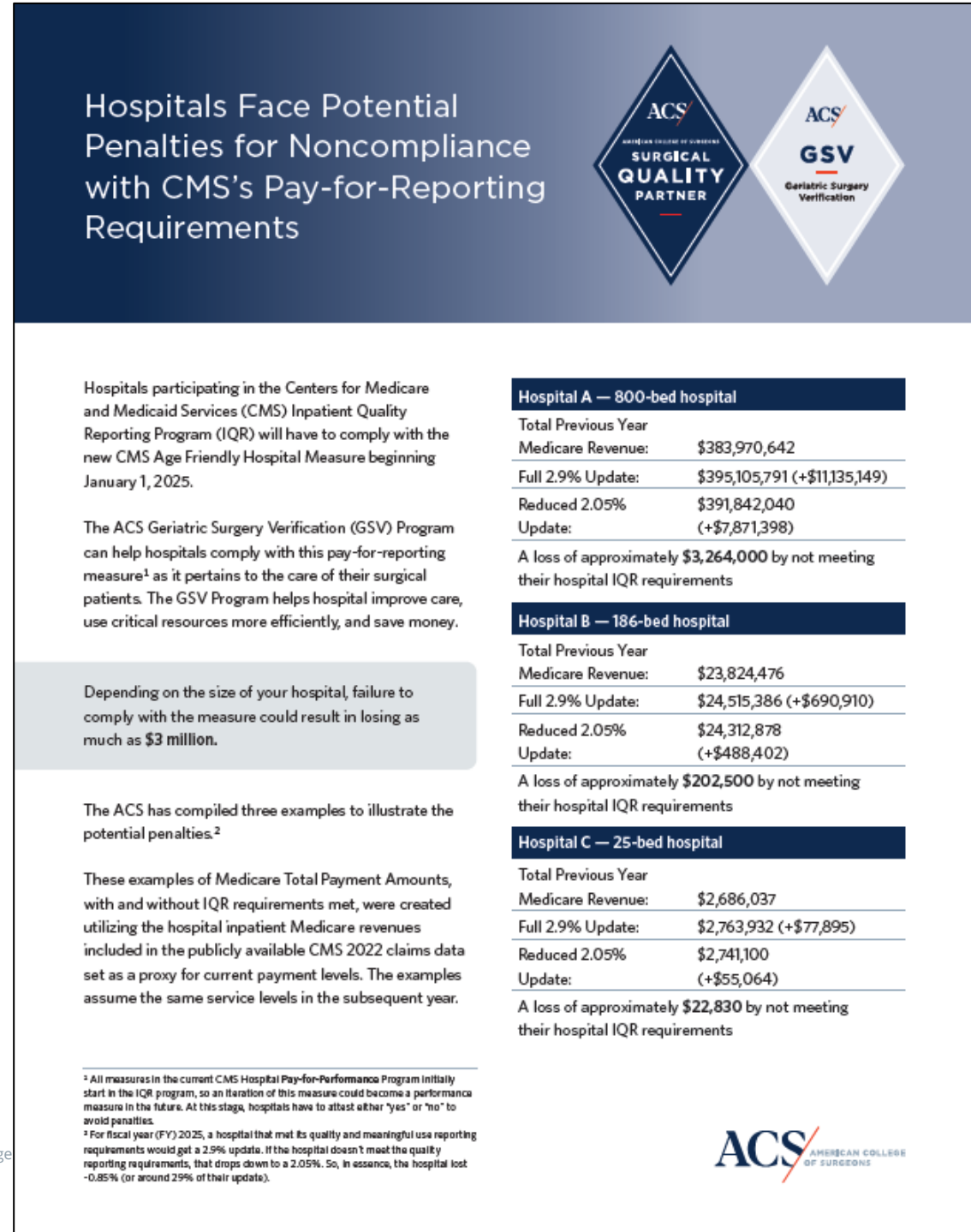

Hospitals Face Potential Penalties for Noncompliance with CMS's Pay-for-Reporting Requirements

ACS SURGICAL QUALITY PARTNER

ACS GSV Geriatric Surgery Verification

Hospitals participating in the Centers for Medicare and Medicaid Services (CMS) Inpatient Quality Reporting Program (IQR) will have to comply with the new CMS Age Friendly Hospital Measure beginning January 1, 2025.

The ACS Geriatric Surgery Verification (GSV) Program can help hospitals comply with this pay-for-reporting measure[1] as it pertains to the care of their surgical patients. The GSV Program helps hospital improve care, use critical resources more efficiently, and save money.

Depending on the size of your hospital, failure to comply with the measure could result in losing as much as **$3 million.**

The ACS has compiled three examples to illustrate the potential penalties.[2]

These examples of Medicare Total Payment Amounts, with and without IQR requirements met, were created utilizing the hospital inpatient Medicare revenues included in the publicly available CMS 2022 claims data set as a proxy for current payment levels. The examples assume the same service levels in the subsequent year.

Hospital A — 800-bed hospital

Total Previous Year Medicare Revenue:	$383,970,642
Full 2.9% Update:	$395,105,791 (+$11,135,149)
Reduced 2.05% Update:	$391,842,040 (+$7,871,398)

A loss of approximately **$3,264,000** by not meeting their hospital IQR requirements

Hospital B — 186-bed hospital

Total Previous Year Medicare Revenue:	$23,824,476
Full 2.9% Update:	$24,515,386 (+$690,910)
Reduced 2.05% Update:	$24,312,878 (+$488,402)

A loss of approximately **$202,500** by not meeting their hospital IQR requirements

Hospital C — 25-bed hospital

Total Previous Year Medicare Revenue:	$2,686,037
Full 2.9% Update:	$2,763,932 (+$77,895)
Reduced 2.05% Update:	$2,741,100 (+$55,064)

A loss of approximately **$22,830** by not meeting their hospital IQR requirements

[1] All measures in the current CMS Hospital Pay-for-Performance Program initially start in the IQR program, so an iteration of this measure could become a performance measure in the future. At this stage, hospitals have to attest either "yes" or "no" to avoid penalties.

[2] For fiscal year (FY) 2025, a hospital that met its quality and meaningful use reporting requirements would get a 2.9% update. If the hospital doesn't meet the quality reporting requirements, that drops down to a 2.05%. So, in essence, the hospital lost -0.85% (or around 29% of their update).

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CMS Age Friendly Hospital Measure

5 Domains

1. Eliciting Patient Healthcare Goals
2. Responsible Medication Management
3. Frailty Screening and Intervention
4. Social Vulnerability
5. Age-Friendly Care Leadership

- Public reporting through the CMS Care Compare website would begin in the fall 2026
- Not currently proposed to be part of any value-based program

The Centers for Medicare & Medicaid Services released a new Age Friendly Hospital Measure on August 1, 2024, based on work by the ACS[1] and designed to improve the care and outcomes for older adult patients.

Beginning in January 2025, all hospitals participating in the Hospital Inpatient Quality Reporting Program (IQR) must report on their compliance with the measure. All hospitals that don't meet participation requirements could face significant financial penalties. The measure will be reported on the CMS Care Compare website to allow patients and caregivers to know which hospitals deliver age-friendly care for seniors in 2026.

This new type of "programmatic" measure was developed based on the standards of the ACS Geriatric Surgery Verification (GSV) Program, which launched in 2019 to meet the specific needs of older adult patients undergoing surgery. The ACS GSV program is grounded in scientific evidence and provides hospitals with proven ways to improve such things as postoperative delirium-related complications, reduce readmissions costs, and enhance patient quality of life. By implementing the GSV Program, a hospital can reduce the average length of stay, generating significant cost savings while helping patients achieve their care goals.

The Age Friendly Hospital Measure will evaluate hospitals' progress toward improving care for patients aged 65 and above across various settings, including hospital wards, operating rooms, and emergency departments. The measure is structured into five domains:

1. **Eliciting Patient Healthcare Goals:** Ensures patient health-related goals and treatment preferences are obtained to inform shared decision-making.
2. **Responsible Medication Management:** Optimizes medication management by monitoring pharmacological records to avoid inappropriate drugs for older adults.
3. **Frailty Screening and Intervention:** Screens for cognitive impairment (including delirium), mobility, and malnutrition, allowing for early detection and intervention.
4. **Social Vulnerability:** Recognizes and addresses social issues impacting older adults as part of the care plan such as social isolation, economic insecurity, ageism, caregiver stress, limited access to healthcare and elder abuse.
5. **Age-Friendly Care Leadership:** Identifies an age-friendly champion or committee in the hospital to ensure compliance with all components of the measure.

