Michigan Vascular Society
Vascular Study Group Meeting

Thursday, May 14, 2015
Amway Grand Plaza, Grand Rapids, MI, 12:00 – 5:00 PM

Minutes

Attendees:

Alex Shepard, MD (Medical Director)	Henry Ford Hospital
Loay Kabbani, MD	Henry Ford Hospital
Kathy Jevons	Henry Ford Hospital
Ryan Shelters, Quality Analyst	Henry Ford Hospital
Kim Finch	Henry Ford Hospital
Sachinder Hans, MD	Henry Ford Macomb
Eugene Laveroni, MD	Botsford Hospital
Rob Molnar, MD	McLaren, Flint
Stephens Taylor, MD	McLaren, Bay City
Peter Henke, MD	Univ of Michigan Medical Center
Nick Osborn, MD	Univ of Michigan Medical Center
Matthew Jonovich, MD	Allegiance Health
Paul Bove, MD	Beaumont, Royal Oak
Ash Mansour, MD	Spectrum Health System
Robert Cuff, MD	Spectrum Health System
Krishna Jain, MD	Borgess Medical Center
John T. Morris, DO	Mercy Health St. Mary's
John Gribar, MD	Holland Hospital
Dale Leffler, DO	Sparrow Hospital
Brian Halloran, MD	St. Joseph's Mercy Ann Arbor
Vernon Dencklau, DO	St. Joseph Mercy Port Huron
Phillip Goodney, MD (Guest)	Dartmouth
Matt Regan	M2S

I. Welcome: Peter Henke, MD /Alex Shepard, MD

II. BMC2 PCI-VIC Data : Henke
Review of statewide data in various general categories (e.g. CEA, CAS, lower extremity bypass) followed by a specific focus on EVAR and open AAA repair for both elective and ruptured cases.

III. National VQI Physician Updates: Shepard
A. New PSO Staff:
Dan Neal, M.S. as SVS PSO Analytic Director
Megan Mathy, PSO Administrative Support

B. New Reporting feature in the Analytics engine was discussed: The M2S Pathways Analytic Engine can now display variation across centers in the entire VQI or variation among participating centers in the regional quality group for the variables in each procedure module. Risk adjusted outcomes are available as well. In addition to variation amongst the centers the engine can also display variation among Physicians in their Center, and physician variation regionally and nationally.
C. TEVAR for Type B Dissection Project Update: 200 patients enrolled so far.
D. Lombard Aorfix Surveillance Project: Prospective, non-randomized, multicenter evaluation of the long term safety and effectiveness of the Lombard Aorfix AAA flexible stent graft system. Participants reimbursed for additional reporting requirements.
E. SVS willing to offer CME or self-assessment credits for regional VQI meetings. Discussed preferences amongst the group. Group would like both options if possible, otherwise self-assessment credits.

IV. Regional Data Review: Shepard

A. Currently nine participating centers: Newest members (Detroit Medical Center Harper Hospital and Henry Ford West Bloomfield) welcomed.
B. VQI Reports I – Center, region and VQI rate comparison:
    1. Long Term Follow Up (LTFU)

