Geriatric Surgery Verification
American College of Surgeons

GSV Insight: Data Collection and Review

Susan Gearhart, MD, FACS
Interim Chief of Colorectal Surgery; Associate Professor of Surgery

INTRODUCTION

Michael Bencur [00:00:10] Hello and welcome to GSV Insight. Today let's talk about data collection and review. My name is Michael Bencur. I am the Geriatric Surgery Verification Project Manager, and today I am joined by Dr. Susan Gearhart. Welcome, Dr. Gearhart.

Susan Gearhart [00:00:27] Thank you.

Michael Bencur [00:00:28] Can you tell us a little bit about yourself and your background?

Susan Gearhart [00:00:31] Yeah. Good morning, Michael. Yes, I am Susan Gearhart. I'm Associate Professor of Surgery and I'm currently the Division Chief for colorectal surgery at Johns Hopkins. My clinical practice is located at Johns Hopkins Bayview Medical System Center, which is within the Johns Hopkins Health System. It is a 420-bed hospital with a level two trauma center and a regional burns center. And I have dedicated the last decade of my life to implementing quality programs at Johns Hopkins Bayview. And the Geriatric Surgery Verification Program has been one of the most gratifying programs that I have been involved in. And I'm fortunate to work with an amazing team of geriatricians at Bayview and a fun fact, the Bayview Campus is home to the National Institute of Aging.

Michael Bencur [00:01:21] Wow, very interesting. Well, thank you.

QUESTION #1

Michael Bencur [00:01:21] Wow, very interesting. Well, thank you. So moving on to our questions, for Standard 6.1 - Data Collection and Review, can you describe the key steps taken to implement a practice for data collection and review, which meets the GSV standards, and that includes planning meetings, creating task forces, how you obtained buy-in from key participants?

Susan Gearhart [00:01:45] Yeah, this was a big initiative that did take quite a bit of work, but to start with myself and our surgical, Geriatric Surgery Coordinator, Dianne Bettick, began meeting together and looking first at creating a spreadsheet of the standards and determining what data points needed to be tracked to examine our compliance and determine what outcome metrics are necessary for the GSV Standards. We then analyzed what our current documentation is in our EMR, we use Epic, and we looked at what areas we were able to capture in Epic and what areas needed to be added and what outcomes we were able to obtain from Epic and what needed to be added. When doing this process, I think one of the biggest ones we realized we were not completely able to capture was delirium. And I'll talk a little bit more about that later and how that process went into implementing a delirium screen.

So once we completed our list of what we needed, we then went ahead and approached hospital leadership. And prior to doing this, we did work with the Geriatric Surgery Verification Program closely because I think they added a lot of resources and assets to us before we went to leadership. We also talked

with different stakeholders, our institution, that we felt would be important in our approach to leadership. And our request was that they would help us with EMR build by supplying us with IT support. And the support would be not only to build our metrics into the EMR, but also allow us to build a dashboard in which we could collect and capture all of the necessary components of the GSV in one place. And this would also give us the ability to do real-time data monitoring in review. So when you build something into Epic or your EMR, it often requires approval from different committees. So we had to go to all the different committees, including ambulatory committees, nursing committees, pharmacy, periop, and once that committee approved the changes to our EMR, we had to obtain Epic support or IT support to incorporate the build. Incorporating the build required you to make sure it fit with workflow to whomever would be using the EMR. And then we had to develop some education around that workflow. And then finally we had to just look at the data and made sure it was a valid data that we were capturing.

With regards to data review, we had to really develop an easy and consistent way to visualize our data for presentation that aligned with how different forms of data were being presented already at many of the meetings that we host at Bayview, we had several pre-meetings to review data prior to presentation. We selected specific venues to present at venues that would be important for us to share our work with, and would expect to get feedback back about what things we were doing, specifically something like OR committee or peri-op meetings or joint practice committee meetings, specific meetings with different multidisciplinary teams including like neurosurgery, orthopedics, urology, gynecology. All those required us to really make sure they were aware of what we were doing and what data we'd be able to provide back. I think it was also important to be in tune with what the institution was, the goals they were trying to achieve. We had a big push for reduction length of stay about a year ago. And so we made sure that that data was available from our GSV and our geriatric surgery work, when we would provide our data for review. And then I think finally what was also helpful is that when we built our dashboard and our data processing methods, we wanted to make sure that that data could then be translated into work that we could disseminate for publication.

QUESTION #2

Michael Bencur [00:06:15] Great. That's a lot of work. And who was involved in implementing the standard and how long did that take?