Find out how the ACS can help your hospital meet this new regulatory requirement

[1] The ACS led the development of the Age Friendly Hospital Measure in collaboration with the Institute for Healthcare Improvement (IHI) and the American College of Emergency Physicians (ACEP) with support from The John A. Hartford Foundation.

How does the ACS GSV Program help my hospital meet the requirements for the new CMS Age Friendly Measure for older adult surgical patients?

The ACS has streamlined its GSV Program[1] Standards to give hospitals the guidance and tools to both attest to and fulfill the requirements of the new measure while improving the delivery of surgical care for this growing population. GSV includes evidenced-based practices that enable hospital care teams to deliver optimal care to help patients achieve their care goals. Not only will participating in the new GSV level allow your hospital to fulfill the requirements of the measure for surgical patients, but your hospital will also be awarded GSV verification status and recognition as an ACS Surgical Quality Partner.

The 6 GSV Standards:

1. **Age-Friendly Care Leadership –** Hospitals must appoint a dedicated individual (Age-Friendly Surgery Director) that acts independently or as chair of an interprofessional committee to ensure that age-friendly care issues are prioritized and addressed across care teams.
2. **Treatment and Overall Health Goals –** Helping care teams understand what matters most to patients and their caregivers, and creating the structures to facilitate these critical conversations is foundational to delivering optimal care. Shared decision-making with patients hinges upon high-quality communications and empowers patients to fully participate in their care.
3. **Geriatric Vulnerability Screens –** Patients must be screened for high-risk characteristics that could significantly impact their ability to recover well from surgery or to achieve their healthcare goals. The areas of potential vulnerability include Social Determinants of Health (including social isolation, economic insecurity, limited access to healthcare, caregiver stress, and elder abuse); impaired cognition (i.e., brain health) and delirium risk; impaired functional status and/or mobility; and malnutrition and swallowing.
4. **Management Plan for Patients with Positive Geriatric Vulnerability Screens –** Patients that have positive vulnerability screens need to have documented management plans in place to address positive findings. The management plan should consider all phases of each episode of care (e.g., pre-, intra-, postoperative, post-discharge).
5. **Age-Friendly-Specific Postoperative Protocol –** In addition to high-quality, routine postoperative care, hospital care teams should ensure processes are in place to address age-friendly geriatric items such as nutrition and hydration; responsible medication management; opioid sparing, multimodality pain management; delirium precautions; and mobility and function.
6. **Data Review –** The rigorous use of data is essential to continuous quality improvement and delivery of optimal care. The hospital must collect and review data on all patients included in the scope of the GSV Program. While this data includes that required by CMS and The Joint Commission, the hospital should also include data points related to the rates of postoperative delirium, rates of unplanned discharge to non-home settings, and other data identified that may further improve geriatric care at the local level.

[1] The GSV Standards clearly lay out the definition and requirements about what needs to be done and provides a research-based rationale to allow hospital teams to more fully understand why they are important.

GSV Levels of Participation

With the growing population of older adults aged 65 and above, hospitals across the United States can work towards improving the care and surgical outcomes for this population

Through ACS GSV, hospitals can achieve this:

New GSV Level*

- 6 Standards
- Patients 65+
- Helps attest to new CMS Age Friendly Hospital Measure

**The majority of hospitals will be able to achieve this level with minimal resources required.*

Focused Excellence Level

- 30 GSV Program standards in one or more surgical specialties
- Must reach between 25 and 49 percent of the hospital's total population of eligible surgical patients aged 75 years or older.

Comprehensive Excellence Level

- 30 GSV Program standards in one or more surgical specialties
- Must reach 50 percent or more of the hospital's total population of eligible surgical patients aged 75 years or older.

Four Major Components of the GSV Program

DATA AND QUALITY IMPROVEMENT

STRUCTURE

EDUCATION

PROCESSES AND PROTOCOLS

(including screening)

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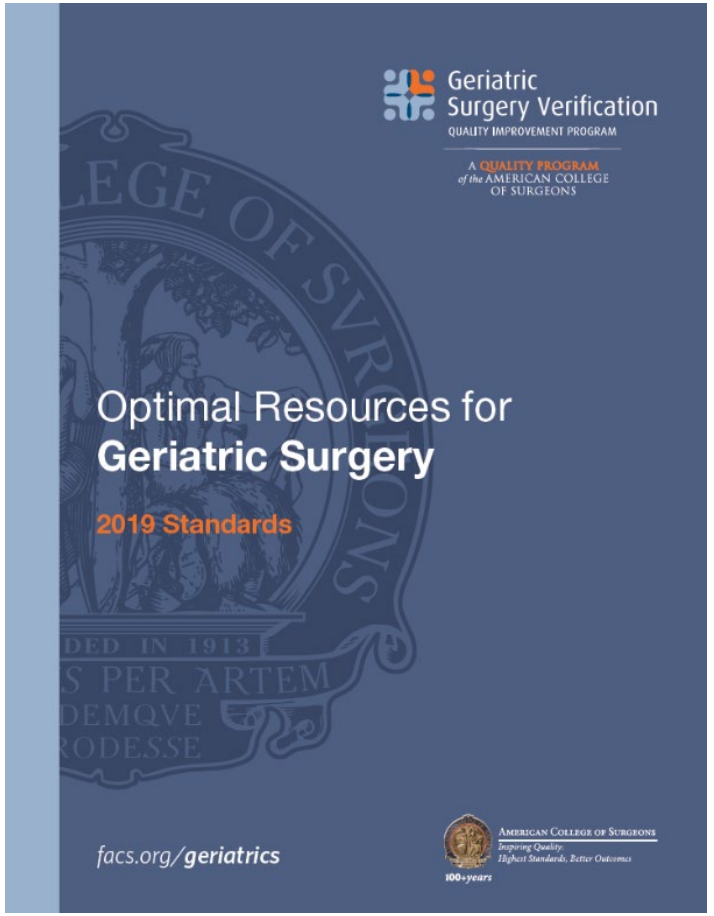
GSV Comprehensive and Focused Levels

- Institutional Administrative Commitment
- Program Scope and Governance
- Facilities and Equipment Resources
- Personnel and Services Resources
- Patient Care: Expectations and Protocols
- Data Surveillance and Systems
- Quality Improvement
- Professional and Community Outreach
- Research



30 Required Standards
(2 additional optional)

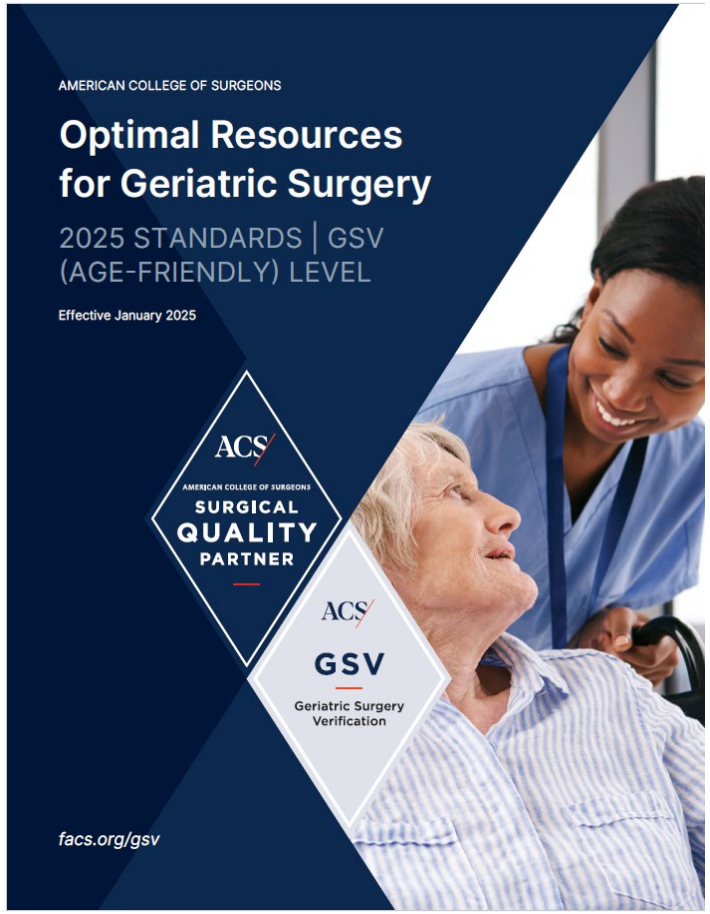
GSV (Age-Friendly) Level

The new GSV Level is designed to engage hospitals to **begin the journey** to improve surgical care for older adults and requires little to no additional resources to purchase or hire

