Geriatric Surgery Verification
American College of Surgeons

GSV Insight: The Rural Experience of High-Risk Geriatric Evaluation Using Telemed to Bridge the Gap of Limited Resources in the Rural Setting

INTRODUCTION

Kataryna Christensen [00:00:08] Welcome to GSV Insight. I'm Kataryna Christensen, the Geriatric Surgery Verification Program Manager. Today, Dr. Matt Schiralli will be joining me to discuss the rural experience of high-risk geriatric evaluation, using technology to bridge the gap of limited resources in the rural setting. Welcome, Dr. Schiralli. To begin, can you please tell us a little bit about yourself and about the hospitals within Rochester Regional Health?

Matthew Schiralli [00:00:32] Sure. Thanks for having me on, Kat. It's a pleasure to be able to share our experience with others, sites that are trying to develop their GSV Program. I have the privilege of being the medical director of our larger geriatric program across the entirety of the Rochester Regional Health system, and at this point it includes three actively built hospitals, one which is about 250-bed suburban hospital and two rural hospitals that we're going to talk about today. Those are in Newark and Clifton Springs. Clifton is really a small rural hospital. It's only got about 40 inpatient beds. And Newark-Wayne is kind of a medium sized rural hospital with about 70 inpatient beds. And so, the experience at these smaller hospitals really has been different in ways and we'll get into that today.

Kataryna Christensen [00:01:25] Great, thank you.

QUESTION #1

Kataryna Christensen [00:01:25] And let's move on to some of the other questions. To begin, how did you obtain buy-in from key participants to implement the GSV Program across several Rochester Regional Health hospitals?

Matthew Schiralli [00:01:36] The first thing that we had to do is really take a look at our population statistics. Once we did that analysis within our communities, we realized that not only is New York State aging faster than many areas of the country, but upstate western New York where we live, is getting older faster than a majority of the rest of the state. This is really very true in the rural communities. And so, once we presented the local data for the population that would be served by this type of a program to our other health care professionals, there was then really concrete evidence that this was something that was worth spending their time on. Additionally, everyone feels this that all of the professionals at the hospitals know that the older population is one of our most frail and vulnerable populations that we serve in surgical care. And so, it feels right to focus on that population. So, when we brought together dedicated standards from the College, along with a really good reason as to why this was appropriate for the community, we had a lot of buy-in.

QUESTION #2

Kataryna Christensen [00:02:48] That's amazing. And how do you utilize telemed at your rural hospitals?

Matthew Schiralli [00:02:54] Well, one of the interesting things, I was a big hospital kind of guy and then went out to the suburban hospital and got used to building a practice and building GSV in the suburban hospital, which had basically all the resources that you would expect to have in a modern hospital. Coming

out to the rural communities, that was a little bit of a homecoming for me as I grew up in really rural New York State, like the communities we serve now, but it was also eye opening. When I came into these hospitals and took stock of the work they were doing and the resources they were doing it with, I was really struck by the good work they were doing with how many limited resources they had, and so then we had to start getting creative. We had a model that we felt from the beginning that we developed along with the ACS in our hospital. We had a model at Unity that we felt was scalable to all the other hospitals. And while it's true, we were able to use a majority of the structure that we had created at Unity and replicated at the other hospitals, we had some real significant differences. One was in our ability to have geriatrics consultants, geriatric trained consultants in the hospitals. Those did not exist at all. And for all of the years that preceded us starting the GSV Program, the hospitalist and the primary care doctors provided all of the care. And so, we had to be sensitive to the fact that, you know, as healthcare professionals, we're really proud of the work we do, but also, we had to bring people along. The idea of some specialization can add, can really add to the care we provide. And getting the opinions of geriatrics-trained professionals would be a value add to these to the care of these patients. And so, with that understanding, once we worked through that, we then looked to see how can we extend resources within a health system, across the greater geography of the health system. And for us, we're talking about 50 miles away, 45 to 50 miles away from the more heavily resourced facilities. And so naturally telemed was on our mind. Add to that, we kicked off our program in January of 2020, and if there was a worse time to try to develop a major program, I'm not sure what it would be. However, in the early days of the pandemic, the entire country went toward telemed to try to preserve services and provide the continuity of care that our communities needed. And so, it was a natural fit. And so, all of a sudden, spring boarded by the pandemic, and also with our own understanding of resources that we had available and resources that we needed, we landed in a hybrid model where we do some in-person geriatrics consultations with our geriatrics trained APPs and then some telemed and really have worked to mix this all together into a sustainable program.

QUESTION #3

Kataryna Christensen [00:06:22] I mean you have done some amazing work and I can certainly attest to that. So, congratulations. For the next question, among the hospitals participating in the GSV Program, can you please describe the differences and difficulties between conducting the high-risk screenings at each facility and how telemed factors into that?

