MEETING: Midwest Vascular Collaborative Biannual Meeting
DATE: 05/15/15
TIME: 10:00 AM
LOCATION: IU Health Neuroscience Center Auditorium- GH1030, Indianapolis, IN

	Present:				
✓	Aasar, Sami MD	✓	Dalsing, Michael MD	✓	Martens, John MD
✓	Ali, Mir Ishti MD	✓	Devarapalli, Sai MD	✓	Motaganahalli, Raghu MD
✓	Agarwal, David M. MD	✓	Dilley, Russell MD	✓	Saleemi, Lisa
✓	Aumillr, Ben	✓	Forrest, Leslie	✓	Simmonds, Sherry
✓	Baker, Mary	✓	Gardner, Adairius	✓	Stopper, Cheryl
✓	Bennett, Marci	✓	Garver, Alicia	✓	Vasquez, Ricardo MD
✓	Brassfield, Julie	✓	Glover, Julie	✓	Webb, Thomas MD
✓	Butty, Sabah MD	✓	Hoene, Amy	✓	Weiler, Barb
✓	Camino, Lillian	✓	Kiell, Charles MD	✓	Wollenhaupt, Sandy
✓	Casciani, Thomas MD	✓	Lemmon, Gary MD	✓	Zwinski, Robin
✓	Colich, Karen	✓	Lyon, Audrey		
✓	Cooper, Jeremiah	✓	Maddox, Kathy		
	Guest:				
✓	Enright, John	✓	Mundt, Kelly	✓	Stanfield, T. Mark MD
✓	Goltz, Chris MD	✓	Njoku, Victor	✓	Wang, Casey
✓	Helms, Tricia	✓	Regan, Matt		
✓	Jackson, Cheryl	✓	Roach, Tim		

TOPIC	DISCUSSION	ACTION/ FOLLOW-UP
Call to Order	The meeting was officially called to order at 10:00 am by Gary Lemmon, MD.	None needed.
Welcome Introduction Gary Lemmon, MD	Dr. Lemmon opens with a welcome and reviews housekeeping items and CME instructions. This activity has been approved for *AMA PRA Category 1 Credit™* by Indiana University School of Medicine. MVC Mission Statement is reviewed and officers for the new term (2015-2016) are recognized along with Executive Committee Members. Members are asked to pause for a moment of silence in remembrance of MVC member, Dolores Cikrit, MD, who passed March 25, 2015.	None needed.

National VQI Update - Michael Dalsing, MD (IU Health Methodist Hospital)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
Participating centers, regional groups and total procedures	Dr. Dalsing shares that National Vascular Quality Initiative (VQI) has expanded to 334 Centers participating in over 45 states including Ontario Canada. VQI is in all but 3 states, within the continental states. National VQI total procedures entered into the VQI registry, as of 4/1/2015 is 205,029 cases. There are currently 18 regional quality study groups.	

National VQI Update - Michael Dalsing, MD (IU Health Methodist Hospital)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
New VQI Staff	Analytic Director - Dan Neal, MS from Florida. Quality Director - Nadine Caputo. Administrative Support - Megan Mathy. Megan is full-time and is based in Chicago.	
Analytics Engine: New Report Feature	Powerful tool with report feature can provide variation across centers in VQI or in a region. Can also show variation at the physician level. • Access demo from link https://vqidemo.m2s.com. **User ID**: Databasedemo **Password**: Quality1# • 2 Additional Reports - IVC Filters – user can look at percentage placed on prophylactic indications - Variation in operation time for CEA (elective only)	
TEVAR 1 Year Project	This is a project on aortic dissections for TEVAR. 200 patients enrolled. Reimbursement is $400 for each procedure with a completed 1-year follow up. Reimbursement will be released once the 1 year follow up form is submitted and all associated data inquiries have been addressed/resolved. All reimbursements are disbursed quarterly by the SVS PSO to the designated entity in the contract addendum. Contact Information: • Send all TEVAR Aortic Dissection project related communication to TEVARProject@m2s.com • Send all Non-project related communications/questions to PathwaysSupport@m2s.com or call 603.298.5509 x392	
Lombard Aorfix Surveillance Project	Data used as a post-market surveillance. This project involves an endovascular infra-renal device that is suggested to go into very tortuous vessels; up to 90 degrees off the renals and flexible enough in the iliac system to help maintain its positioning. This is unique in that the company is using the M2S core lab to capture actual imaging data (funded by the sponsor.) • 234 patients enrolled • $1300 reimbursement for initial procedure • $400 for follow up. • Each re-intervention procedure post discharge is $700 reimbursement. • Evaluating freedom from aneurysm-related mortality based on follow up at 30 days post-index procedure and annually through 5 years Contact Information: • Send all Aorfix Project project related communication to Aorfix project@M2S.com or call Elizabeth at 603.298.5509 ext. 337 • Send all Non-project related communications/questions to PathwaysSupport@m2s.com or call 603.298.5509 x 392 • Send All DAC related communications to dac-support@m2s.com or call 603.298.5523	
Regional Update	MVC currently has 17 participating centers from within the metro system of Indianapolis, a few at outlier facilities and scattered throughout the state and four centers in Kentucky. To date our region has collected over 7500 procedures in the VQI registry, as of April 1, 2015.	
CME or Self-Assessment MOC	SVS is looking at sponsoring CME credits. Members indicated this is a perk and of value. Physician members prefer the meetings offer MOC's.	Lisa to report feedback to Carrie Bosela