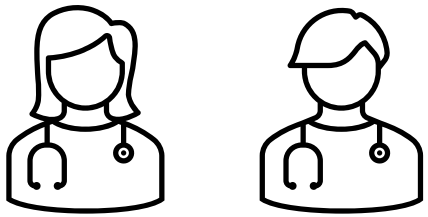
Applicable to a **majority of patients 65+** undergoing inpatient surgery

Focused on **postoperative delirium prevention** and treatment, this level is specifically **designed to help hospitals comply with the CMS Age Friendly Hospital Measure**

Hospitals that are found compliant in all **6 Standards** are awarded verification status



Overview (Age-Friendly) Standards



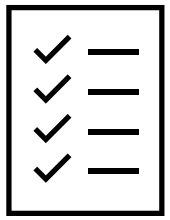
#1 – Age-Friendly Care Leadership

- Hospitals must identify a **designated point person and/or committee** to ensure that age-friendly care issues are prioritized and addressed across care teams
  - Ensures adherence to **standards**
  - Identifies opportunities for **education**
  - Reviews **data** to drive quality improvement.

#2 – Treatment and Overall Health Goals

- Helping care teams understand **what matters** most to patients and their caregivers, and creating the structures to facilitate these critical conversations is foundational to delivering optimal care.
- **Shared decision-making** with patients hinges upon high-quality communications and empowers patients to full participate in their care.

Overview (Age-Friendly) Standards



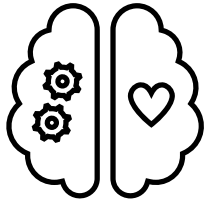
#3 – Geriatric Vulnerability Screens

- Patients must be **screened for high-risk characteristics** that could significantly impact their ability to recover well from surgery or to achieve their healthcare goals.
- The areas of potential vulnerability include:
  - Impaired cognition and delirium risk
  - Impaired functional status and/or mobility
  - Malnutrition and swallowing
  - Palliative care needs
  - Social Determinants of Health (including social isolation, economic insecurity, limited access to healthcare, caregiver stress, and elder abuse)

#4 – Management Plan for Positive Screens

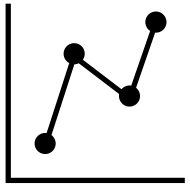
- Patients that have positive vulnerability screens need to have documented management plans in place to address positive findings. The management plan should **consider all phases of each episode of care** (e.g., pre, intra, postoperative, post-discharge).
- Communicate in discharge instructions and to post-discharge facilities

Overview (Age-Friendly) Standards



#5 – Age-Friendly-Specific Postoperative Protocol

- In addition to high-quality, routine postoperative care, hospital care teams should ensure processes are in place to address age-friendly geriatric items such as:
  - **Delirium: prevention, recognition, and treatment**
  - Responsible medication management
  - Opioid-sparing, multimodality pain management
  - Delirium precautions
  - Mobility and function
  - Nutrition and hydration

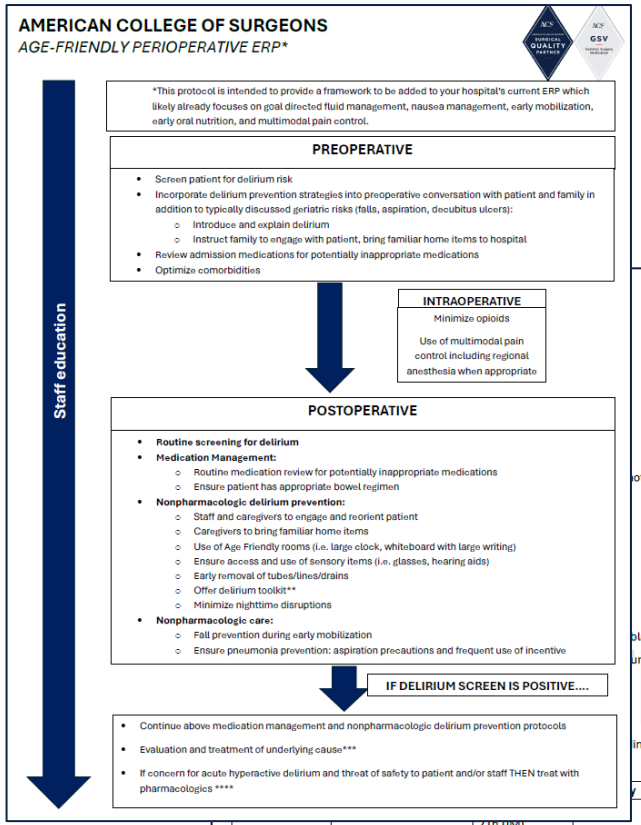


#6 – Data Review

- The rigorous use of data is essential to continuous quality improvement and delivery of optimal care.
- The hospital must collect and review data **quarterly** on all patients included in the scope of the GSV Program.

Resources to Help You

Postoperative Protocol



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*AGE-FRIENDLY PERIOPERATIVE ERP**

Staff education

*This protocol is intended to provide a framework to be added to your hospital's current ERP which likely already focuses on goal directed fluid management, nausea management, early mobilization, early oral nutrition, and multimodal pain control.

PREOPERATIVE

- Screen patient for delirium risk
- Incorporate delirium prevention strategies into preoperative conversation with patient and family in addition to typically discussed geriatric risks (falls, aspiration, decubitus ulcers):
  - Introduce and explain delirium
  - Instruct family to engage with patient, bring familiar home items to hospital
- Review admission medications for potentially inappropriate medications
- Optimize comorbidities

INTRAOPERATIVE

Minimize opioids

Use of multimodal pain control including regional anesthesia when appropriate

POSTOPERATIVE

- **Routine screening for delirium**
- **Medication Management:**
  - Routine medication review for potentially inappropriate medications
  - Ensure patient has appropriate bowel regimen
- **Nonpharmacologic delirium prevention:**
  - Staff and caregivers to engage and reorient patient
  - Caregivers to bring familiar home items
  - Use of Age Friendly rooms (i.e. large clock, whiteboard with large writing)
  - Ensure access and use of sensory items (i.e. glasses, hearing aids)
  - Early removal of tubes/lines/drains
  - Offer delirium toolkit**
  - Minimize nighttime disruptions
- **Nonpharmacologic care:**
  - Fall prevention during early mobilization
  - Ensure pneumonia prevention: aspiration precautions and frequent use of incentive

IF DELIRIUM SCREEN IS POSITIVE....

- Continue above medication management and nonpharmacologic delirium prevention protocols
- Evaluation and treatment of underlying cause***
- If concern for acute hyperactive delirium and threat of safety to patient and/or staff THEN treat with pharmacologics ****

