



Society of Thoracic Surgeons

General Thoracic Surgery Database
Monthly Webinar

October 12, 2022



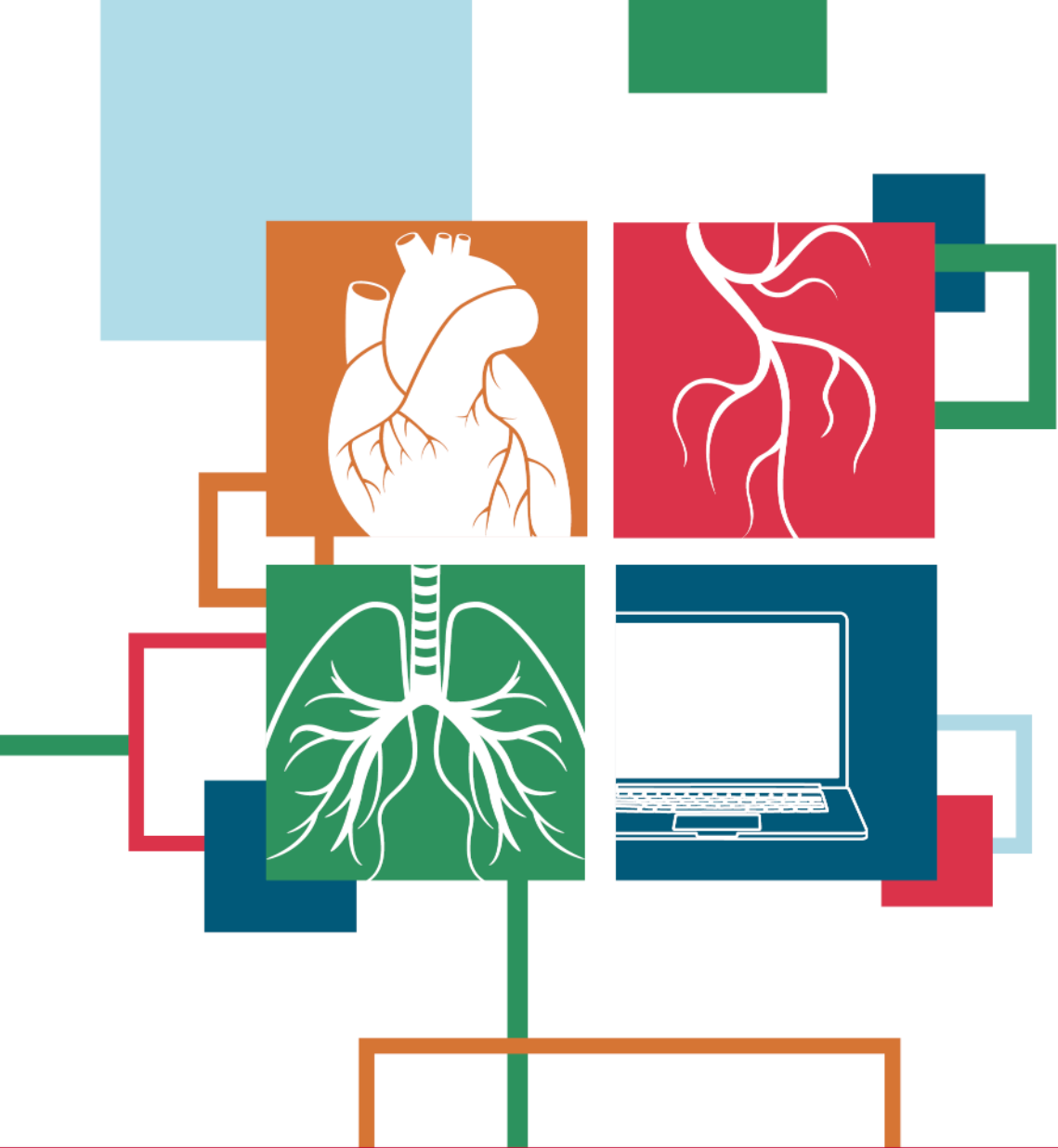
GTSD Monthly Webinar

- Welcome and Introductions
- STS Update
- Education (Ruth Raleigh)
- User Feedback
 - Include Ticket Number/Case Number