Long-Term Follow-Up - Gary Lemmon, MD (IU Health Methodist Hospital)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
Regional LTFU	Participants reviewed why Long-term Follow-up (LTFU) is important. LTFU has impacted care. As it relates to research, LTFU data is used to analyze and ensure data is reliable. Region LTFU – 2012: 67%; 2013: 37%. Other quality database systems use a 30 day follow-up form. VQI requires a 1 year follow-up – anywhere from 9 mos. – 21 mos. LTFU threshold is 80% and distinguishes VQI form all other databases. 80% was determined by VSGNE and endorsed by JVS. Members need only provide one follow-up, to meet the requirement. There is a great deal of variation in the Midwest study group. Between 2012 and 2013, the Midwest region has increased the number of procedures in the region. As the number of procedures has increased, the number of LTFU has decreased by half. In the case of VQI, over all, the actual percentage of follow-up has also decreased. The on-going challenge is to exceed 80%. The Midwest region is meeting 40-50% on some of our best modules. Upper Midwest study group hospitals are close to meeting the 80% threshold because they employ 2 FTE dedicated to completing follow-up forms and enter info registry. Not all have this luxury. Members discussed whether the 80% goal is a realistic and worthwhile goal. Thoughts from participants: • This may be a patient education issue – physician may not be doing a good enough job, on the front end, to inform the patient why it's important they return for a follow-up and/or a follow-up is performed. • If window for FU has not closed, patient should be excluded from analysis, if repeated efforts to contact them has resulted in patient refusal to return • 82% of members agree that 80% rate for LTFU is acceptable • Overall agreement that telephone is not a sufficient for follow-up with patient. Telephone follow-up may provide some value. Phone contact may stimulate an office visit. • 100% agree telephone call for EVAR and LEBPG follow-up, alone, is not sufficient • Overall agreement that telephone follow-up benchmark should be somewhere between ≤ 10-20% • Overall agreement that 50% is reasonable benchmark for telephone follow-up's 50% <u>Low/High Performers (LTFU):</u> • Overall agreement that members should not be penalized for low performance with LTFU but use of data should be limited • Overall majority think [LTFU] data should be included in reports or analysis for low performers. Members question whether this would falsely make data look better to exclude low performers outcomes from regional report <u>Low/High Performers (LTFU):</u> • 54% of members surveyed agreed low performers shouldn't be excluded from participating in research projects and committee work. • 63% of members were surveyed and voted that high performance should be defined as 90% participation • 69% agree high performers should receive some form of accolade. Members did not discuss what would be the award. Results from each regional group will be shared and voted on, during the VAM meeting in June.	Lisa to report feedback to Carrie Bosela