ot exhaustive and is

bladder scan

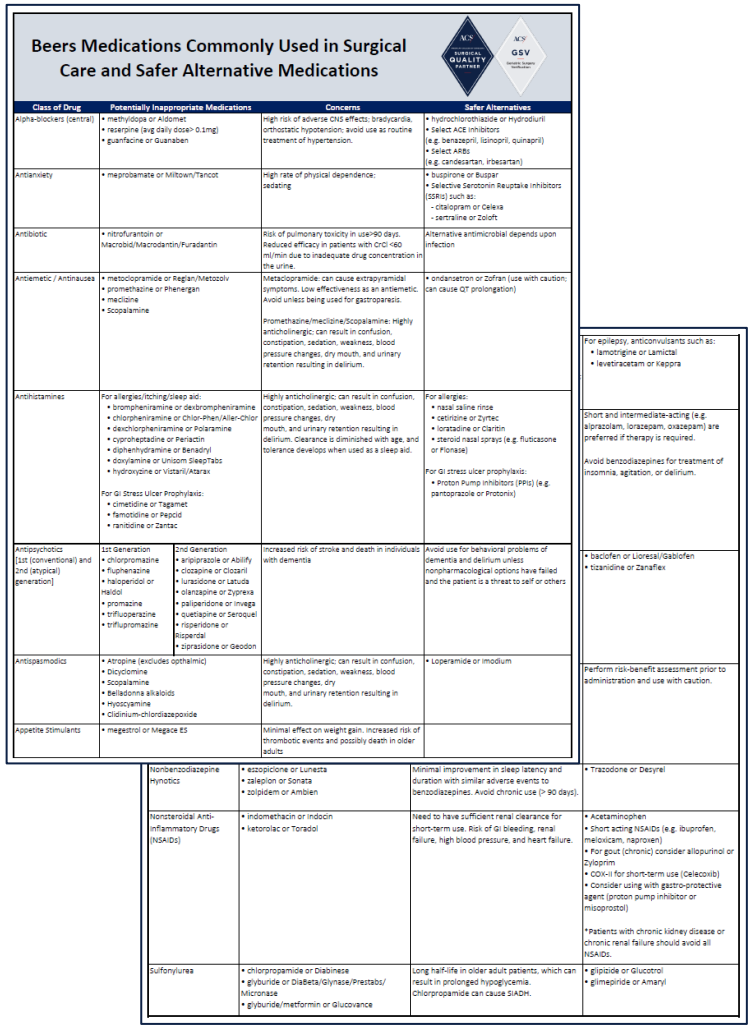
urinalysis, WBC, CT

inical judgement for

				Max Dose
		21h (IM) 14-26h (IV)		3mg/24h
olanzapine	2.5-5mg PO, ODT or IM	21-54h	q12h	20mg/24h
quetiapine	12.5-25mg PO	6-12h	q12h	50mg/24h
risperidone	0.25-0.5mg PO/ODT/solution	3-22h	q4h prn	2mg/24h
ziprasidone	5-10 mg IM, 20mg PO	2-4h (IM) 7-10h (PO)	q12	20mg/24h

*Medications should be administered as a **one-time dose** with repeat patient assessment before additional doses are administered. Onset of clinical effect may be delayed – **avoid scheduling repeat doses.***

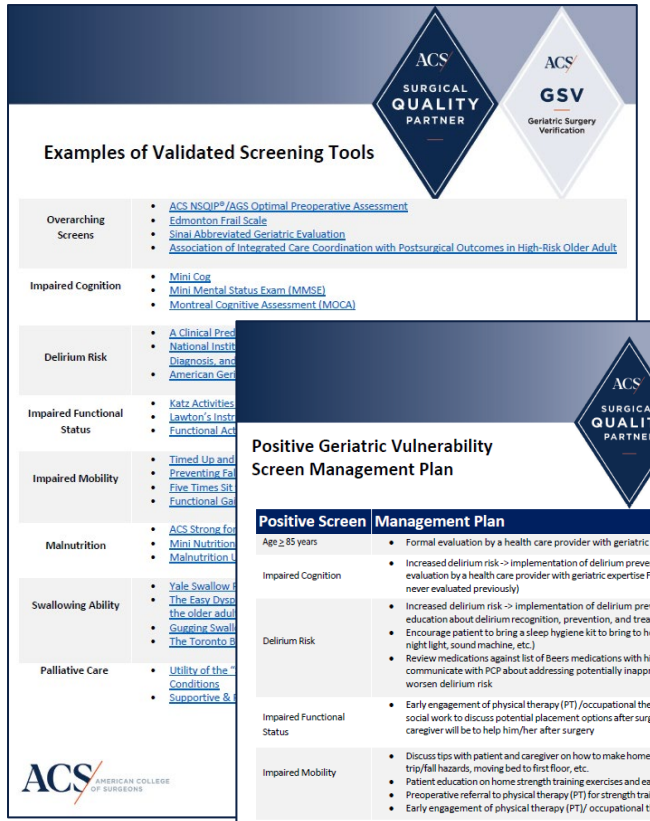
Beers Medications Commonly Used in Surgical Care and Safer Alternative Medications



Beers Medications Commonly Used in Surgical Care and Safer Alternative Medications

Class of Drug	Potentially Inappropriate Medications	Concerns	Safer Alternatives
Alpha-blockers (central)	• methyldopa or Aldomet • reserpine (avg daily dose> 0.1mg) • guanfacine or Guanaben	High risk of adverse CNS effects; bradycardia, orthostatic hypotension; avoid use as routine treatment of hypertension.	• hydrochlorothiazide or Hydrodiuril • Select ACE inhibitors (e.g. benazepril, lisinopril, quinapril) • Select ARBs (e.g. candesartan, irbesartan)
Antianxiety	• meprobamate or Miltown/Tancot	High rate of physical dependence; sedating	• buspirone or Buspar • Selective Serotonin Reuptake Inhibitors (SSRIs) such as: - citalopram or Celexa - sertraline or Zoloft
Antibiotic	• nitrofurantoin or Macrobid/Macrodantin/Furadantin	Risk of pulmonary toxicity in use>90 days. Reduced efficacy in patients with CrCl <60 ml/min due to inadequate drug concentration in the urine.	Alternative antimicrobial depends upon infection
Antiemetic / Antinausea	• metoclopramide or Reglan/Metozolv • promethazine or Phenergan • meclizine • Scopolamine	Metaclopramide: can cause extrapyramidal symptoms. Low effectiveness as an antiemetic. Avoid unless being used for gastroparesis. Promethazine/meclizine/Scopalamine: Highly anticholinergic; can result in confusion, constipation, sedation, weakness, blood pressure changes, dry mouth, and urinary retention resulting in delirium.	• ondansetron or Zofran (use with caution; can cause QT prolongation)
Antihistamines	For allergies/itching/sleep aid: • brompheniramine or dexbrompheniramine • chlorpheniramine or Chlor-Phen/Aller-Chlor • dexchlorpheniramine or Polaramine • cyproheptadine or Periactin • diphenhydramine or Benadryl • doxylamine or Unisom SleepTabs • hydroxyzine or Vistaril/Atarax For GI Stress Ulcer Prophylaxis: • cimetidine or Tagamet • famotidine or Pepcid • ranitidine or Zantac	Highly anticholinergic; can result in confusion, constipation, sedation, weakness, blood pressure changes, dry mouth, and urinary retention resulting in delirium. Clearance is diminished with age, and tolerance develops when used as a sleep aid.	For allergies: • nasal saline rinse • cetirizine or Zyrtec • loratadine or Claritin • steroid nasal sprays (e.g. fluticasone or Flonase) For GI stress ulcer prophylaxis: • Proton Pump Inhibitors (PPIs) (e.g. pantoprazole or Protonix)
Antipsychotics [1st (conventional) and 2nd (atypical) generation]	1st Generation • chlorpromazine • fluphenazine • haloperidol or Haldol • promazine • trifluoperazine • trifluopromazine 2nd Generation • aripiprazole or Abilify • clozapine or Clozaril • lurasidone or Latuda • olanzapine or Zyprexa • paliperidone or Invega • quetiapine or Seroquel • risperidone or Risperdal • ziprasidone or Geodon	Increased risk of stroke and death in individuals with dementia	Avoid use for behavioral problems of dementia and delirium unless nonpharmacological options have failed and the patient is a threat to self or others
Antispasmodics	• Atropine (excludes opthalmic) • Dicyclomine • Scopalamine • Belladonna alkaloids • Hyoscyamine • Clidinium-chlordiazepoxide	Highly anticholinergic; can result in confusion, constipation, sedation, weakness, blood pressure changes, dry mouth, and urinary retention resulting in delirium.	• Loperamide or Imodium
Appetite Stimulants	• megestrol or Megace ES	Minimal effect on weight gain. Increased risk of thrombotic events and possibly death in older adults	
Nonbenzodiazepine Hynotics	• eszopiclone or Lunesta • zaleplon or Sonata • zolpidem or Ambien	Minimal improvement in sleep latency and duration with similar adverse events to benzodiazepines. Avoid chronic use (> 90 days).	• Trazodone or Desyrel
Nonsteroidal Anti-inflammatory Drugs (NSAIDs)	• indomethacin or Indocin • ketorolac or Toradol	Need to have sufficient renal clearance for short-term use. Risk of GI bleeding, renal failure, high blood pressure, and heart failure.	• Acetaminophen • Short acting NSAIDs (e.g. ibuprofen, meloxicam, naproxen) • For gout (chronic) consider allopurinol or Zyloprim • COX-I for short-term use (Celecoxib) • Consider using with gastro-protective agent (proton pump inhibitor or misoprostol) *Patients with chronic kidney disease or chronic renal failure should avoid all NSAIDs.
Sulfonylurea	• chlorpropamide or Diabinese • glyburide or DiaBeta/Glynase/Prestabs/Micronase • glyburide/metformin or Glucovance	Long half-life in older adult patients, which can result in prolonged hypoglycemia. Chlorpropamide can cause SIADH.	• glipizide or Glucotrol • glimepiride or Amaryl
For epilepsy, anticonvulsants such as: • lamotrigine or Lamictal • levetiracetam or Keppra			
Short and intermediate-acting (e.g. alprazolam, lorazepam, oxazepam) are preferred if therapy is required. Avoid benzodiazepines for treatment of insomnia, agitation, or delirium.			
• baclofen or Lioresal/Gablofen • tizanidine or Zanaflex			
Perform risk-benefit assessment prior to administration and use with caution.			

