MAY 2014 FGVSG Meeting Minutes

Welcome and FGVSG Update

The group introduced themselves and Dr. Beck reviewed the current data for the national VQI. The VQI is now comprised of 16 regional quality groups, 289 medical centers, 45 states and 142,136 procedures, a sizable increase from our fall 2013 meeting. The group then went through their packets and reviewed their own respective data while Dr. Beck pointed out the current FGVSG collective data. The group discussed the possibility of implementing future project:

TEVAR Aortic Dissection Project-Gore and Medtronic PAS approved by FDA, **patient consent and IRB approval will most likely not be required**. However, your institution may ultimately require IRB involvement. Target to Acute or Chronic Descending Aortic Dissections, the Non-identifiable data shared with FDA and Industry. Chaired by Dr. Rich Cambria; Project Manager: Nadine McLeod; please contact via TEVARproject@m2s.com if you interested in.

Dr. Beck briefly covered IVC Filter module which developed based on AVR module. It initiated in February, 2013. 10 Centers submitted data through December; 25 Centers now participating; and 365 IVC filter cases submitted in 10 months compared with 238 during 2012 for AVR.

He also mentioned Varicose Vein Module which currently under development. Group discussed the benefits of VQI Venous Participation.

Group shared information from Arterial Quality Committee. The follow hot topics were discussed within the group.

1) HR & BB workgroup
2) Auditing VQI Data Input: Statistical method
3) DC medicine workgroup
4) Geographic regions
   – Larger regions to identify regions for outcome measures
   – Use the 5 Vascular Societies
5) New workgroups being formed for each module
6) COPI CEA LOS released December 2013
7) Next COPI report: EVAR LOS

M2S update/Analytics & Reporting Tutorial

Anne Parker from M2S was able to join us from New Hampshire, and gave an update on the SVS VQI at the national level.

Ms. Parker went over the new improvements to the Analytics and Reporting Engine, highlighting the VQI life Tables reports that are available in real time. The SVS VQI is also working on providing charts and graphs in addition to the downloadable reports that have regional and national benchmarking capabilities.

Finally, Ms. Parker demonstrated on how to run those reports. No questions were raised in this point.

Emory Readmission Causes and Cost Analysis

As you all are aware, readmission rates after our procedures are not insignificant, and our hospitals are acutely interested in looking for ways to decrease these events.

Yazan Duwayri from Emory presented their local data regarding readmission rates after vascular procedures, and the staggering cost to our healthcare systems. We currently have no mechanism for following readmissions in the VQI, but several centers around the country are piloting some additional data fields to give us a way to measure these events. Hopefully we will have the ability to measure readmissions soon in the VQI so we can develop some quality efforts around decreasing readmissions in our region.

10 minutes breakout

Risk Factor Modification in a Socioeconomically Disadvantaged Population

Dr. Rajani discussed if standard risk factor modification can be accomplished in a disadvantaged patient population. He stated that Efforts toward improving risk factor modification must address poor smoking cessation rates in uninsured patients. Group discussed the barriers to modification and potential solutions.

Optimal medical therapy and effect on survival in the VQI: impact on survival of anti-platelet therapy and statin medications in the vascular surgery population

Dr. Beck recommended to improve our optimal medical management of patients eligible for statin and anti-platelet therapy to >90%.

Optimal medical management has been demonstrated repeatedly to improve postoperative outcomes in patients with atherosclerotic cardiovascular disease, and improve upon survival after vascular operations. Randy DeMartino from the Mayo clinic will be presenting national VQI data at the June SVS meeting that will demonstrate the same. Our region is in line with the rest of the country at around 70% of our patients on statin/anti-platelet medications, which we can obviously improve greatly upon. At this meeting in Atlanta, Dr. Beck presented data showing that Cardiologists have been able to improve their discharge rate of patients on statin/anti-platelet medication after acute MI to 95-100% at most centers using national quality efforts.

There is certainly no reason why we can't achieve the same level for our patients. He thought too often we are deferring to our patient's primary care providers to initiate these medications, and it just isn't happening. His personal opinion is that if we are comfortable putting a clamp on someone's aorta, we should be comfortable writing a prescription for a statin and aspirin when it's appropriate.