Arterial Quality Committee Update – Charles Kiell, MD (Franciscan St. Francis Hospital-Indianapolis)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
QCDR Measures Center Opportunity Profile for Improvement (COPI) Studies	QCDR: Due to pressure and lobbying from specialty societies (including SVS), CMS created a program where vendors could apply and become QCDR's, allowing them to submit measures specific to their specialty that reach PQRS approval. These measures can be submitted in addition to original PQRS to reach the threshold of required measures per year, which was hard to do for vascular surgeons just using PQRS measures. • M2S approved QCDR (Qualified Clinical Data Registry) – M2S can serve as your agent (for a fee) to report quality measures CMS requires. • Submit Measures not currently covered by PQRS measures • Registry Committees submitted measures • Finalized white paper of measures after CMS approval Reporting requirement is three measures on 50% of your patients. COPI: • Infra LOS to be released this Spring • On deck: - 1-One year stroke/mortality after elective CEA/CAS for asymptomatic carotid stenosis - 2-One year mortality after open AAA/EVAR for elective AAA less than 6cm - Approved QCDR Measures 2 Data Collections: 1. Regional variation in postoperative myocardial infarction – almost exclusively elective procedures -Unadjusted, in hospital post MI rates • 5-VQI procedures: CEA, EVAR, °AAA, SUPRA & INFRA • 2003-January 2015 • 18 regions, 245 centers • Exclusion criteria: - Emergent procedures (ruptured aneurysms) - ANY suprainguinal bypass in which graft origin was not from abdominal aorta • Unadjusted in-hospital POMI rates (EKG/clinical vs troponin) according to region There is a wide variation in POMI. Conclusion: • Regional variation exists in unadjusted POMI rates • Regional and procedural variation exists in type of MI/method of dx (i.e.: EKG/clinical vs troponin) • As expected regional variation in POMI rates varies by procedure: °AAA > SUPRA > INFRA> EVAR~CEA • Further analysis is necessary Regarding the discussion on whether POMI rates are referenced to EKG & clinical changes, alone, verses troponin combination, this makes a huge difference when talking to insurance carriers and addressing quality information related to the 5 procedures. Recommendation is that there needs to be consensus on the definitions on POMI & whether troponin leaks are really spurious or they have validity. 2. Antiplatelets and Statins • Trend toward greater discharge on antiplatelets and statin agents. • There is some center variation. • The importance of this study is that it demonstrates discharge on these agents improve long term survival.	

Venous Quality Committee Update – Sabah Butty, MD (IU Health Methodist Hospital)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
IVC Filter Registry	The chair of the committee is Jose Alameida, MD. The committee will be reviewing the IVC Filter and Varicose Vein registry. IVC Filter Registry: • 2312 procedures • 56 centers • CMS Quality Measure: Appropriate management of Retrievable IVC filters Varicose Vein Registry: • 56 procedures in first month • 14 centers contracted • Focus on vein centers, integrate with vein-specific EMR vendors - VeinSpec - SonoSoft: signed contract ready to implement - StreamlineMD- - MedStreaming - Includes Quality of Life variables In terms of the follow-up, follow-up data is harvested prior to 30 days and after 30 days.	
Research Advisory Committee Update – Raghu Motaganahalli, MD (IU Health Methodist Hospital)		
Research	There are currently 42 National Projects and 80 Regional Projects Approved Project list on line: http://www.vascularqualityinitiative.org/wp-content/uploads/VQI_Approved_Projects_List_February-11-2015.pdf The goal of the research committee is to assist in the acquisition of datasets for specific research questions. Aid with study design, application process, etc. Recommendation for future meetings is that the study group submits 1 or 2 papers.	
Data Manager & Abstractor Update - Barb Weiler (St. Vincent Hospital/St. Vincent Heart Center of Indiana)		
Data Manager & Abstractor Updates	Using you abstractor, locally, is critical to getting good performance data. • 17 regional sites • Over 7500 procedures entered into the registry for our region – PVI and CEA have the largest module participation Deadline for Harvesting: In response to the biannual meetings, analysis is completed as follows: • Fall regional reports: - Data entry cut off Jun 1st - Procedure date cut off Apr 1st • Spring regional reports: - Data entry cut off Jan 1 - Procedure date cut off Nov 1st Challenges: • Deadlines too short • Many variables without definitions • EVAR, TEVAR: Devices not in appropriate drop downs (Iliac devices that are only in the Aortic Device drop down) • EVAR: Aortic Neck angles not documented anywhere PVI: TASC, # Lesions Treated, Occlusion Length, Treated Length - Results in submitting without validation	