Examples of Screening Tools & Management Plans



Examples of Validated Screening Tools

Overarching Screens	• ACS NSQIP®/AGS Optimal Preoperative Assessment • Edmonton Frail Scale • Sinai Abbreviated Geriatric Evaluation • Association of Integrated Care Coordination with Postsurgical Outcomes in High-Risk Older Adult
Impaired Cognition	• Mini Cog • Mini Mental Status Exam (MMSE) • Montreal Cognitive Assessment (MOCA)
Delirium Risk	• A Clinical Pred • National Instit Diagnosis, and • American Geri
Impaired Functional Status	• Katz Activities • Lawton's Instr • Functional Act
Impaired Mobility	• Timed Up and • Preventing Fal • Five Times Sit • Functional Gai
Malnutrition	• ACS Strong for • Mini Nutrition • Malnutrition U
Swallowing Ability	• Yale Swallow P • The Easy Dysp the older adul • Gugging Swall • The Toronto B
Palliative Care	• Utility of the " Conditions • Supportive &

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Positive Geriatric Vulnerability Screen Management Plan

Positive Screen	Management Plan
Age ≥ 85 years	• Formal evaluation by a health care provider with geriatric expertise
Impaired Cognition	• Increased delirium risk -> implementation of delirium prevention bundle after surgery Formal evaluation by a health care provider with geriatric expertise Formal evaluation by neurology (if never evaluated previously)
Delirium Risk	• Increased delirium risk -> implementation of delirium prevention bundle patient/caregiver education about delirium recognition, prevention, and treatment • Encourage patient to bring a sleep hygiene kit to bring to hospital (e.g. ear plugs, eye mask, night light, sound machine, etc.) • Review medications against list of Beers medications with high anticholinergic burden; communicate with PCP about addressing potentially inappropriate medications that can worsen delirium risk
Impaired Functional Status	• Early engagement of physical therapy (PT) /occupational therapy (OT) after surgery Referral to social work to discuss potential placement options after surgery Discuss with patient who caregiver will be to help him/her after surgery
Impaired Mobility	• Discuss tips with patient and caregiver on how to make home safer for mobility (e.g. removing trip/fall hazards, moving bed to first floor, etc. • Patient education on home strength training exercises and early ambulation after surgery • Preoperative referral to physical therapy (PT) for strength training • Early engagement of physical therapy (PT)/ occupational therapy (OT) after surgery
Malnutrition	• Home supplementation with nutritional supplement shakes (e.g. Ensure, Boost, etc.) and high protein foods • Preoperative referral to nutrition to evaluate for nutritional supplements prior to surgery
Difficulty Swallowing	• Implementation of aspiration precaution protocols after surgery • Referral to speech pathology/therapy (preoperative or immediately postoperative prior to diet advancement)

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Targeted Procedure: Geriatric Surgery

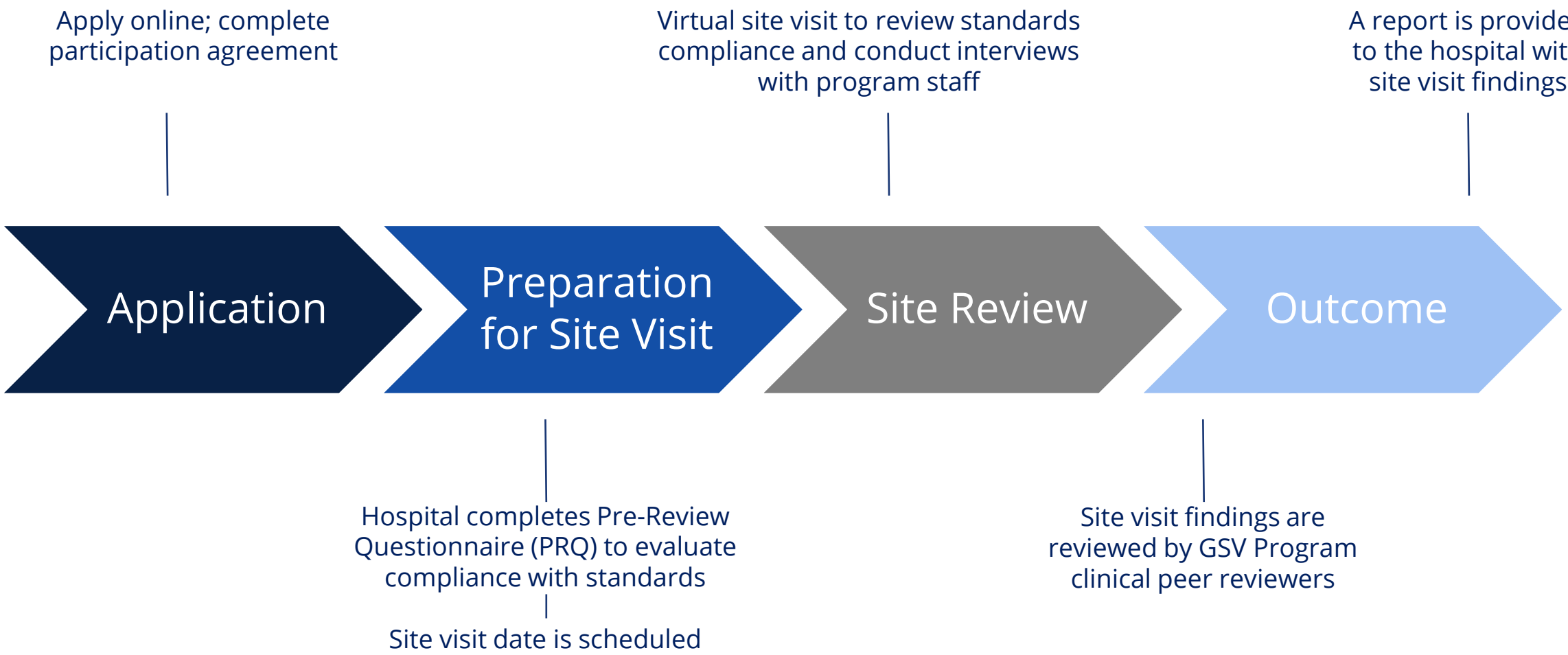
These variables are collected by **ALL Adult NSQIP** participants for cases with **patients ≥ 65** years of age at the time of surgery:

1. Home Origin Status – Support
2. Fall History
3. History of Dementia or Cognitive Impairment
4. Postoperative Delirium
5. Functional Health Status on Discharge
6. Home Discharge – Services

Available Hospitals participating in NSQIP can choose elect to target Geriatric Surgery:

1. Surrogate Signed Consent
2. Preoperative Use of Mobility Aid
3. Preoperative Pressure Sore
4. Preoperative Treatment Goals Discussion
5. New DNR Order During Hospitalization
6. New Postop Pressure Sore
7. Postop Use of Mobility Aid
8. Fall Risk on Discharge
9. Place of Residence at 30 Days Postop
10. Functional Health Status at 30 Days Postop
11. Perceptions of Physical Function at 30 Days Postop

Overview of the Verification Process



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Implementing the GSV Program will satisfy Standard 7.4

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7.4 Cancer Program Goal

Definition and Requirements

Annual goal setting provides direction for the strategic planning of cancer program activities. Each calendar year, the cancer program establishes, and documents in the cancer committee minutes, one cancer program goal appropriate and relevant to the cancer program and its patient population.

