Geriatric Surgery Verification
American College of Surgeons

GSV Insight: Let's Talk About… Interdisciplinary Input or Conference for Elective, High-Risk Patients

INTRODUCTION

Kataryna Christensen [00:00:07] Hello and welcome to GSV Insight. Let's talk about how to implement an interdisciplinary conference at your hospital. I'm Kataryna Christensen, the Geriatric Surgery Verification Project Manager. Today, I'll be talking to Dr. Alexandra Briggs, and she will be joining me from Dartmouth-Hitchcock Medical Center. We will be discussing how her hospital implemented GSV Standard 5.8: Interdisciplinary Input or Conference for Elective High-Risk Patients. Hello Dr. Briggs, thank you for joining me today.

Dr. Alexandra Briggs [00:00:35] Hello and thank you so much for having me on today's podcast - it's great to be here.

Kataryna Christensen [00:00:40] Can you please tell us a little bit more about yourself and your hospital?

Dr. Alexandra Briggs [00:00:43] Absolutely. I'm a trauma and acute care surgeon and assistant professor of surgery here at Dartmouth and my main focus is on the care of older adults who present after injury or with acute surgical needs. Two years ago, I became an ACS associate fellow scholar in geriatric surgery and then launched efforts to create a geriatric surgery program here at Dartmouth-Hitchcock, along with my colleague, Dr. Stacy Deiner, who's a professor of anesthesiology here. To tell you a little bit about Dartmouth. Dartmouth-Hitchcock Medical Center is a 396-bed hospital, though it's about to expand with a new wing located in Lebanon, New Hampshire. It's the sole academic medical center in our state and also the only level one trauma center in our state.

Kataryna Christensen [00:01:21] Wonderful. Now to dive into the questions.

QUESTION #1

Kataryna Christensen [00:01:24] Can you please describe how your hospital began implementing the standard?

Dr. Alexandra Briggs [00:01:28] Of course. Dr. Deiner and I were able to securefunding from the Levy Incubator at Dartmouth that allowed us to bring together a multidisciplinary team for a year of work to really evaluate current processes at DH and determine how to create a program that would meet GSV standards. In the second six months of that process, we really started doing more implementation work, and during this time we identified partners who would serve on the interdisciplinary team and participate in the weekly conference about patients. But before we could start those conferences, we invested a great deal of time creating the screening that would identify the high-risk patients who merited further discussion, along with creating the actual referral pathway to the program. And we had weekly meetings with our electronic medical record team at our institution - we use Epic, to create note templates and flow sheets that will allow us to track data and track our recommendations to make sure that we could then follow up on our quality. Once we had that base to work with, we started actually refining the process

itself, and one of our amazing nurses, Annie Burlow, calls our high-risk patients at home and runs through a set of screening questions that we put together that gets more information about their areas of vulnerability. The other things she asks about are screening questions that our case managers use to assess support at home, safety at home, and considerations that can affect discharge planning. And her role is absolutely vital because she's able to find out so many details that are really important from who social supports are, who's planning to stay with them after they get home, how many steps they need to enter their house, how to get to the bedroom, those little details that are really important. And the social determinants of health questions that are really vital because she can help identify who might have food insecurity and maybe could benefit from Meals on Wheels or housing challenges. I mean, we have folks that don't have running water at home, things like that, that will factor into their care and so she brings all of that information together and shares it with the rest of the team the Monday prior to our Wednesday morning conference. So that way, we're all ready to discuss the case and make recommendations that day.

Kataryna Christensen [00:03:25] Wow, that's great.

QUESTION #2

Kataryna Christensen [00:03:26] How difficult was it to implement this standard?

Dr. Alexandra Briggs [00:03:29] You know, honestly, the most difficult part of the implementation was really all the prep work to actually identify the high-risk patients we needed to talk about. And we're still refining that process. It took about six or eight months to construct and complete a reliable referral process, and we had elements of it earlier on, but it really came together starting in January of this year with a much smoother referral process to our multidisciplinary group, once our pre-anesthesia, testing clinic was able to actually do the referrals and now we're averaging about 40 referrals a month.