Data Manager & Abstractor Update - Barb Weiler (St. Vincent Hospital/St. Vincent Heart Center of Indiana)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
Data Manager & Abstractor Updates	Challenges: • Analytics and Reporting Issue Can't compare across modules due to variable differences. Example: Urgency for Open AAA = Elective, Symptomatic and Rupture. Urgency for Supra-inguinal = Elective, Urgent and Emergent. EVAR is fairly complex. It has been revised in the past year.	
Regional Comparative Report - Mir Ishti Ali, MD (IU Health Ball Memorial Hospital)		
Discharge Medications Procedures	This is a review of comparative data of the Midwest region and national VQI. Reports will become more robust, as the study group matures. The data is vetted, so that these are elective procedures and they've had the appropriate risk adjustments. We're compliant 76% of the time (VQI-73%). There is opportunity for improvement. Could be due to documentation or lack of education, on behalf of the physician.	
Percentage of Infra inguinal Bypass Procedures with Chlorhexidine or Chlorhexidine + Alcohol Skin Prep	Midwest is at 72% - VQI rate is 75%. There is tremendous variation within the region; between 11 and 100%. You were excluded if using an Iodine base antimicrobrial. This data may be a little skewed, because physicians are using Iodine drape or Dura-prep. Betadine is not as effective as Chlorhexidine and alcohol or Chloro-prep. Dr. Lemmon has issues with how this data is presented. He suggests there is a tremendous variation within the region, depending on how your abstractor enters the data into the registry. This slide may not reflect current practice. Physicians using Chloro-prep plus Dura-prep and Ioban, they will be excluded from this slide because Chloro-prep is Chlorhexidine and alcohol. Hardly anyone uses Chlorhexidine, alone, as a prep agent, anymore. But this is how this graphic is described. Not sure this reflects current practice. Dr. Lemmon polls surgeons in the room on use of Betadine on a regular basis, not using Chlorhexidine or Chloro-prep. There are a number using a combination of Chlorhexidine, Ioban, Dura-prep. They may need to refine this data, better.	
Percentage of Major Complications after Infra-inguinal Bypass	Midwest region is at 4%, as is national VQI. As a region, we are doing well or at least the average.	
Mean Preoperative Ipsilateral Duplex Peak Systolic Velocity in Asymptomatic Patients undergoing CEA	Mean should be around 300 cm/sec. Midwest region is 332; national VQI 348. Majority of centers are doing a good job. We do have one outlier doing elective a-symptomatic Endarterectomy patients who have a low peak systolic velocity. We would be interested to figure out why. If that center would be willing to share, let us know.	
Percentage of Percutaneous Femoral PVI Procedures Using Ultrasound Guidance	Midwest region 24%; VQI 41%. This excludes cut downs. The variations may be due to how it is dictated. If it is not dictated by the physician, the abstractor will enter it as no ultrasound use. It may also be contingent on the specialty performing the procedure. It might be interesting to know if there is a difference in outcomes of those physicians using ultrasound versus not using ultrasound guidance. It may cause physicians to consider using ultrasound guidance more. This might be a good quality project. Dr. Lemmon agrees and suggests this may be a good opportunity to look at our region to see if there is an inter-specialty variance, regarding outcomes after percutaneous interventions.	

Regional Comparative Report - Mir Ishti Ali, MD (IU Health Ball Memorial Hospital)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
Percentage of Percutaneous Femoral PVI Procedures Using Ultrasound Guidance	Right now, our region doesn't have the data to determine whether or not ultrasound has an influence over fluoroscopic imaging, but suggest this is important. It would be interesting to see from our study group if this is worthwhile to pursue.	
CEA Stroke or Death in Hospital	National VQI risk adjusted rate is about 1%, Observed rate is a little below 1%. Our region is doing well at below 1%. This report is as of December 2014. Our region's numbers are very low. The "n" is very low, which might explain why the regional percentage is higher for the one center reporting. One center can impact our regional report, for some time. Overall, the Midwest region tends to be a little higher, but this could be driven by the one center reporting. Dr. Lemmon reminds members, the comparative slides are cumulative from the time a center began participating until Dec. 2014. If a center has begun a performance improvement project, it may be embedded in this report, but you will not be able to see a big difference in this slide. It would be nice if SVS PSO/M2S could provide us with a yearly report reflecting our improvement, instead of only the comparative reports. Change in practice parameter per institution would be very beneficial. On some of the lower volume procedures, it will take some time to see change impact. Matt Regan advises this is being addressed by SVS PSO.	
Open Non-ruptured AAA in Hospital Mortality	MVC is ~3%; National VQI ~3%. Most centers within the region have performed well, accept for one outlier. If this is your center, look at your center's data and try to determine if this is a matter of the "n" being very low or is it some quality indicator, e.g. surgical technique or whatever may need to be rectified.	
CEA: Percentage of Patients with LOS > 1 Day	Our region is doing well. MVC 80% patients are staying < 1 day; National VQI reports 75% of patients are staying < 1 day. It is up to participating centers to look their data to determine why they are an outlier. Mary Baker states the group is not provided data grids to show performance quarterly and/or every 12 months. She questions whether a report should be prepared in advance to supplement these graphics and show improvements. Dr. Ali states that each center can self-report, but it is voluntary. Mary suggests creating a blinded graph. Dr. Lemmon advises confidentiality is paramount. Based on the PSO agreement of confidentiality, a participating center may be asked if they would like to share their practice parameters at the next meeting, but the center must do this voluntarily and ONLY after approval from the Executive Director, Carrie Bosela. Mary shares that our study group's goal is to partner with Anthem/BCBS because of the model they have in Michigan. BCBS Michigan pays for participation in SVS, STS and ACC. There is an element of incentive for physicians and hospitals for performance, which can help offset expenses of the registries. The more comfortable our participating centers are with transparency, the better it will be working with Anthem. Dr. Lee (part-time CT Surgeon in Muncie, IN) is the current president of the Michigan STS Collaborative and would be happy to work with us to try to get Anthem more engaged to start paying for some of this. Matt Regan advises that the two registries referenced are not set up under the PSO governance.	

