Geriatric Surgery Verification
American College of Surgeons

GSV Insight: Data Collection within the GSV Program

Xane Peters, MD – ACS John A. Hartford Foundation James C. Thompson Clinical Scholar in Residence

INTRODUCTION

Michael Bencur [00:00:10] Hello and welcome to GSV Insight. Today we'll be talking about data collection within the GSV Program. My name is Michael Bencur, and I'm the GSV project manager. Today I'm joined by Dr. Xane Peters, the ACS John A. Hartford Foundation James C. Thompson Clinical Scholar in Residence. Welcome, Dr. Peters.

Xane Peters [00:00:28] Thank you so much for giving me the opportunity. Appreciate it.

Michael Bencur [00:00:31] Could you tell us a little bit more about yourself and your background?

Xane Peters [00:00:36] Yeah, so I'm Xane Peters, I'm a general surgery resident at Loyola University Medical Center, just west of downtown here in Chicago. And for the last two years I've been the clinical scholar working with the geriatric program here at the American College of Surgeons. Most of my work has focused around data collection and analysis for the geriatric program and how we feed that back to frontline providers. And I've done a lot of work with cognitive impairment, delirium, and functional assessments for the older adult surgical population.

Michael Bencur [00:01:05] Great. Okay.

QUESTION #1

Michael Bencur [00:01:07] Moving into our questions about GSV standards, 6.1, 6.2, and 7.2, this is frequently talked about, but why is data collection important?

Xane Peters [00:01:17] Yeah, this is a fun one. I think this is maybe a little more philosophical or epistemological, but at its core, you can't really begin to try to improve healthcare quality if you can't measure it, and if you don't know where the problems might be. And so, without measuring this important quality information, hospitals can lack necessary data that is really required to take the next appropriate steps to fix problem areas. So, for example, measuring surgical complication rates, if you don't have that information, you don't know that you have a problem and you don't know where you need to target those resources. I think that's even more important in the current healthcare climate and the current healthcare quality climate, where we have an increasingly frequent need to direct resources in specific areas towards specific problems. And again, data collection is important because it helps us prioritize where the biggest problems are and where we can divert those resources for the greatest impact.

QUESTION #2

Michael Bencur [00:02:18] Definitely. And we have GSV standard 2.3, the Geriatric Surgery Quality Committee. How does data collection pertain to the GSQC?

Xane Peters [00:02:29] Yeah, so I think within the context of the Geriatric Surgery Verification Program, the GSQC, Geriatric Surgery Quality Committee, is really the responsible body for making sure that the data that is necessary to be collected for this patient population is done at minimum quarterly. So, this

data is being reviewed, trends are being identified. Again, like I mentioned, opportunities are being identified. And then the committee is of course sort of responsible for identifying problems, problem areas, and targeting issues that are going to need the most attention and the most resources.

QUESTION #3

Michael Bencur [00:03:11] Okay. And aside from the GSQC, what other data infrastructure is needed for the GSV Program?

Xane Peters [00:03:18] Yeah, I think, and this will trend nicely into something I think we'll discuss later, but at its baseline, the hospital should have the infrastructure to collect clinical patient level data, review that data, and of course analyze it. I think that this can take a variety of forms. We'll talk a little bit about the ACS NSQIP. I know that there are a variety of other data platforms out there, and there's some other existing at many hospitals, most hospitals I should say, data collection that can be sort of rolled into and utilized and leveraged for targeting older adult needs within the GSV Program.

QUESTION #4

Michael Bencur [00:03:57] Great. And so, for data collection, which is standard 6.1, what data are collected for GSV and what are some data collection strategies?

Xane Peters [00:04:08] Yeah, so the nice thing about, there are several nice things about GSV, but I think one of the nice things about GSV is that there are these variety of variables that are highly relevant to the older adult surgical population. And they're already collected, obviously, through CMS, the Centers for Medicare and Medicaid Services, and Joint Commission regulatory requirements for data collection. These include things like inpatient fall rates, healthcare acquired infections, be that from catheters or, excuse me, urinary catheters, or central lines, or ventilators. If patients are having restraints used, while they're in the hospital. And then of course, all the outcome data that we tend to get really interested in, like unplanned readmissions and mortality. And those things are required data points to be collected from other regulatory bodies. And so, hospitals are already collecting this data. So, within any individual hospital that's compliant with CMS or JCAHO, they should already have those mechanisms in place. They should already be collecting that data.

The extra piece for GSV are the two other pieces that are highly relevant for older adults, and that's postoperative delirium and postoperative deconditioning. And those are two really important metrics for surgical care for older adults that are not, you know, boxed within existing CMS or JCAHO, or I guess it's TJC now, The Joint Commission, TJC requirements. And these are, you know, there's some institutional variation, I think, on how this is collected, but they're the two sort of extra requirements. And then the other important piece of this again is postoperative deconditioning. There are many different ways that this can manifest. And there's not a widely agreed upon standardized sort of definition for this or preferred method of screening. And so within the standards, the GSV standards, institutions on an sort of individual level can choose how that's defined and measured. And there are a number of example definitions that are included within additional GSV resources.

QUESTION #5

Michael Bencur [00:06:17] Great. So, you're collecting all of this data and it's also very important for it to be fed back to frontline providers and the hospital quality infrastructure. This relates to standard 6.2, what are some examples of or strategies for establishing this data feedback process/protocol?