It is recommended the goal-setting tool known as SMART (Specific, Measurable, Achievable, Realistic, and Timely) be used when establishing the goal. Goals must be directed toward the scope, coordination, practices, processes, and provision of services for cancer care at the program.

The cancer committee must document substantive status updates on goal progress at two subsequent meetings after the goal's establishment in the same calendar year. For example, the status update may include any progress made, road blocks encountered, or a description of any necessary next steps.

Goals should last approximately one year. If additional time is needed, a goal may be extended for a second year (for a total of two years). However, a new goal must be established at the beginning of each calendar year even if a previous goal is still in progress. If the goal will extend into the second year, then a status update must be provided at the last meeting of the first calendar year. Additionally, there must be at least one additional status update documented in the cancer committee minutes during the second year. By the end of the second year, the cancer program must document in the cancer committee minutes that the goal is either completed or retired.

A goal established under this standard cannot duplicate requirements or be an improvement on requirements from another standard or be a program or initiative submitted to meet requirements of another standard.

Documentation

Submitted with Pre-Review Questionnaire

- Cancer Program Goal Template
- Cancer committee minutes documenting the establishment and status updates of the cancer program goal

Measure of Compliance

Each calendar year, the cancer program fulfills all of the compliance criteria:

1. One cancer program goal is established and documented in the cancer committee minutes.
2. At least two substantive status updates on goal progress are documented in the cancer committee minutes in the same calendar year as its establishment.
3. For any goal extended into a second year, at least one status update is documented in the minutes during the second year to indicate whether the goal was completed or retired.

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Collins J. *Good to Great: Why Some Companies Make the Leap and Others Don't.* New York, New York: HarperCollins Publishers Inc.; 2001.

Kotter, J, Rathgeber, H. *Our Iceberg is Melting: Changing and Succeeding under any Conditions*. 2nd ed. New York: Penguin Random House; 2017.

Pink, DH. Drive: *The Surprising Truth about What Motivates Us.* New York, New York: Riverhead Books; 2009.

Value of GSV for Cancer Patients and Participating Hospitals

Holistic Long-Term Plan of Care

WHY THIS MATTERS
Older adults often have multiple chronic conditions that can complicate cancer treatment. They may face mobility issues, cognitive decline, or frailty. Age-friendly protocols evaluate and address these concerns to ensure patients can safely undergo and recover from treatment tailored to the patient's overall health.

Reduce complications and readmissions

WHY THIS MATTERS
Age-friendly care emphasizes what matters most to the patient, including their treatment goals, independence, and quality of life. This approach is vital for older patients, who may prioritize comfort and daily functioning over aggressive treatments. Hospitals using age-friendly protocols see better outcomes, fewer readmissions, and higher patient satisfaction scores.

Interdisciplinary Care

WHY THIS MATTERS
Older cancer patients may require support from multiple specialists and caregivers. Age-friendly protocols enhance communication among healthcare providers and include caregivers in decision-making, ensuring coordinated care.

Designation as a GSV Partner

WHY THIS MATTERS
In a competitive healthcare market, GSV verification positions the hospital as a leader in geriatric care. Displayed with your cancer designations, this shows that you have the expertise and resources to address the unique challenges and needs associated with aging and cancer treatment. This distinction helps attract patients, partnerships, and referrals, particularly in regions with a high older adult population.

A growing body of literature supports the GSV Program

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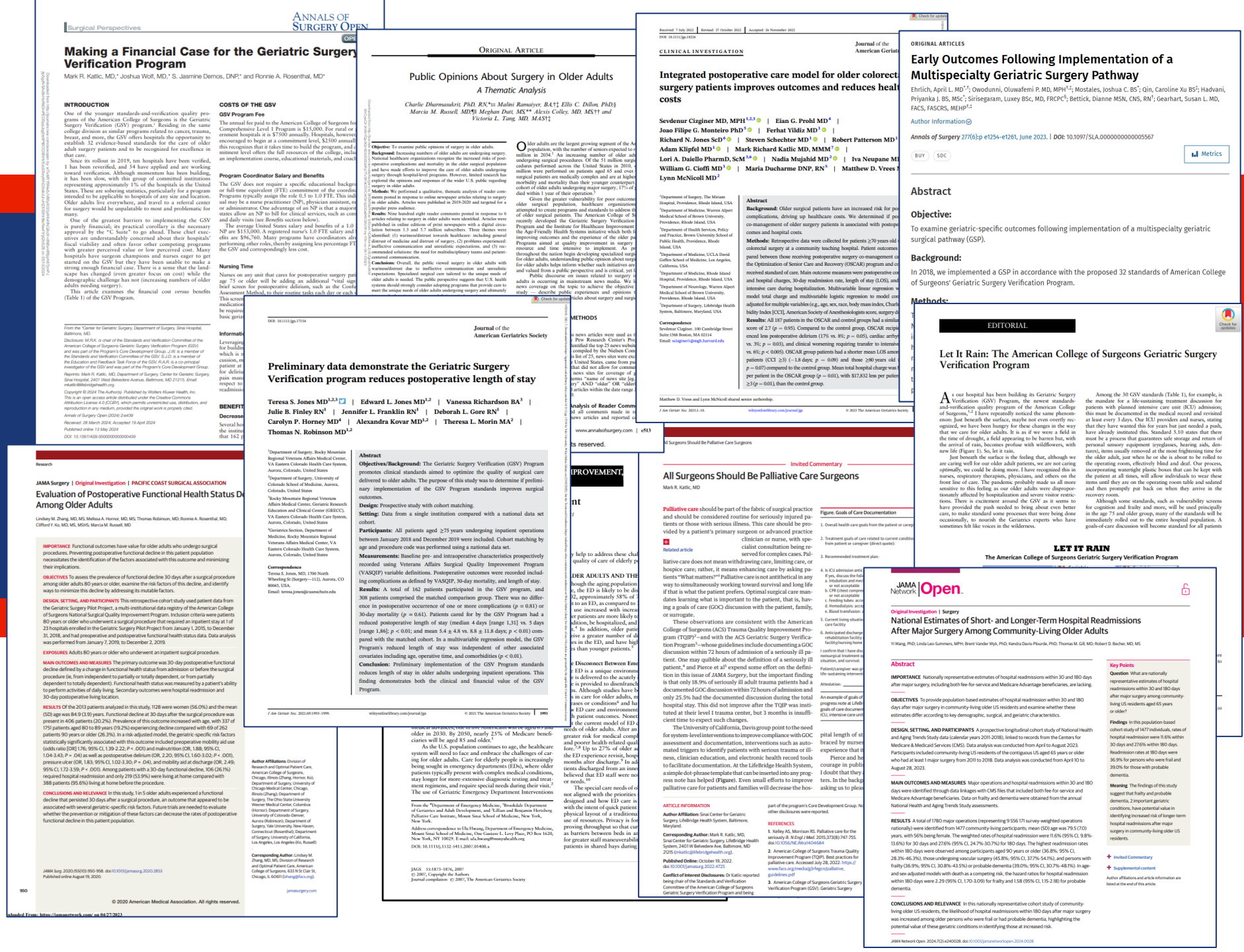

Making a Financial Case for the Geriatric Surgery Verification Program

Public Opinions About Surgery in Older Adults
A Thematic Analysis

Integrated postoperative care model for older colorectal surgery patients improves outcomes and reduces healthcare costs

Early Outcomes Following Implementation of a Multispecialty Geriatric Surgery Pathway

Preliminary data demonstrate the Geriatric Surgery Verification program reduces postoperative length of stay

Evaluation of Postoperative Functional Health Status Decline Among Older Adults

All Surgeons Should Be Palliative Care Surgeons

Let It Rain: The American College of Surgeons Geriatric Surgery Verification Program

National Estimates of Short- and Longer-Term Hospital Readmissions After Major Surgery Among Community-Living Older Adults

Geriatric Surgery Resources:
For all Levels

Implementation Materials

There are a variety of resources available that will help your hospital embark on the verification journey, such as:

- Gap Analysis
- Implementation Course
- Q&A Calls with Geriatric Experts
- GSV Hospitals' Best Practices

Site Visit Materials

The GSV staff team is available to support you every step of the way as you prepare for your site visit:

- Site Visit Guidelines
- Site Visit Agenda
- Steps in the GSV Verification process
- Access to the Pre-Review Questionnaire (PRQ)

Video Podcast Series: *GSV Insight*

GSV Insight is an educational series consisting of short videos that focus on how specific standards are implemented in participating GSV hospitals. Guest speakers discuss topics such as implementation strategies, the resources and skills needed to do so, barriers that were encountered and tips for overcoming them.

