

2013 Spring FGVSG Meeting Minutes

Welcome and FGVSG Update

Dr. Duwayri began the meeting by telling the attendees that the FGVSG is now comprised of 16 medical centers, a sizable increase from our October, 2012 meeting. He gave a brief history of the VQI at Emory, and introduced a fourth year Medical student, Jonathan Goss, who has been serving as Emory's VQI Database Manager, and has helped Emory in the process of integrating VQI with their EMR system.

Dr. Duwayri then spoke about the changing healthcare system in our country due in large part to the Affordable Care Act, and said that VQI will help it's participating centers move towards a pay per performance system rather than the current pay per service system. Moving towards a pay per performance system, emphasizing the quality rather than the quantity of services, could greatly help the Southeast in particular, as the Southeast has the highest expenditure in the nation for healthcare.

New Modules and Ongoing Changes for Current Modules

Dr. Beck introduced himself as the Medical Director for the FGVSG, and asked everyone to go around and state his or her name, position, and medical center affiliation. He then moved into a broader discussion of the current state of the FGVSG, stating that our region's data is nearing the maturity level needed for meaningful quality improvement and research endeavors, which he would like to be our region's primary focus. FGVSG's first Quality Improvement project will be on smoking cessation.

Dr. Beck then moved into a brief overview of broad VQI topics including the mandatory 80% compliance for one-year follow up data and the challenges this creates with certain procedure modules; VQI's new modules in the pipeline to serve as case report forms for clinical trials, and new industry partnerships that will help centers offset the cost of participating the VQI. He also gave a summary of the major national Quality Initiatives that have taken place, including surgical site infection risk factors and length of stay for carotid procedures, noting Roper Hospitals' success in decreasing length of stay for Carotid Endarterectomies.

Dr. Beck then presented the FGVSG and national risk adjusted data, noting regional improvements such as increased statin use in the FGVSG.

SVS VQI Business Update

Meridith Mitchell from M2S was able to join us from New Hampshire, and gave an update on the SVS VQI at the national level. She began with stating the SVS VQI goal of having SVS an integral part of Quality Improvement at each participating center. She spoke about how VQI can help centers, noting that VQI can help with their CMS requirements and is certified to submit to PQRS.

The SVS VQI is growing; there are now 228 participating centers in 45 states, 15 regional groups, and 87,226 procedures submitted. Ms. Mitchell went over the new improvements to the Analytics and Reporting Engine, highlighting the new risk adjusted variables available for Carotid Endarterectomies and Carotid Artery Stents. The SVS VQI is also working on providing charts and graphs in addition to the downloadable reports that have regional and national benchmarking capabilities.

Ms. Mitchell discussed the SVS VQI's new partnership with the American Venous Society, and gave a brief overview of the new Inferior Vena Cava Filter Module. Other endorsing societies and new partnerships were also mentioned.

SVS VQI programs in development were then detailed, including the OVERPAR trial, that will let centers participate in FDA post approval studies using the VQI. Ms. Mitchell elaborated on the FDA's partnership with VQI, noting that FDA and industry are interested in using VQI data for post approval device studies, and linking Medicare claims to capture outcomes at one-year post procedure. These new partnerships and enhanced capabilities are all examples of the benefits of participating with M2S, and are selling points that physicians can use when negotiating SVS VQI budgets with their hospital boards.

EMR Integration

Jonathan Goss began his presentation by noting one of the most common barriers to VQI participation being the lack of human resources and time available for data collection. He calculated the number of variables needed to enter one procedure in M2S to be 100, which is relatively high compared to other Quality Initiatives such as NSQIP, which has an average of 60-70 variables. Currently, Emory uses 2 nurses that are well-trained to perform the data entry, and it takes each nurse 15-45 minutes to enter all of the data into this system. As a medical student, he noted that he spends about 20-25 minutes entering data for each patient, thus in part providing the motivation for Emory to begin the process of using EMR integration.

Mr. Goss then detailed the automation process. EMR integration is made possible through EMR notes that must be tailored to each procedure module. Emory is in the process of validation this integration. Procedures with qualifying VQI CPT codes are entered into VQI, and Mr. Goss must screen all patients entered weekly to ensure no patients who meet exclusion criteria are entered. This process saves a substantial amount of time, and Emory is thus far pleased with their EMR integration.

What Would You Do With Six More Years?

Dr. Dodson began by quantifying how many more years a patient will on average gain if they stop smoking by age 35, which was calculated to be six. Age 35 is important, as it is estimated that virtually all excess mortality can be avoided if all patients stopped smoking at age 35. Dr. Dodson gave sobering facts throughout his presentation, including that the number of people killed by smoking each year is equivalent to three 757 airplanes crashing every day for one year.

Dr. Dodson described the history of the marketing of smoking from the 1940s to today, adding in quotes and pictures of prominent figures throughout the various time periods, all of whom were rarely photographed without a cigarette. He then moved on to a tobacco literature review, showing that pulmonary complications are the most common complication due to smoking, followed by cardiovascular complications.