Susan Gearhart [00:06:22] So, I think as you can see from the my initial description of the key steps that there were several different groups of people that we interacted with. But I think the most important take back about how to, who was involved and how to implement was that you really need a full-time person to keep track of where things were in the process of implementation. Someone who would email committee members to make sure they had all the appropriate information for review, for putting things into our EMR, someone to reexamine and evaluate workflow and someone to really look at the validity of the data that we were pulling. And then about how long did it take? You know, I think this process, if I were to say the startup bit took about two years to get through this, but it's really an ongoing process. It's not ever really done. There are times when things need to be modified and corrected as we get feedback. One of the things that just for instance we are doing is that we do have a high-risk screen. And, you know, due to the changes in workflow and personnel, we needed to go to a more self-reported version. So that goes through MyChart and then that has to be updated into our dashboard. So all that processes just keep going. So, I don't really ever think it's ever done, but to get it started it probably took about two years.

QUESTION #3

Michael Bencur [00:07:48] Sure. Great to know. And whom did you identify as important individuals to share data and review metrics?

Susan Gearhart [00:07:56] Yeah, this was something we thought quite a bit about when we, Dianne, who works closely with me, we together implemented our enhanced recovery after surgery program several years ago. And we learned from that experience that really providing frontline individuals, nursing, and other providers with the data as real time as possible is extremely helpful in motivation and in their engagement. We would share some of the outcomes in morning huddles. We would give call outs and I think that's one of the key areas that we often forget, but is absolutely necessary. We also chose to share our data on a joint practice meeting, which is sort of our perioperative joint practice group that meets monthly. This has a lot of key stakeholders who help us do what we do to improve geriatric care. And so we built in a geriatric dashboard review on that monthly meeting. This also has, is a meeting where the minutes are recorded. And so it met some of the criteria for the Geriatric Surgery Verification process. We did meet with hospital leadership initially. It was quite frequently we met with case management leadership, quality leadership, and then our educational leadership. And now it's more on about every six month interval that we meet with them, but more so we are interacting with a multidisciplinary teams. We've now become a hospital that's going forth with the Age-Friendly initiative. And so, it's much more multidisciplinary meetings that we have now to keep moving forward with our GSV.

QUESTION #4

Michael Bencur [00:09:45] It sounds very integrated. And were there any barriers or setbacks to implementation and what were the solutions to those barriers?

Susan Gearhart [00:09:53] Yeah, so, our largest barrier I think right off was the lack of a delirium screen, which I mentioned before. And just getting that implemented was an amazing feat. We in initially had to go through all the process measures that I mentioned before, but it really wanted to be a hospital-wide program, and then a system-wide program. So it took about two years for us to get that through. And I'll talk a little bit about some of the issues when we talk further. The other issue, which I think a lot of people struggled with, was the fact that we had a lot of critical people who redeployed during COVID. We lost our IT support because they were building COVID alerts and order sets, et cetera for our EMR. So I think those were the two biggest barriers to implementation that I can share with you.

QUESTION #5

Michael Bencur [00:10:50] Great. And then on that note, what are some tips for other hospitals that may be struggling to implement this standard?

Susan Gearhart [00:10:57] Yeah, so, I think one of the things that we have learned probably more slowly than we had wished was just how important it is to educate, educate, educate. When we built the delirium screens and put them into process, we actually didn't realize that there was nothing that the nurses knew what to do with when it was a positive screen. Luckily we had a lot of nurses that were trained to be geriatric resource nurses, so had great ideas of how to interact and actually came together and created a delirium protocol so that now there is a protocol of what to do if a delirium screen is positive and who to notify and how to do the non-pharmacological approaches to taking care of patients who have delirium. We do also know that one of the big struggles we have is many of the EMRs that we all work with have different phases of care. And because the Geriatric Surgery Verification Program is a program that has a preoperative stage, intraoperative, postoperative care stage and discharge stage, it's important to make sure that the information that you're trying to gather and put into your EMR follows those different stages of care and can be followed across all different platforms for your EMR. I do think making sure that the flow

is appropriate for frontline providers is very, very important. And that's almost a full-time job in itself to make sure that the documentation's correct because that's what provides us with the data that we can use to make improvements. And I guess the number one tip I really want to share with everyone is really involvement with the Geriatric Surgery Verification Program. There's a wealth of information that can be gathered by being a part of the GSV, for example, these podcasts. And so if you are thinking about getting into geriatric surgery care, I would really highly recommend you get involved with the GSV.

CLOSING REMARKS

Michael Bencur [00:13:09] Well, that was wonderful. Thank you so much, Dr. Gearhart, and Dr. Gearhart's contact information is up on the screen if you would like to reach out to her with any further 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.