STS Updates

- **October Training Manual to be posted by end of this week**
- **New Data Manager Webinar Rescheduled!!!**
 - OUR SINCERE APOLOGIES
 - To be held **Wednesday, October 19th @ 2:30CT**
- **Fall 2022 Harvest in Analysis**
 - Analysis results expected in November
 - Participants will be notified when available
- **Spring 2023 Harvest Underway**
 - Spring and Fall 2023 Harvest close dates to be posted soon
 - Spring 23 Reporting period: 1/1/2020 – 12/31/2022
 - Fall 23 Reporting period: 7/1/2020 – 6/30/2023
- **IQVIA Platform Access**
 - Adding new user accounts or deactivating current user access
 - Complete the STS Participant Contact Form (<https://www.sts.org/sts-participant-contact-form>)
 - Contact STSDb@sts.org for assistance



ADVANCES IN QUALITY & OUTCOMES: A Data Managers Meeting

October 26-28, 2022 ■ PROVIDENCE, RHODE ISLAND



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ADVANCES IN QUALITY & OUTCOMES: A Data Managers Meeting

October 26-28, 2022 ■ PROVIDENCE, RHODE ISLAND

AQO Registration is Open!

Receive Early Bird Registration Pricing through Friday, August 26.

STS MEMBER	Early Bird (August 26, 2022)	Standard
One Track	\$550	\$650
Two Tracks	\$900	\$1,100
Multi-Day (Three Tracks)	\$1,150	\$1,450
Virtual Pass	\$300	\$300

NON-MEMBER	Early Bird (August 26, 2022)	Standard
One Track	\$650	\$750
Two Tracks	\$1,100	\$1,300
Multi-Day (Three Tracks)	\$1,450	\$1,750
Virtual Pass	\$400	\$400



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Wednesday, October 26, 2022 – General Thoracic Session

	In Person	Virtual Pass
• In-person sessions with live Q&A	✓	
• On-demand content (available mid-October)	✓	✓
• Recorded archive of in-person sessions (available mid-November)	✓	✓
• Breakfast, lunch, and refreshment breaks	✓	
• Personal interactions and networking with peers	✓	
• Networking Reception with speakers, vendors, and colleagues	✓	
• Face-to-face time with exhibitors	✓	
• Complete exhibitor listing	✓	✓
• Exhibit Hall giveaways and Passport to Prizes	✓	
• AQO Hot Topics Webinar (in January)	✓	✓
• Digital conference materials (PowerPoint presentations, handouts, and case scenarios)	✓	✓
• Opportunity to view and vote on your favorite e-poster	✓	✓
• Continuing Education/CEU Credits	✓	✓
• Explore the sights and sounds of Providence, Rhode Island	✓	



**The Society
of Thoracic
Surgeons**

**ADVANCES IN QUALITY & OUTCOMES:
A Data Managers Meeting**
October 26-28, 2022 ■ PROVIDENCE, RI



- Educational sessions and social events will take place at the Rhode Island Convention Center (1 Sabin St, Providence, RI 02903).
- A block of rooms have been reserved at the Omni Providence Hotel (1 West Exchange St., Providence, RI 02903). The special AQO group rate of \$259, plus state and local taxes, is guaranteed through **Tuesday, October 18**, or until the group block is sold out.
- [Reserve online](#)
- Call 401-598-8000. Be sure to reference “AQO” or “Advances in Quality and Outcomes.”



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STS Education
Ruth Raleigh
(GTSD Consultant,
Trinity Health)

ECOG Scores

The frequency of ECOG scores not being reported has significantly increased

ECOG score IS still used to risk-adjust cases

When left blank, ECOG is imputed as 0 (i.e. lowest risk possible)

This is potentially decreasing the star-rating at sites, surgeons are not getting 'credit' for operating on patients that do not have optimal functional status when ECOG is left blank



ECOG Scores

- Discuss importance of documented ECOG with your surgeons
- Add ECOG to H&P templates
- Remember, ECOG can be documented by any clinician that has assessed the patient – perhaps another office clinician besides the surgeon is more optimal at your site
- Zubrod or Karnofsky Scores can be crosswalked to ECOG – your site just needs to use the same tool to crosswalk all cases



Documentation of Death after 30 days

Sites are not **REQUIRED** to track patients after 30 days from discharge (unless they are discharged to hospice in which case you must track patients until death) however, many sites like to enter mortality information if death known. This practice will not alter mortality data reported for your site.