QUESTION #3

Kataryna Christensen [00:03:59] What resources were used and what skills were needed to put this standard in place at Dartmouth?

Dr. Alexandra Briggs [00:04:04] Well, our interdisciplinary team consists of representation from surgery, anesthesia, psychiatry, geriatrics, and nursing. I'm the surgeon representative. Dr. Deiner's one of the two anesthesiologists. The other is Dr. Vinka Chow, and she actually runs the PCC, which is our preoperative clinic that helps us perform the vulnerability screen, in addition to many other things they already do. Both Vinka and I are critical care physicians, so we have that element that adds to the team as well. Dr. Fernandez is our geriatrician and she's been invaluable because she not only provides geriatric folks focused expertise, but she's also liaison to many of our local skilled nursing facilities as she provides work there as well and she has links to both primary care and also our geriatric palliative care physician that works with us. Dr. Landsman is a psychiatrist who has great insights into delirium risk, pharmacy related to pain, and psychiatric history and that also helps us with delirium and prevention management recommendations. I mentioned Annie Burlow before, she's an OR nurse, which is a great addition and also has prior floor nursing experience and she's our program coordinator who does all the phone screens and helps create the notes and route them. And then we have Catherine Morante, who's another one of our nursing colleagues who has extensive geriatric experience and also is an honor and care decision specialist, which I think is really vital. While our case management colleagues can't currently attend each week, we do work with them as well because they're able to help us prepare visiting nurse services, identify SNF and rehab facilities that patients prefer, and get those referrals ready so we can expedite that process once a patient's actually admitted. I think one of the most difficult parts of putting together these kinds of workflows are cost. And right now our main funded position is our nursing coordinator and we're working towards protecting the time of the other team members as well. Right now, it's just we're all passionate

about it and want to make it successful. We have created our business plan that demonstrates that the financial benefit from length of stay that we anticipate will allow funding for our key staff and still provide a positive margin to the hospital. So that's what we're working towards next.

QUESTION #4

Kataryna Christensen [00:06:05] Were there any setbacks or roadblocks that occurred while trying to implement this standard?

Dr. Alexandra Briggs [00:06:09] You know, one of the early barriers was really getting the patients to us. We knew that there were high-risk patients out there but creating the actual process to refer to as multiple levels of revision. We initially tried to have that referral process sit with the surgical clinics themselves. But that's really tough, particularly given the flow of surgical clinic and how busy people get and having surgeons remember to do it, and even though they're interested in it, it is hard. So, once we were able to establish a comprehensive screening program in the PCC, that pre anesthesia clinic that I was talking about, we're able to streamline referrals and create prompts that would remind providers to place the order that would then come into our program inbox. You know, I think we still have all of that revision is still going. We're revising less now than we were six months ago, but we still have our PSA cycles to identify elements that we can improve. And so, what we used to do is spend an hour each week with our electronic medical record team on the note templates and flow sheets, etc. But now we've graduated to just needing to intermittently email them when we want to make a change, which is a huge step forward.

QUESTION #5

Kataryna Christensen [00:07:10] And can you share with us any tips for other hospitals who are struggling to implement the standard?