To ensure that we are measuring our optimal medical management accurately, he would encourage all of VSG participants to ensure that whoever is entering your data for all medications are putting in correct information. If your patient is not eligible for any particular medication because of an allergy or a prohibitive side effect, the medication should be listed as "no for medical reason." If they have been prescribed, but the patient is non-compliant, of course it should be listed that way. If "no," is entered, it is basically interpreted as the patient wasn't on it because we didn't prescribe it like we should.

The VQI will soon be distributing a "tool kit" for improving the rate of optimal medical management in the near future, which will include the current recommendations for these medications and guidelines for how to monitor your patients after initiating statins. Let's be the first region to demonstrate that vascular specialists can achieve the same rate of optimal medical management in our patients as are achieved for acute MI patients.

Physician Breakout

Smoking cessation in the FGVSG

After the 4th bi-annual meeting last year, we have initiated a smoking cessation protocol at the University of Florida, and we have had some notable early successes at getting our patients to quit smoking. At this meeting, the group agreed that we would like to implement a region wide smoking cessation protocol that we can all follow and determine if we can improve rates of smoking cessation. At a later time point, we can look to our data to determine if this improves our overall outcomes from the procedures we perform.

We will be distributing the protocol and electronic copies of the patient literature that we are using at UF soon. Please let me know of any questions or criticisms, and if there is anything that we can do to help implement this protocol into your practice.

A report from the SVS VQI: Initiation of beta-blockers prior to major vascular surgery procedures is not beneficial, and may be harmful

The arterial quality committee of the SVS VQI will soon be making a statement regarding the initiation of beta-blockers in our patients who are not currently on those medications before their operation. Using national VQI data, we have demonstrated that it is generally not helpful to initiate beta-blockers, and may indeed be harmful, as some other recent reports have suggested. Sal Scali, from the University of Florida, will be presenting those data at the national meeting in Boston in June.

Heart rate and the VQI

Dr. Beck updated the group on the VQI heart rate project, which was initiated to determine if the VQI needs to continue to collect heart rate in the future. Most would agree that this is a difficult data point to obtain, especially with retrospective chart abstraction, and the project was meant to determine if heart rate is an important predictor of outcomes.

This project is still underway, pending completion of the VQI beta-blocker project, but the results seem to support that heart rate is not going to be important enough to continue to collect. This information will be distributed nationally once the data analysis is complete, and centers should continue to collect the data until the Arterial Quality Committee decides for certain that we will no longer collect.

Frailty in the vascular patient

Dr. Arya presented some background data regarding frailty in vascular surgery patients, and her own data, which she will also present at the Vascular Annual Meeting in Boston this year.

Lost to Follow-up in Patients with Aneurysm Disease-Does it matter?

Dr. Brewster presented data regarding the follow up of patients after endovascular aortic procedures, and demonstrated that our follow-up of our patients is

generally poor. His slide set is included in the master slide set that has been distributed for everyone’s review.

Data Abstractor Breakout

Analytics & Reporting Engine Report-Advanced Filtering

Anne Parker demonstrated the workflow and how to run reports in VQI. Attendees have no questions raised.

Analytics & Reporting Engine Report

Yuming Lin demonstrated on how to Analytics & Reporting Engine Report in VQI. She also highlighted that the patient safety work product should be considered privileged and confidential. The group recommended that it would be benefit for members to have the on-site training from VQI. Anne will follow up on this.

>9 Month Follow-up Roadblocks (Open Discussion)

Rosha Nodine demonstrated the workflow at the heart hospital and requested help regarding the long term follow up. Group had open discussion and requested more training through VQI. Anne will follow up on this.

Yuming Lin surveyed all attendees after meeting. The results will share with the group later.

Closing Remarks

Dr. Beck and Dr. Duwaryi concluded the meeting by expressing enthusiasm for the future research studies, thanked everyone for their attendance, and the group agreed that the next meeting should be held in 6 months, and will likely be held in Gainesville, FL.

Meeting Adjourned.