Dr. Dodson concluded by describing the biggest barrier to getting patients to stop smoking: they do not want to quit. It is not uncommon for patients to be diagnosed with lung cancer and still not want to quit, although the literature has shown that patients' motivation to quit will increase after an open AAA repair or other major surgery when compared to patients who have undergone an endovascular repair approach. Of note, Dr.

Dodson's literature review showed that Nicotine Replacement Therapy does work, and the group considered writing more prescriptions for NRTs as part of their practice.

The final slide was a picture of Dr. Dodson's daughter and granddaughter, which was placed at the end of the presentation to answer the question of what he would do with six more years.

A 10 minute break was given.

AHEC's Role in Smoking Cessation

Anna Maynard was a guest speaker from the Area Health Education Centers (AHEC) of Florida, a program that is federally funded and locally controlled, with the mission of providing free education and smoking cessation services to Florida residents. Ms. Maynard began by explaining that the Florida AHEC is comprised of five medical centers and 10 non-profit regional centers. In a comprehensive folder handout that all meeting attendees received, Ms. Maynard showed each FGVSG center which AHEC was closest to them, and provided the contact information for that AHEC so that each medical center could contact their local AHEC.

While AHEC is federally funded, Florida has substantially more money and resources than other states due to the Tobacco Settlement Trust Fund Monies. AHEC uses a systems approach that focuses on the "2A's and 1 R": Ask, Advise, and Refer. Ms. Maynard stated that while many providers will ask their patients whether or not they are still smoking and will advise them not to, the referral component is largely missing, which is what AHEC seeks to change.

Ms. Maynard emphasized that quitting is difficult, and oftentimes patients will try to quit 8-10 times before they are successful. Florida AHEC is authorized to provide four rounds of NRT twice per fiscal year. As part of the counseling component, a smoking cessation specialist will talk with the patients and discuss triggers that lead them back to smoking, and help patients rid their homes of these triggers.

Ms. Maynard then concluded by detailing the 2 programs AHEC offers: an intensive 6 week program that meets once a week for an hour for six weeks, and a less intensive program consisting of one 2 hour session. The two programs have a 37% and a 30% cessation rate, respectively, measured by patient smoking status at 7 months after their quit date.

FGVSG Quality Initiative: Smoking Cessation

Following Ms. Maynard's presentation, Dr. Beck took the podium with her to lead an open discussion of how FGVSG would use AHEC in its smoking cessation quality improvement project. Of note, it was stressed that as a region, documentation on follow-up forms regarding smoking status will need to be improved. All providers agreed they would start prescribing Chantix to their patients and recommending them to their local AHECs by distributing brochures as part of their standard of care clinical practice.

After a few minutes of discussion, a tentative quality improvement project was outlined. On the procedure module, FGVSG will request that M2S provide additional data points asking if the patient would like to participate in one of the two AHEC programs, and if they enrolled in one. If the patient does not wish to enroll, a data point

will be added to document if Chantix was prescribed and if AHEC promotional materials were provided. On the follow up forms, FGVSg will request M2S to add quit date if the patient was a previous smoker and is not currently smoking at the time of follow-up. The groups of patients that received AHEC counseling and those who did not will then be compared to see if there is any statistically significant smoking cessation difference.

Clinical and Administrative Challenges to Follow-Ups

Vida Rivera began by stating the current follow up rate for the region and the nation, which was well below the mandatory 80% compliance. She continued by detailing the challenges to follow-up that are commonly faced including geography of the Southeast region, lack of patient willingness to return for an appointment when they feel fine, differences in clinical standard of care follow up from M2S requirements, particularly for HD Access and Open AAA repair modules, and patients losing their insurance and therefore their ability to pay for clinic appointments and CT scans.

After Ms. Rivera's presentation, Dr. Molnar suggested that for future meetings, providers and data managers and administrators should be separated to that relevant issues for the two groups can be discussed, to which Dr. Beck replied is the current practice of the VSGNE. All agreed that for the next meeting, data administrators and providers will be broken out into two groups.

Lessons Learned from the VSGNE

Dr. Scali presented three papers that have been published from the VSGNE. The first paper detailed the impact of diabetes on postoperative outcomes. The paper compared Major Adverse Events (MAE) and in-hospital mortality for four groups of diabetics, and found that there was no difference in in-hospital mortality, but the number of MAEs was significantly higher for insulin dependent diabetics than for the other three groups. Dr. Scali used these data to segue into the fact that he has trained at multiple institutions, one of which has a strict diabetes protocol, and most of which do not have an organized diabetes protocol. The floor was then opened for a discussion on different hospitals' diabetes protocols.