Regional Comparative Report - Mir Ishti Ali, MD (IU Health Ball Memorial Hospital)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
CEA: Percentage of Patients with LOS > 1 Day	One of the benefits of the VQI is that it's blinded so that we can have a collaborating, non-fear competitive environment to improve quality. There is a component of quality assurance to the other registries that they apply to gain support from Anthem. Right now, by HRQ law, we cannot present identifiers of who is doing what with their data, even if a center chooses to share their information. This would require a law or regulation change of the governance.	
EVAR: Percentage of Patients with LOS >2 days	MVC is 10%; National VQI is ~20%. Our region is doing very well. Dr. Lemmon shares that, from a national prospective, our region is best in the nation, on both EVAR and CEA. Our region has been asked to present on why our region is consistently performing so well. Possible reasons: • We're doing a lot of percutaneous punctures on EVARS • We're getting our foley catheters out, because we have a foley catherters protocol.	
°AAA Repair: Percentage of Patients with LOS ≥ 8 Days	MVC is ~ 20%; National VQI is ~ 25-30%. Across the board, the region seems to be doing really well.	
Operation Time for Elective CEA (as of 12/31/2014)	The mean time nationally is 115 minutes. MVC is 106 minutes. There is significant variation within the regional center. Possible reasons: • how efficient your institution is, with regards to the OR and nurses • how diligent your operator is • you may be training residents and fellows, which might take a little longer	
Operation Time for Elective CEA (as of 12/31/2014)	Dr. Lemmon suggests it might be interesting to see if these are high performer eversion endarterectomy hospitals versus carotid with patch. This is something our regional study group can look at internally. There is a lot of opportunity to look at why these numbers have such great variation. Our stroke rates are good.	
Prophylactic IVC Filter (12/31/2014)	National VQI is 17%; MVC is 25%. We are within the national norms.	
All reports reviewed – see slides		
Regional Growth & M2S Pathways Updates – Gary Lemmon, MD and Matt Regan (M2S, Inc.)		
Expansion	Currently, MVC consists of 17 participating centers. The goal is to increase the number of institutions participating in the VQI. We are providing physician-to-physician recruitment and scheduling recruitment dinners in IN and KY. If members know of others that are in the target sites (2% or greater of the vascular market), please volunteer to promote the VQI as an ambassador and recruit more institutions. Please let Lisa Saleemi know, if you are interested in volunteering as a volunteer. As the Midwest region expands statewide and contiguous states, the study group will address travel to meetings. We are also working collaboratively with Matt to expand the Midwest region.	Lisa will reach out to members to identify volunteer ambassadors
Pathways Development/Improvements	Matt would like participants to provide feedback on improvements to the platform. Improvements will include: • Center/Physician Variation charting • Push Reporting - (COPI report will have a selective email alert • Developing additional technology to share reporting matrix – if a region wanted to build a report, you could access that in the cloud space, within other centers, potentially	

Regional Growth & M2S Pathways Updates – Gary Lemmon, MD and Matt Regan (M2S, Inc.)		
TOPIC	**DISCUSSION**	**ACTION/ FOLLOW-UP**
Pathways Development/Improvements	• Drill down functionality – Develop in Q2-3. They are developing the ability to drill in to see what patients make up that chart. Also click on the data element that might be driving it. More flexible way to view the data. • Varicose Vein EHR integrations (Sonosoft) • Reporting on follow-up data within analytics engine • Decoding raw data download • Combined data file for large systems with multiple procedures • Developing PAD medically managed registry	
Quality Projects	Three projects were identified by members, during the Decompress portion of the meeting: 1. Ultrasound Guidance using data from the PVI module 2. Antiplatelet and Statin 3. CEA Operative Time – comparing other practice time	• Leads: Drs. M. Ishti Ali, and Sai Devarapalli • Lead: Raghu Motaganahalli, MD