Xane Peters [00:06:37] Yeah, I think it varies on an institutional level, but I think that there's a lot of leveraging different existing, in terms of getting that data back to the people that it's going to be most relevant to, and that's your frontline providers, frontline clinicians, and staff. And there are a variety of ways to do that. But I think that it, in general, it looks like, you know, you're having, for example, the Geriatric Surgery Quality Committee, you have individuals that are coming to that meeting that are responsible for then taking that information, that data review, which again is a requirement of the Geriatric Surgery Quality Committee. And they take, you know, they may be responsible for taking it back to, if you have clinical nursing leadership, they're responsible for taking that information back to frontline nursing leadership. And then maybe there's another additional level where they're responsible for talking to nurses on a ward or a unit level. So, it's a little bit of, sort of effective game of telephone between the folks that are in the room when the data is being reviewed, and then who is responsible for passing that information down the line. So, I mentioned the Geriatric Surgery Quality Committee, and that's of course like an existing, sort of body, a meeting, an event that's required. And so that is an efficient, one example of an efficient use of something that you're already going to do to get that data back to frontline providers.

But another potential option is getting folks involved with other existing quality meetings. And so, if there's another surgical quality meeting that isn't the GSQC meeting, then you can leverage that in the same way, make some people responsible for giving that data back to frontline providers. And then another important one that I've seen come up that I actually really like is sort of just engaging your team members at other touchpoints. So, it doesn't have to be a geriatrics, excuse me, a surgical quality meeting, because those are the people that are really interested, right? Those are the people that have sort of already bought into the quality, right? That they're at the meeting already. So, and they will distribute that information as best they can. But it's nice to sort of try to engage other people that are involved in clinical care that wouldn't otherwise maybe be directly digesting that information. And I think using other conferences, interdisciplinary input settings, touchpoints with other team members, like team rounds or shift changes, to communicate that data, and that is probably more likely further down the chain. So, someone at the GSQC is, you know, gives some information to a shift nursing leader or another clinical team member, and then they're passing that information to the people that they're working with right on the front lines at those critical touchpoints. And I think that kind of, it's a very long-winded answer, but there's several different sort of nodes for information exchange. And leveraging all those is going to give you probably the best chances of improving the effect of whatever quality initiative or priority that you've identified.

QUESTION #6

Michael Bencur [00:09:51] Yeah, absolutely. So, we also have the optional GSV standard 7.2, the Geriatric Surgery, ACS NSQIP collaborative. Can you describe what that is, and then also what are some of the benefits of participating in this collaborative?

Xane Peters [00:10:07] Yeah, absolutely. I don't know if I should also mention some of my personal bias. I've done a lot of work with the ACS NSQIP dataset, and specific to geriatric population. So, I have some degree of bias about it. I think it's an excellent opportunity. But for anyone unfamiliar, just sort of big picture, high level, the ACS NSQIP, National Surgical Quality Improvement Program, is a network of hospitals broadly with a goal, shared goal of improving quality of surgical care. And then the Geriatric Surgery NSQIP Collaborative is a sort of a subset of this data collection mechanism that is designed to collect geriatric specific metrics for the same purposes that we look at other common surgical adverse events for benchmarking and to identify quality improvement targets, I should say. And then the ACS NSQIP broadly is risk-adjusted, it's outcomes based. So, it accounts for, as a data set and a and a quality improvement program, it accounts for presenting risk of individual patients. And so, in that way, it's risk-adjusted that is, you know, accounts for various comorbidities and variable presenting conditions of certain patients.

Currently the ACS NSQIP is present in about 700 hospitals. And the geriatric collaborative component of that, again, targets these geriatric specific variables for the same purposes to provide some risk-adjusted benchmarked information about how your hospital is doing for these older adult surgical patients compared to other hospitals that are also collecting these variables. I think there are a variety of benefits, I think that they roll into sort of, big picture, trying to improve geriatric surgical care by identifying the issues that are specific and germane to this population. And so, some of the variables that are collected through the collaborative include things like preoperative use of a mobility aid, the issues surrounding surrogate signed consent, advanced care planning, you know, really specific issues that are highly important to older adults. And so, they give you, again, a more patient centered really and specified way of evaluating this patient population in the context of issues that really matter to them. I think that's the real, maybe that's the punchline, that's the real value, is that within the ACS NSQIP at large, you can look at things like surgical site infection and readmission, and all those things. But the Geriatric NSQIP Collaborative provides access to really what matters to these patients. And they relate to things like, did they get a new mobility aid after surgery? Did they have a mobility aid when they came in from surgery? What's their functional status? Where are they at one month after surgery? Are they at a rehab facility or are they at home? Those kinds of things that I think are just really highly relevant to this population.

CLOSING REMARKS

Michael Bencur [00:13:06] Yeah, definitely. Well, thank you so much for being here today, Dr. Peters, and sharing your experience with the data collection components of the GSV Program.

Xane Peters [00:13:15] Yeah, thanks so much for having me. I really appreciate it. Always happy to talk about this stuff.

Michael Bencur [00:13:19] Dr. Peters' email is up on the screen if you'd like to reach out to him with any follow-up questions. And then I hope you all have learned as much as I have today. If you would like to share your GSV implementation strategies, please don't hesitate to reach out to me at mbencur@facs.org. Thank you.