GSV FAQs

If you have questions during the enrollment process or about standards implementation, access the FAQ documents available:

- General Questions
- Standard Specific
- Chart Review and Site Visit
- Reverification

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How ACS Can Help Hospitals?

Enroll Today!

Questions?

Kat Christensen
Manager, Geriatric Surgery Verification Program

Sarah Valek RN MSN MBA
Manager, Clinical Quality Resources

geriatricsurgery@facs.org

Thank you!

Contact information:

- Kataryna Christensen: kchristensen@facs.org

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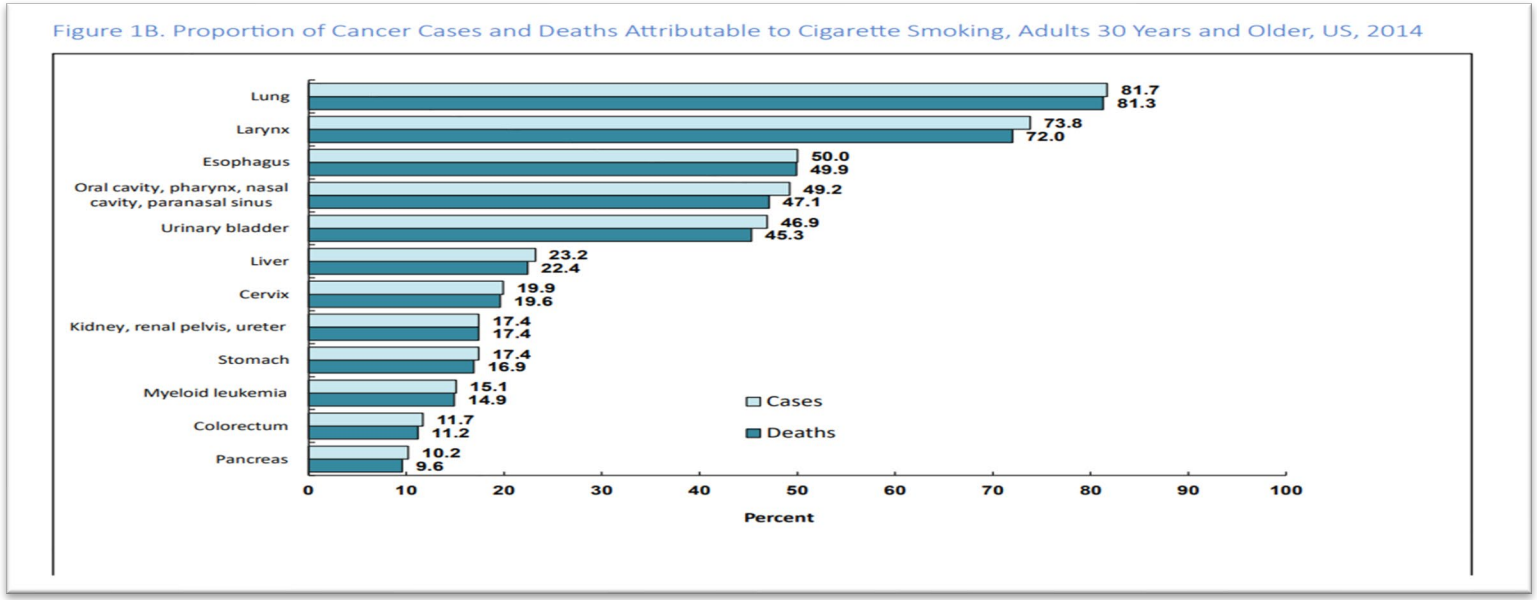
ACS CancerRisk360™

Molly Black
Director, Early Detection

A comprehensive risk assessment platform to empower individuals to take proactive steps in reducing their cancer risk as part of the American Cancer Society's collective goal of ending cancer for everyone.

Why do we need a Cancer Risk Assessment Tool?

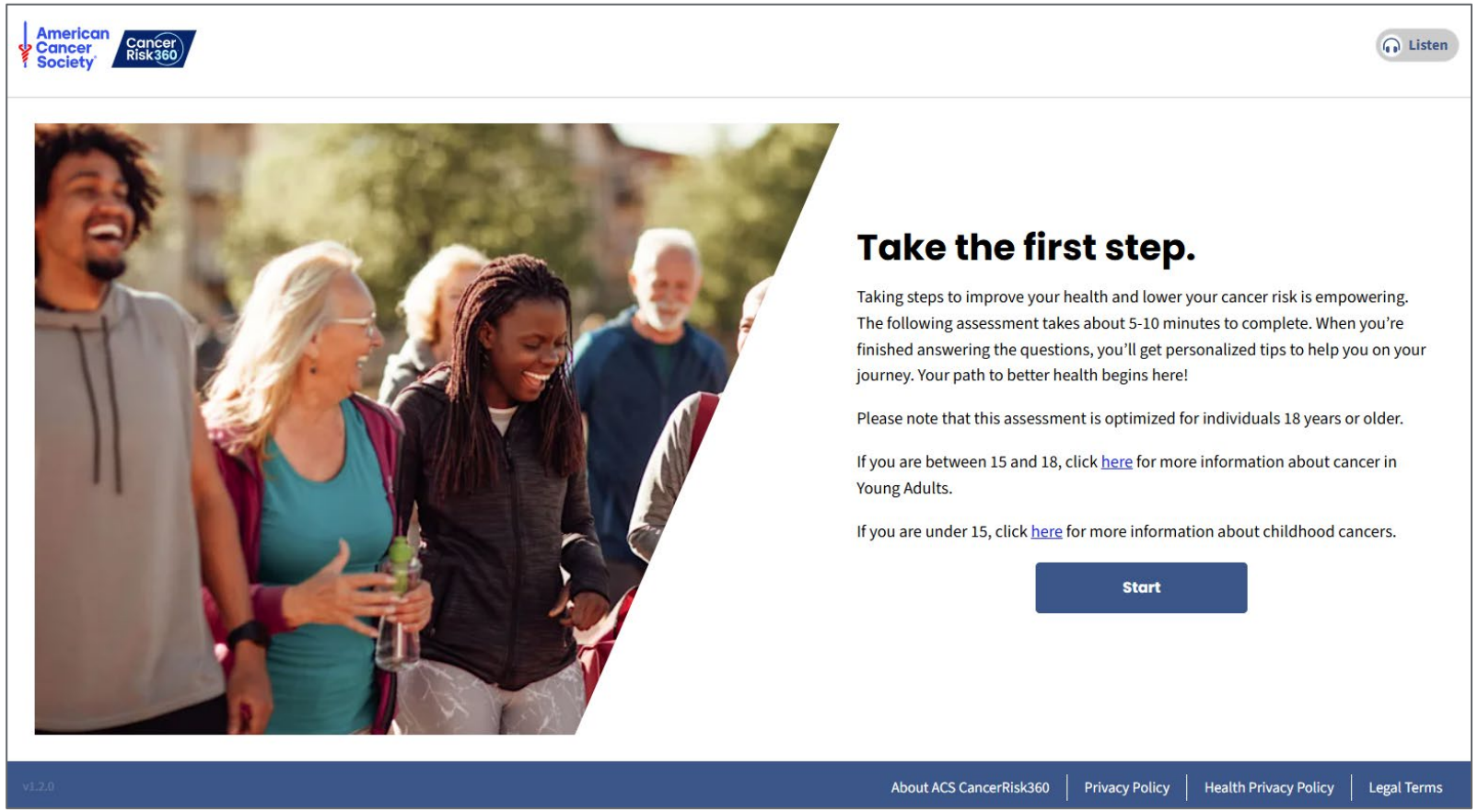
- 1 in 2 men and 1 in 3 women will face cancer in their lifetime, with many waiting until they have symptoms to visit a doctor.
- At least 40% of adult cancer diagnoses in the U.S. - about 811,000 in 2025 - are linked to potentially modifiable risk factors including excess weight, alcohol and tobacco use.
- 5-10% of all cancers are tied to genetic mutations. 75% of eligible patients with breast or ovarian cancer have never discussed genetic testing with a health care provider.
- Empower and ensure everyone has access to tailored information and resources to reduce their risk of cancer