    Group Discussion:
        a. Although MVSG has one of the best LTFU rates in the VQI, this remains a significant problem for most groups.
        b. 80% follow-up at one year is the established benchmark – should it be adjusted? Probably not.
        c. Telephone f/u is helpful, but no replacement for face-to-face visit; it can also be abused.
        d. Required data fields necessary for some procedures (e.g. max sac diameter at 1 year after EVAR)
        e. Penalties for low performers and rewards for high performers?
    2. ASA and statin prescribed on discharge after arterial procedures – MVSG had the best rate of all the regional study groups.
    3. Chlorhexidine for skin prep for infrainguinal bypass – MVSG rate higher than VQI average, but not clear why it is not higher.
    4. In-hospital death, amputation, graft thrombosis after infrainguinal bypass for CLI – Same rate as VQI nationally.
    5. Mean ICA PSV for asymptomatic patients undergoing CEA
    6. *NEW REPORT* – Percentage of percutaneous femoral peripheral vascular interventions using ultrasound guidance (data for region not available as MVSG does not have 3 or more centers participating in this module)
    7. *NEW REPORT* – Operative time for elective CEA – Operative time for MVSG in upper range of study groups.
    8. *NEW REPORT* – Prophylactic IVC filter insertion (data for region not available as MVSG does not have 3 or more centers participating in this module)
C. VQI Reports II -- Risk-adjusted reports showing observed and expected rates over last 4 years, for key quality metrics: center, region and VQI:
    1. CEA stroke or death in hospital – primary, isolated, elective procedures
    2. CAS stroke or death in hospital – elective, primary, atherosclerotic procedures
    3. Open AAA repair mortality– death in hospital for non-ruptured procedures
    4. CEA LOS > 1 day – primary, isolated, elective procedures
    5. EVAR LOS > 2 days – non-ruptured procedures
    6. Open AAA LOS> 8 days – non-ruptured procedures
    7. For the MVSG, observed rates at or lower than expected rates in all reported measures except for the number of elective open AAA repairs with a LOS ≥ 8 days where the observed rate was slightly higher than the expected rate.

D. MVSG AAA Data: Summary of significant findings
    1. Elective AAA Repair
        a. EVAR: MVSG participants have a slightly lower rate of utilizing EVAR for elective AAA repair than nationally.
        b. Open repair: MVSG participants use suprarenal/supraceliac clamping more frequently than nationally with a slightly greater risk of renal dysfunction, but a lower overall mortality.
    2. Ruptured AAA Repair
        c. MVSG participants have good mortality rates for both EVAR and open repairs.
        d. Patients with ruptured AAA treated with EVAR in the MVSG have a lower discharge rate home and a longer LOS than nationally.

V. MVSG Committee Reports

A. Arterial Quality Committee Report: Shepard (for Dr. Shanley)
    1. Revised data collection forms for EVAR and TEVAR – significant concern re: the added time and complexity of the new data elements. Takes significantly longer to abstract and enter the data.
    2. M2S had been approved by CMS to be a QCDR (Qualified Clinical Data Registry) – This will allow VQI participants to meet PQRS (Physician Quality Reporting System) requirements for Medicare (to avoid payment penalties) using specific vascular surgery quality outcome metrics (e.g. statin and ASA at time of D/C, amputation-free survival at one year following lower extremity bypass for claudication).
    3. New COPIs in the works:
        a. Lower extremity bypass LOS.
        b. 1 year stroke/mortality after elective CEA/CAS.
        c. 1 year mortality after elective open AAA repair/EVAR.

B. Venous Quality Committee Report: Shepard (for Dr. Lin)
    1. IVC filter registry: 2312 procedures in 56 center; appropriate management of a retrievable filter now a CMS quality measure.
    2. Varicose vein registry: 20 centers contracted with 250 procedures entered in the first month. Collecting procedural and follow up data – 30 day and 1 year.

VI. Presentations from the Group

A. Popular Ratings of Vascular Surgery: Implications for Practice – Nicholas Osborne, MD, U of M Medical Center
B. Open Proximal Abdominal Aortic Aneurysms: Techniques and Outcomes – Loay Kabbani, MD, HFH
C. Fenestrated Endovascular Aneurysm Repair (FEVAR) – Robert Cuff, MD, Spectrum Health

VII. Research Advisory Committee Report: Henke / Shepard (for Shanley)

A. Regional QI project discussion
    1. Reducing Radiation exposure during EVAR
    2. Socioeconomic status and the effect on outcomes
    3. Reducing CIN (Contrast Induced Nephropathy)
    4. SSI reduction after infrainguinal bypass.
B. Comments by Dr. Goodney, Chair of the national VQI Research Advisory Committee

VIII. Discussion – Group

Proposed topics for next meeting: Contrast induced nephropathy, SSI after infrainguinal bypass

IX. Meeting adjourned

Next Meeting on September 24, 2015 in conjunction with MVS meeting at Hotel Baronette, Novi, MI

Submitted by Alex Shepard