The second paper was about serious COPD in patients undergoing Open AAA Repair. While the paper's results weren't a surprise – patients with serious COPD have increased in-hospital mortality and rates of MAEs than patients without COPD – this paper led to an open discussion of how surgeons decide which patients with COPD they will perform an open AAA repair on and which ones they will recommend to undergo endovascular repair. Most surgeons agreed that while there is no standardized COPD medical management protocol that they follow and that they are wary of operating on patients with a PFT <1, they feel that “eyeball” test is the best measure. The eyeball test was validated by an anesthesiologist, Dr. Duggan, who detailed the risks of reintubation over waiting 30 more minutes in the OR and extubating in the OR. While waiting an extra 30 minutes in the OR is not always realistic, Dr. Duggan stated that in her experience, waiting to extubate in the OR is usually better than relying on another provider to extubate in the ICU, or risking reintubation because the patient was prematurely extubated. Dr. Duggan also recommended epidurals for patients with COPD undergoing open AAA repair.

The third paper was about intraoperative dextran, and its associated risks for cardiac complications following Carotid Endarterectomy. While intraoperative Dextran was not associated with statistically significant postoperative death, stroke, or risk for a secondary procedure due to bleeding, the risk for MI was greatly increased. This finding has led to a decreased use of intraoperative dextran.

Recent Publications from the VQI

Dr. Duwayri presented 3 recent papers from the VQI, the first of which described optimal selection of CEA patients. Currently, the 5 year survival rate for CEA is 82%, with the major risk factors being age >70, NIDD, COPD, CHF, and eGFR >60. The paper divided patients undergoing CEA into three groups: low risk, medium risk and high risk, and found that medical management might be a better option to treat high-grade carotid stenosis than CEA.

The second paper discussed strategies to decrease readmission rates, a particularly salient topic due to the changing Medicare reimbursement policies in the coming years. The paper found that risk factors were difficult to determine, as much of what contributes to a patients' readmission does not lie in the quality of medical care the patient receives. Vascular surgery is also at a disadvantage for decreasing readmission rates since many procedures are staged, including as carotid subclavian bypass before TEVAR, and Medicare claims lack procedural information.

The third paper was related to the FGVSG's new quality improvement project, smoking cessation. The paper assessed factors that lead patients to successfully quit, and found that cessation was largely medical center dependent, which validates the FGVSG's quality improvement project of center-wide cessation efforts. Other details of the paper were previously discussed by Dr. Beck and Ms. Maynard earlier in the meeting.

Risk Factor Modification

Dr. Wells presented a number of papers detailing risk factor modifications in patients with Peripheral Vascular Disease. Statin use was recommended for patients with LDL >100 as long as the patient's LDL was not <70 during or after treatment, as statin therapy has been shown to increase average walking distance as well as overall Quality of Life. ACE-inhibitors are also recommended for PAD, as demonstrated in the HOPE trial with Ramipril, which was shown to decrease the risk of stroke, MI and death in vascular patients. Anti-coagulation therapy was then discussed, and Dr. Wells stated that coumadin had not been shown to decrease favorable cardiovascular endpoints. Plavix was shown to be only slightly better than ASA, but due to the fact ASA can be purchased over the counter, it might be a better option for patients. Of note, prescribing both Plavix and ASA was not recommended. The final medication discussed was beta blocker use in patients undergoing renal artery stents, which was proven to be a successful treatment option. All of these risk factors have led to the revised cardiac risk index, with is now available on the SVS website.

Dr. Wells summarized the CLEVER trial, which demonstrated that supervised exercise in conjunction with medical management of PAD and conservative use of stenting is favorable. The DECREASED-II trial showed that stress testing was not necessary in patients.

Dr. Beck then took the podium and presented a template for risk factor modifications to be sent to patient's primary care provider if their vascular surgeon has started them on any additional medications, as well as a patient letter to explain to them the reasons they have been started on statin therapy. These letters will be distributed by e-mail to the FGVSG listerv.

How Institutional Databases Can Influence Carotid Therapy and Where They Fall Short

Dr. Brewster discussed the literature pertaining to contralateral occlusion as an important risk factor in patients undergoing CEA. Dr. Brewster stated that the literature review he conducted showed that generally contralateral occlusion increases perioperative events in patients undergoing CAS, but did not increase perioperative events in patients undergoing CEA. However, papers published in Italy and France found the exact opposite results.

Dr. Brewster then presented the CREST study, which demonstrated an increased risk of stroke and death rate in patients undergoing CAS, suggesting that they may have fared better with CEA. One of the limitations of this paper, and of many papers about CEA, was that death and stroke were grouped together as one adverse outcome, making it impossible to separate the two.

The presentation was concluded by publications showing that length of stay was shorter on average for patients undergoing CAS than patients undergoing CEA, but patients undergoing CEA had better outcomes both perioperatively and postoperatively.

Closing Remarks

Dr. Beck and Dr. Duwayri concluded the meeting by expressing enthusiasm for the FGVSG's first quality initiative of smoking cessation, thanked everyone for their attendance, and the group agreed that the next meeting should be held in 6 months, either in Gainesville, FL or Orlando, FL.

Meeting Adjourned.