Matthew Schiralli [00:06:42] Definitely. So, when we look at our suburban hospital, in the hospital, we have a single campus and we have then the ability to embed a provider, an APP, geriatrics-trained APP, within different components of care, both all the phases of care that hit the hospital campus. So, pre-op, immediately pre-op, intra-op, and post-op, they are physically present and able to travel across the campus and do the different components of care. When we looked at the rural campuses, we said, well, we have two campuses we're trying to simultaneously build because they really act as sister hospitals. And we have limited resources where in the beginning we only had about 50% of the time could we have a person at either of the campuses. And so that was half of the week. We had one person at one of the campuses. And so, then we brought in telemed, we brought that into our pre-admission testing process, which is a standard process within the Rochester Regional Health system, where we're doing the high-risk geriatric screening and the pre-admission testing clinic does their normal work to prepare patients for surgery, doing their pre-op risk screening. And then we add in the geriatric risk screening. And if someone scores high-risk, we try to immediately move them on to the high-risk geriatric APP. And when they're in person, when they're on the campus that day, they can do it face-to-face. And it works just like it works at Unity, but when they're not on the campus, we bring a dedicated telemed cart that was already in the hospital. We bring it right into the room that the patient is in, in their pre-admission testing clinic, and we connect in real-time on demand, connect to our geriatrics APP, who has the flexibility of starting and stopping other works to assist with on demand needs of doing the high-risk evaluation in the pre-admission testing clinic. We found that by using a dedicated telemed cart, the audio and the visual was better. We were trying different things and even trying remote visits where the patients were at home, but

we struggled very heavily with bringing some of the bridging some of those technology gaps, whether it was access to the Internet, stable Internet, or just trying to troubleshoot someone's camera and microphone speakers were so much better when we had our own dedicated cart, we wheeled it right in front of the patient. And so that's the process that we're using now.

QUESTION #4

Kataryna Christensen [00:09:37] Awesome. And then can you describe what other resources were used to complete the high-risk review in the rural setting?

Matthew Schiralli [00:09:44] Sure. This is, again, part of the pandemic experiences that we got out of the conference rooms and the board rooms, and we went to Zoom meetings. Really a strange event for many of us who are accustomed to seeing each other and sitting down face-to-face and drinking stale coffee and having conversations. But we went over to Zoom meetings, and that actually helped us tremendously in the rural community, because when we talk about two sister hospitals, we talk about providers that move across those hospitals, but also the regional offices, ambulatory offices. We're talking about a really large geographic footprint, and on any given day we'll only have some of the providers in one location. So, by going to Zoom or a virtual meeting, whatever platform your institution uses, by going to a virtual meeting, we are consistently able to put somewhere between 15 to 20 different healthcare professionals on the meeting to complete that multidisciplinary high-risk review. If we were to try to do that just on one of the campuses, we would have maybe half that many participants. And what we found is that the more participants, the more robust the conversation and the more of the subtle details that really affect patient outcomes, especially around the social determinants of healthcare, our social workers in care management and their tasks around planning healthcare, we really dig into a lot more those details with a bigger, more robust group. And so, by going to these virtual meetings, we use the Zoom platform, it's been tremendously helpful to complete that multidisciplinary review in the rural community.

QUESTION #5

Kataryna Christensen [00:11:33] Great, and describe how you sustained momentum with your team with limited resources.

Matthew Schiralli [00:11:41] Well, I will not take credit for all of this. I think Jana and Julie Giles, our high-risk geriatric APP, deserve a lot of the credit for sustaining momentum. One of the things we realized early on was that if we went number 1, followed by 1.A, followed by 1.B, followed by 2, followed by 2.A, followed by 2.B, if we went through the standards like that on our campuses, we would kind of stumble. It wasn't, we didn't gain a lot of momentum and we didn't feel like we were making a lot of progress right away. And so, we rearranged the standards as far as development was concerned, and we put them in different groupings where we knew the first group that we attacked is the grouping of standards that we know we can get them completed in a quick turnaround, and that helps us psychologically to say, look, we're making progress. And then we weave in some of the more difficult to accomplish standards as the group gains traction and gains some confidence. And so, in doing so, we've been able to really sustain the momentum. Even though it's not the same group that we would have at Unity, by getting early wins and early gains and building the confidence of the group, we've been able to really roll through the program development on both campuses.

Kataryna Christensen [00:13:12] Yeah, I always tell people to always celebrate the small wins and it goes a long way for sure.

Matthew Schiralli [00:13:18] Absolutely.

QUESTION #6

Kataryna Christensen [00:13:19] And then the last question for today, what are some tips for other hospitals who are trying to implement the GSV Program in the rural setting?

Matthew Schiralli [00:13:28] I think the first thing is that you have to become part of the community. There is a tremendous amount of stranger danger, outsider type of opinion in these small communities and was one of the more helpful steps in developing the program was that I started practicing in the community. And so, I wasn't some guy from some other place within the health system telling people what to do, but I was a participant in the local care. I think that's tremendously helpful. That's not practical. I can't move my practice ten times over to keep building at different hospitals, but what the next step for me has become is really identify the local champion. We now have a system that we've worked out that we feel works pretty well in developing across hospitals in our health system, and so we can provide a lot of that administrative support having figured out a whole bunch of details. I need to be able to have my boots on the ground, local champion, have that person be in a position of influence within the hospital and a respected member of the hospital and of the surgical care, and then have your local champion really be your voice on the campus, because there is a lot of avoidance of outsiders in these small communities.

CLOSING REMARKS

Kataryna Christensen [00:14:56] Yeah, that's great advice. So, I just wanted to thank you for joining us today and sharing your experience implementing the GSV Program across Rochester Regional Health.

Matthew Schiralli [00:15:07] Excellent. Thanks for having me on, Kat. As always, we're happy to speak to other sites and share our experience, but also learn from their experience, so feel free to reach out.

Kataryna Christensen [00:15:17] Yes, you've done amazing work. So, thank you again for all that you've done for us and all that you've accomplished and congratulations. And I know that you've all learned as much as I have today. If you'd like to share your GSV implementation strategies, please don't hesitate to reach out to me at kchristensen@facs.org. Thanks.