Dr. Alexandra Briggs [00:07:15] I think that particularly in the current financial environment, funding is one of the greatest challenges and, you know, we've been fortunate that we have a team that absolutely believes in this process and the program and so we've made the time to make this a success while we just have one member of the team being funded. I think that that's probably one of the biggest barriers in trying to create that business plan to show that there's a benefit to then go back to your institution and have them help fund the positions to make it successful is a big step. Our screening process is incorporated into the existing pre-operative infrastructure, so we haven't needed to find funding for that, which I think is really important. In terms of staff, I think it's really important to know who can provide perspective that's needed for your patients and also within the hospital structure that you have. You know, the standard tells you what roles should be filled in terms of surgery and anesthesia, nursing, geriatrics, etc. But there might be people in those specialties that fill roles in the institution that provide additional insider help. You know, for example, we know that psychiatry at our institution is often involved and consulted for delirium management, for surgical services, and they also have a team called the “Bit Team” that helps patients with coping postoperatively. So they were a natural addition to our group because we can identify patients that might have a lot of anxiety around surgery or things like that where having them know about those patients ahead of time is really helpful. With Dr. Chow being a part of the PCC but also part of our group, she actually links up with anesthesiologists the night before surgery and says, hey, don't forget this patient tomorrow has such high-risk factors that please remember that when you're doing their anesthetics. So I think that's really helpful. And when thinking about buy-in, there was a lot of meetings and presentations to different surgical groups and other stakeholders to introduce and explain the process to make it successful. So make sure you tailor that to the different groups in your hospital that are going to be referring your patients. We've made our meetings open for members of surgical teams to come join and see our process or weigh in on certain patients. So it won't be, you know, unreasonable to do that, invite a nurse practitioner or invite a surgeon to talk about their patient in particular, and kind of see how the process goes, so that it's less of a mystery and then people may be more likely to embrace it, that's

where your roadblock might be in your hospital.

QUESTION #6

Kataryna Christensen [00:09:26] Great. And can you describe how you sustain the activity with your team?

Dr. Alexandra Briggs [00:09:30] Absolutely. Our interdisciplinary team meets weekly for our conference, but also regularly communicates in between those meetings. All of our team members are part of our core program staff and so in addition to the high-risk patient discussions we have, we also regularly meet as we're moving the whole program forward, which really adds to our ability to ensure that we're performing as we should. We also have a program dashboard made by our fabulous analyst, Christine Charette, and she pulls data to identify how many patients have been screened, how many screened positive, how many of the high-risk patients have actually had a referral, how many complete the process with us, etc. and she puts it in a spreadsheet that has a red, yellow, green marker on our dashboard to basically show us if we're meeting our percentage goals or not and so that's been a really invaluable tool to identify areas for improvement and make sure that we're actually meeting our standards.

QUESTION #7

Kataryna Christensen [00:10:18] Oh, wow, that's fantastic! And what educational resources does your hospital provide to staff.

Dr. Alexandra Briggs [00:10:24] For this specific standard our education was really focused on explaining the process and interventions to surgeons and surgical clinic staff, to the anesthesiologists and others who are going to see our notes in the medical record. Because that way, if they're going to be changing their practice based upon our recommendations, we wanted to make sure they knew where that was coming from. So as we explain the screening process, what the areas of vulnerability were, and then what our recommendations meant and how those could be used to then improve the care of their patients.

QUESTION #8

Kataryna Christensen [00:10:50] And lastly, are there any final tips or considerations to share with our listeners?

Dr. Alexandra Briggs [00:10:55] I think that it's really important to figure out what the process specifically is in your hospital and identify the stakeholders who are going to be central to making it successful. Definitely be proactive about getting feedback as you implement the process because it's incredibly helpful to hear both the great things, but also maybe the bad things that people think about in order to make it better. And certainly, don't forget the people that challenge you the most are probably the ones that are going to benefit your process most. We all love hearing compliments about what's going on but hearing when people may not necessarily agree with what you're doing or have suggestions for you is what's going to make it better moving forward.

CLOSING REMARKS

Kataryna Christensen [00:11:32] Well, thank you so much for joining us today and sharing your experience implementing Standard 5.8 at your hospital.

Dr. Alexandra Briggs [00:11:37] Thank you so much for this opportunity, Kat. I really appreciate being able

to share our experience and my email's up on the screen if anybody would like to reach out with any questions or see our templates for the EMR or anything like that moving forward.

Kataryna Christensen [00:11:50] Wonderful. I hope you all learned as much as I did today. If you would like to share your GSV implementation strategies, please don't hesitate to reach out to me at kchristensen@facs.org.