Statistical Analysis of Operative Mortality



- Data managers should faithfully follow STS directions for the two Status fields. STS GTSD Operative Mortality outcome is currently defined as either MtDCstat or Mt30stat indicating death.
- MtDCstat = 'discharge alive, died after discharge' entry is a live discharge and will NEVER be counted as Operative Mortality without additional evidence. The patient with this status will be registered as 'Alive' at discharge and the Operative Mortality algorithm will go on to examine the second criterion – is Mt30stat indicating death?

Statistical Analysis of Operative Mortality

For patients that died more than 30 days after surgery – Mt30stat is coded as alive.

The mortality date in seq 4300 does not factor into inclusion as an operative mortality. The date of death should be recorded here.



Statistical Analysis of Operative Mortality

SeqNo: 4220

Long Name: Hospital Discharge Status

Short Name: MtDCStat

Format: Text (categorical values specified by STS)

Definition: Indicate whether the patient was alive or dead at discharge from the hospitalization in which the primary surgery procedure occurred.

ParentLongName: Patient Is Still In Hospital

ParentShortName: StillInHosp

ParentValue: 2

ParentHarvestCodes: = "No"

Harvest Codes:

<u>Code:</u>	<u>Value:</u>
3	Discharged Alive, last known status Alive (other than hospice)
4	Discharged Alive, died after discharge
5	Discharged to Hospice
6	Died in Hospital

Statistical Analysis of Operative Mortality

SeqNo: 4300
Long Name: Mortality Date
Short Name: MortDate
Format: Date in mm/dd/yyyy format

Definition: Indicate the patient's date of death (even if after discharge).

ParentLongName: Hospital Discharge Status
ParentShortName: MtDCStat
ParentValue: 4|5
ParentHarvestCodes: = "Discharged Alive, died after discharge" or "Discharged to Hospice"

Intent/Clarification:

SeqNo: 4310
Long Name: Status 30 Days After Surgery
Short Name: Mt30Stat
Format: Text (categorical values specified by STS)
Definition: Indicate whether the patient was alive or dead at 30 days post surgery (whether in the hospital or not).

Harvest Codes:

<u>Code:</u>	<u>Value:</u>
1	Alive
2	Dead
3	Unknown

Intent/Clarification:

[This field is required for record inclusion. If missing data, the entire record will be excluded from the analysis.](#)

What About Hospice Patients?

- The training manual is explicit – follow the directions exactly and the operative mortality will be recorded regardless of date of death. This is intentional.

SeqNo: 4200

Long Name: Patient Is Still In Hospital

Short Name: StillInHosp

Format: Text (categorical values specified by STS)

Definition: Indicate if, at the time of data submission, the patient remains an inpatient in the hospital.

Harvest Codes:

Code: Value:

1 Yes

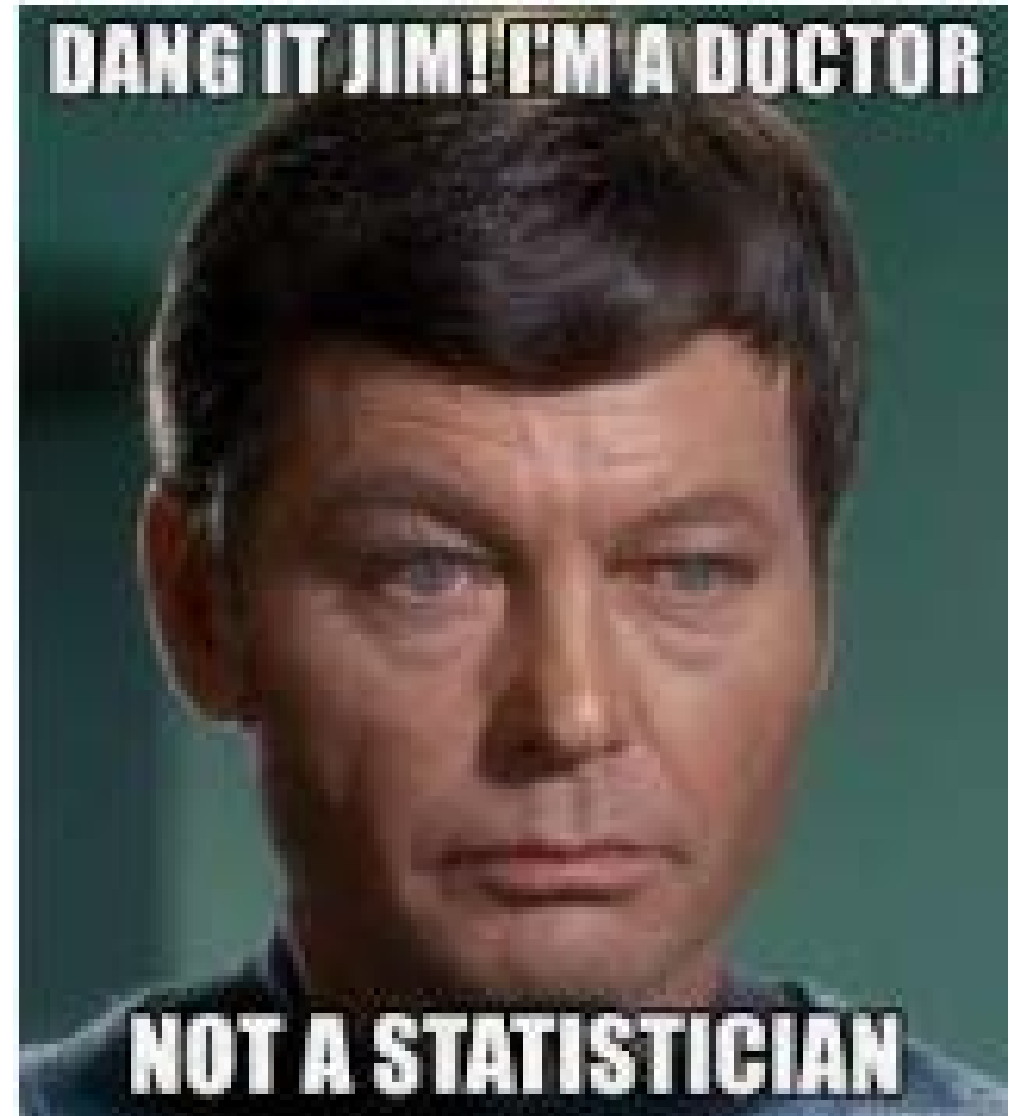
2 No

Intent/Clarification: Indicate if the patient remains in the acute care setting following the index operation. This field is the parent to the discharge/mortality section. Answering 'yes' will not allow you to answer the discharge/mortality questions and will remove the case from analysis.

Starting with version 5.21 - Patients discharge to hospice are considered an operative mortality, regardless of date of death. For patients discharged to hospice, code still in hospital (StillInHosp – seq 4200) = 'yes' until the patient expires. Then code MtDCStat (seq 4200) = Discharged to Hospice AND MortDate (seq 4300) with date of death.

Primary Category of Disease and Why it Matters

While looking at the harvest file it was noted that more than 4% of patients with EsophCancer='Yes' or LungCancer='Yes' along with qualifying **Primary Procedure** for the cohort are excluded from the current GTSD analyses because they don't have a qualifying CategoryPrim code.



Let's Dig Into the Data: Lung

Description	nRows
Solitary pulmonary nodule (not a tumor, e.g., granuloma, subpleural lymph node, pulmonary infarct) (R91.1)	578
Other unlisted category of disease	416
Lung tumor, metastatic (C78.00)	291
Lung tumor, benign (e.g., hamartoma) (D14.30)	94
Abnormal radiologic finding (R91)	75
Malignant poorly differentiated neuroendocrine carcinoma, any site (C74.1)	34
Interstitial lung disease/fibrosis (J84.1)	19
Lung nodule/Mass/Other disorders of lung (J98.4)	17
Pneumonia (J18.9)	14
Non-Hodgkin Lymphoma, intrathoracic lymph nodes (C85.92)	12
Pulmonary sequestration (Q33.2)	8

Let's Dig Into the Data: Esophagus

Description	nRows
(Esophageal Cancer) Malignant neoplasm of the esophagus, unspecified (C15.9)	143
	20
Barrett's esophagus with High Grade Dysplasia (K22.711)	15
Lung cancer, lower lobe (C34.30)	11
Esophageal tumor-benign (i.e., leiomyoma) (D13.0)	11
Barrett's esophagus (K22.70)	7
(Stomach Cancer) Malignant neoplasm stomach unspecified (C16.9)	7
Barrett's esophagus with High Grade Dysplasia (K22.711)	5
(Esophageal Cancer) Malignant neoplasm of the esophagus, unspecified (C15.9)	5
Achalasia of esophagus (K22.0)	5
Esophageal stricture (K22.2)	4

Let's Review: When to Code Primary Lung Cancer Resection Performed

V5.21.1 LungCancer (SeqNo. 1510)

Definition: Indicate whether a major lung resection was performed for a primary lung cancer (e.g. wedge, segment, lobe, pneumonectomy), open or VATS.