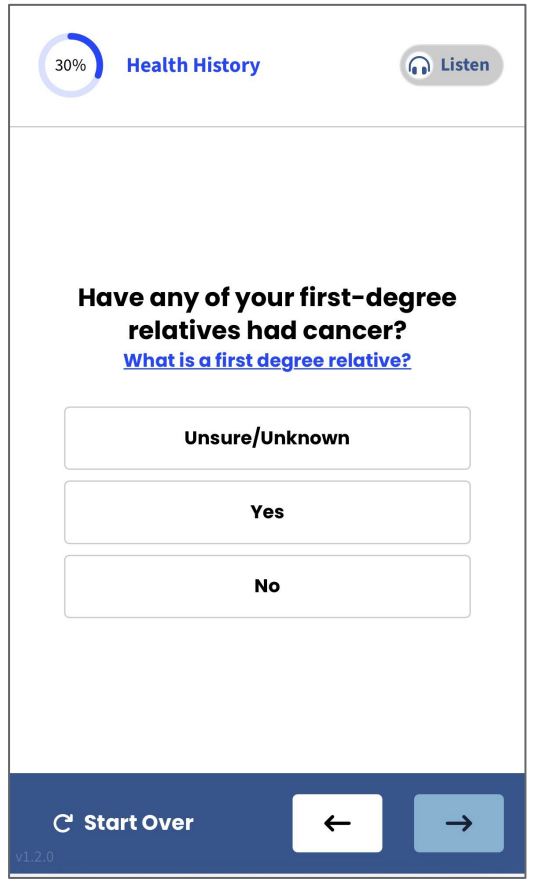
Star J et al. *Cancer Epidemiol Biomarkers Prev* 1 July 2023; 32 (7): 879–888.
Christopher P. Childers et al.. *JCO* **35**, 3800-3806(2017).

Assessment Look and Feel

Desktop



Mobile



Assessment Makeup

Dynamic set of questions & content to identify areas of risk

The Basics

- Age
- Sex
- Race & ethnicity
- Zip code

Health History

- Genetic mutations
- Hereditary cancer syndromes
- Family history of cancer
- Personal medical

Daily Life

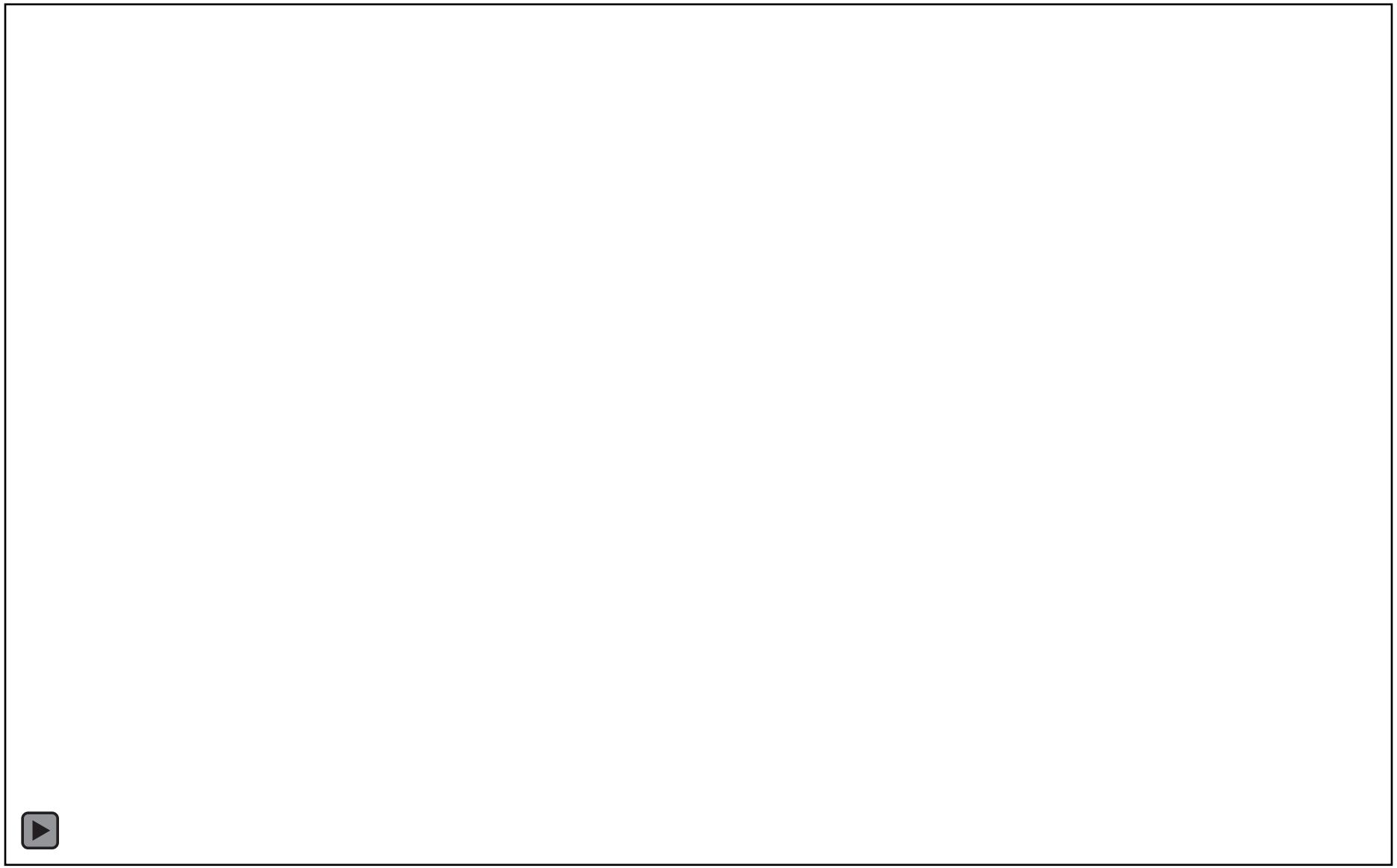
- Tobacco use
- Alcohol consumption
- Diet
- UV exposure
- Sleep
- Physical activity
- Environmental

Screening History

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Lung Cancer
- Screening
- Prostate Cancer Screening

Personalized Action Plan, Information & Resources

Action Plan Look and Feel



What ACS CancerRisk360™ is NOT:

- Not a risk calculator
- Not a medical device
- Not a replacement for a visit with a doctor or other healthcare professional
- Not a research tool/project

Utilization: 2025 Year to Date Totals

*As of 4/1/2025

22,359	Assessments completed
60,780	Visitors to web app
72%	Average completion rate
4.29	Average rating (out of 5)

What are people saying about ACS CancerRisk360™?

"This is the best thing that has happened to me in a long time."

"Thank you for this assessment! It is actually the first time anyone has taken the time to care about this in my own personal life."

"Knowledge is our best defense against cancer. Thanks for giving me this opportunity to evaluate my current health care situation."

"Thank you for the ability to do this for free. Will share the survey with others to take as well."

"I learned a whole lot from the test about cancer and how it works and what I need to do. I'm going to get out of this bed and start exercising and getting up everyday I promise myself this.

American Cancer Society®

Cancer Risk360®

"A participant in our session on ACS resources told me that she actually completed it a few weeks ago and found out she should be screened for lung cancer. She is a previous smoker and never has had a physician recommend the screening! She has it scheduled for next week!"

ACS CancerRisk360™: A simple tool to check your cancer risk.

How it works:

1. Go to **acscancerrisk360.cancer.org**
2. Take the test in about 5 mins. *No prep or studying needed.*
3. Get a personalized action plan.
4. Improve your whole health.

You can save your results by downloading, printing, or sending it to yourself.

Don’t forget to encourage your friends and family to take the assessment too!

SCAN TO TAKE ASSESMENT

Questions

Molly Black
Director, Early Detection

American Cancer Society

Cancer Risk360

For questions, feedback and collaboration:

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o: 980.308.0311
c: 828.337.5136

Commission on Cancer
American College of Surgeons

Open Forum

Commission on Cancer
American College of Surgeons

Thank you!

Questions?

Melissa Leeb: mleeb@facs.org

facs.org/quality-programs/cancer-programs/

ACS Cancer Programs

@AmColSurgCancer