Frequently Asked Questions

Age-Friendly Level: Standard-Specific

Standard 1: Age-Friendly Care Leadership

Q **Does the Age-Friendly Surgery Director role need to be fulfilled by a single person?**

A No, depending on your hospital resources, this role can be shared between two individuals.

Standard 2: 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.

Q **What should I do if a patient doesn't want to discuss their treatment goals?**

A If a patient is unwilling or unable to discuss their treatment goals, this should be clearly documented in the medical record.

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.

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.

Standard 3: Geriatric Vulnerability Screens

Q **Are the vulnerability screens to be performed on all patients 65+ undergoing inpatient surgical admission with expected stay of 2+ days?**

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

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 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.

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 4: 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 of the GSV Implementation Course and within the standards manual.

Standard 5: Age-Friendly Postoperative Protocol

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.

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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Q **For medication management, 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.

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.

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).

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 (prevention, recognition, and treatment of delirium; medication management; opioid-sparing multimodal pain management; nutrition and hydration) which can greatly impact patients' outcomes.

Standard 6: Data 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 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.

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 the GSV Implementation Course for more information.