Intent/Clarification: Only primary lung cancer resections are to be entered in this field. A primary lung cancer is a tumor that originated/started in the anatomical location of the lung where surgery is being performed.

If 'yes,' please complete section F.

There are two reasons for performing procedures: diagnostic and therapeutic.

Diagnostic resections are those procedures intended to confirm a diagnosis or to better understand the disease process and **are not captured here.**

Therapeutic procedures are performed to treat the disease and **are captured here.**

Differentiating between diagnostic and therapeutic intent can be difficult. If you are uncertain, [please submit a clinical question for guidance.](#)

Let's Review: When to Code Primary Lung Cancer Resection Performed – Cont'd

V5.21.1 LungCancer (SeqNo. 1510)

Mar 2022: In the case where a therapeutic lung resection is performed for recurrent lung cancer, code 'no' to seq 1510. The intent of seq 1510 is to capture data on NEW primary lung cancer resections.

Apr 2022: Surgical resections of a lung cancer previously treated with SBRT/CyberKnife are not NEW lung cancer resections. Code 'no' to 1510.

Apr 2022: Lobectomy after prior same lobe segmentectomy for recurrent lung cancer is not NEW lung cancer. Code 'no' to 1510. For example, code 'no' to 1510 for a LL Lobectomy performed in 2022 for recurrent lung cancer that was resected via LLL segmentectomy in 2020.

Apr 2022: Lung resection completed for adenosquamous lung cancer, after lung resection for adenocarcinoma years prior is a NEW second primary lung cancer. Code 'yes' to 1510.

July 2022: Given clarification provided in March that the intent of seq 1510 is to capture data on NEW primary lung cancer resections and that 'no' should be coded to seq 1510 for recurrent lung cancers, sites are not required to abstract cases performed for recurrent lung cancer. The STS General Thoracic Registry version 5.21.1 requires submission of all lung resections for NEW primary lung cancer.

July 2022: Code 'yes' to 1510 for new primary carcinoid tumors of the lung that are therapeutically resected.

July 2022: If a new primary lung cancer is therapeutically resected, it must be captured. For example, patient had a pneumonectomy for recurrent infections – on final pathology the patient had adenocarcinoma staged mpT1 apN0. This case is required for entry.

Aug 2022: There is not currently a separate code for a VATS/RATS approach to sleeve lobectomy, please use removal of lung, sleeve lobectomy (32486) for all surgical approaches to sleeve lobectomies.

Aug 2022: If a wedge resection is completed for a new primary lung cancer – it can be either therapeutic or diagnostic depending on the extent of the disease at the time of resection. If you are unsure, it is helpful to discuss with your surgeon and document your conversation for your records.

Let's Review: When to Code Esophageal Cancer Resection Performed

V5.21.1 EsophCancer (SeqNo. 1530)

Definition: Indicate whether an esophagectomy was performed for esophageal cancer.

If yes complete clinical and pathological staging.

Intent/Clarification: Only primary esophageal cancer resections are to be entered in this field. A primary esophageal cancer is a tumor that originated/started in the anatomical location of the esophagus where surgery is being performed.

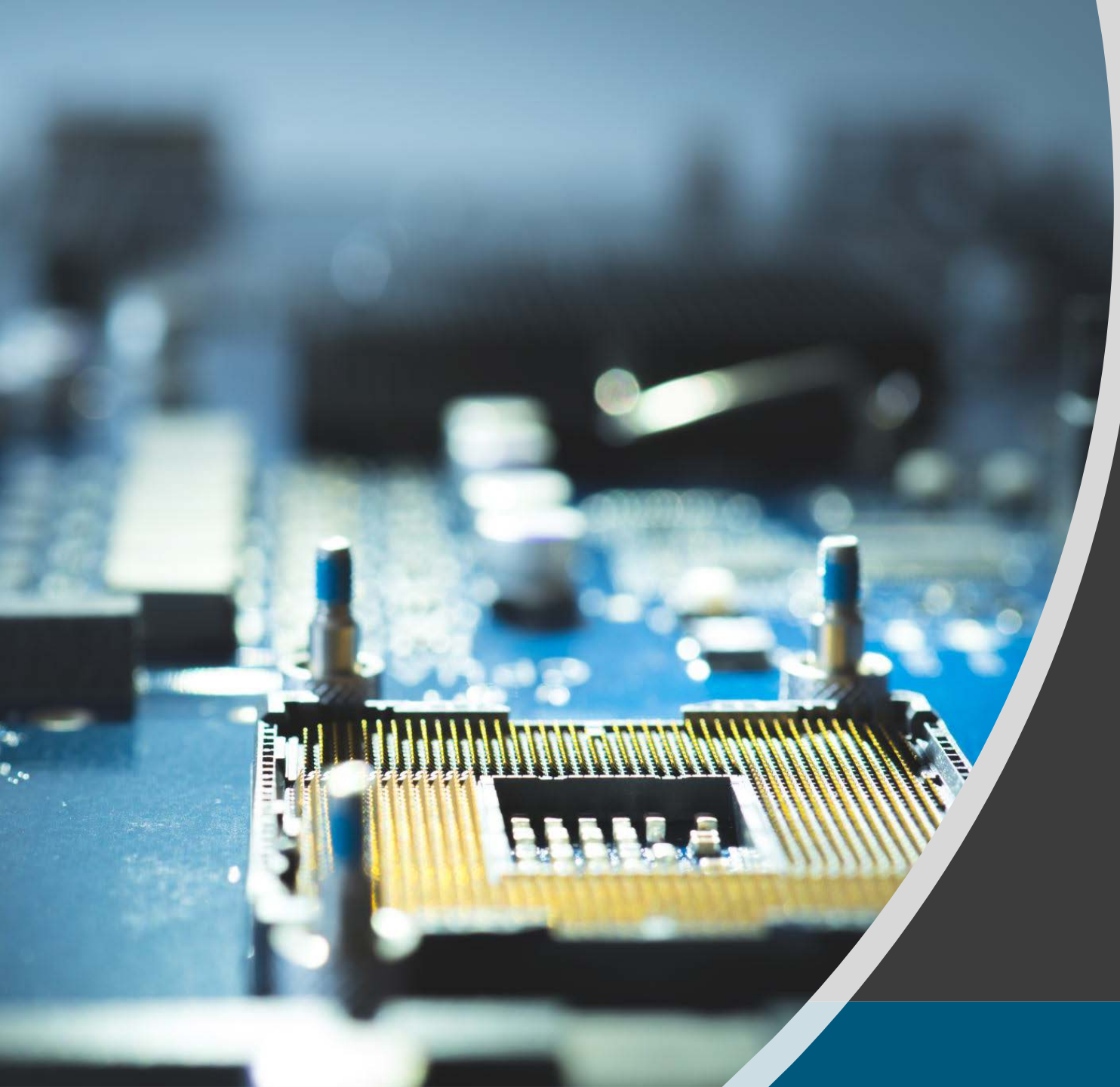
If 'Yes,' please complete section G.

Esophagectomies are sometimes performed for benign disease. **These procedures are not captured here.**

If you are uncertain whether an esophagectomy is required for entry in the database, [please submit a clinical question for guidance.](#)

June 2022: In the case where a therapeutic esophageal resection is performed for recurrent esophageal cancer, code 'no' to seq 1530. The intent of seq 1530 is to capture data on NEW primary esophageal cancer resections.

Sept 2022: Esophageal cancers that have been previously resected via EMR that are subsequently followed by esophagectomy are to be captured as new primary esophageal cancer resections.



IQVIA Review

Joe Brower

IQVIA Update

Please note: Submitted tickets are currently under review and the IQVIA support team will follow up on resolution and/or target release confirmation.

The IQVIA Team is currently reviewing items to be targeted for an upcoming release. Those items will be posted to the Notifications section.

Contact Information

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Database Operational
Questions

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Upcoming GTSD Webinars

New Data Manager Webinar

- October 19 @ 2:30CT

Monthly Webinar

- November 9 @ 1:30CT



Open Discussion



PLEASE USE THE Q&A FUNCTION.



WE WILL ANSWER AS MANY
QUESTIONS AS POSSIBLE.



WE ENCOURAGE YOUR FEEDBACK
AND WANT TO HEAR FROM YOU!



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THANK YOU FOR JOINING!