Carolinas Vascular Quality Group (CVQG)

May 7, 2021
10 am – 12:30 pm ET
Remote
Before we get started, please sign in.

1. Click “Participants” in the box at the top or bottom of your screen.
2. If your full name is not listed, hover next to your name and you’ll see “rename”.
3. Click and sign in.

If you can’t sign in, please email Leka Johnson at ljohnson@svspso.org and let her know the identifier you were signed in under (ex –LM7832 or your phone number).

**SPECIAL NOTE: We do give credit to residents/fellows that don’t have a PATHWAYS user account !!!

Sign in with your Full name, MD, Name of Institution
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>CE Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 am</td>
<td>Welcome</td>
<td>No</td>
</tr>
<tr>
<td>10:05 am</td>
<td>Regional Data Review</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Katharine McGinigle, MD, Regional Medical Leader, CVQG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning Objectives:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Use the VQI regional reports to establish quality improvement goals for the vascular patients (outcomes) and for their center (process).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Interpret and compare each centers’ VQI results to regional and national benchmarked data.</td>
<td></td>
</tr>
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<td>• Learn, through group discussion the VQI regional results to improve the quality of vascular health care by monitoring measurable performance indicators, SVS PSO evidence-based research, and outcomes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identify high performing regional vascular centers to discuss variations in care and clinical practice patterns to improve outcomes and prompt quality improvement recommendations for vascular care patients. Sharing of best practices/pathways of care.</td>
<td></td>
</tr>
<tr>
<td>11:05 am</td>
<td>Regional QI Proposal</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Katharine McGinigle, MD, Regional Medical Leader, CVQG</td>
<td></td>
</tr>
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<td></td>
</tr>
</tbody>
</table>
# Agenda (con’t)

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>CE Credit</th>
</tr>
</thead>
</table>
| 11:35 am | National VQI Update  
Jim Wadzinski, Deputy Executive Director, PSO  
Learning Objectives:  
• Use the VQI regional reports to establish quality improvement goals for the vascular patients (outcomes) and for their center (process).  
• Identify high performing regional vascular centers to discuss variations in care and clinical practice patterns to improve outcomes and prompt quality improvement recommendations for vascular care patients. Sharing of best practices/pathways of care. | Yes       |
| 12:05 pm | AQC Update – Thomas Todoran, M.D.                                     | No        |
|          | VQC Update – Maureen Sheehan, M.D.                                    | No        |
|          | RAC Update – Elizabeth Genovese, M.D.                                 | No        |
|          | Governing Council Update – Katharine McGinigle, M.D.                  | No        |
| 12:20 pm | Case Presentations  
1. Vascular Services Performance Improvement: Discharge Meds – Wake Med | No        |
| 12:30 pm | Open Discussion/Next Meeting/Meeting Evaluation                       | No        |
No presenter has a disclosure or conflict of interest to report.
Welcome and Introductions

Alamance Regional Medical Center
Anmed Health
Atrium Health Cabarrus
Atrium Health Pineville
Atrium Health Union
Beaufort Memorial Hospital
CarolinaEast Medical Center
CaroMont Regional Medical Center
Catawba Valley Medical Center
Cone Health
Duke Raleigh Hospital
Duke Regional Hospital
Duke University Medical Center
McLeod Regional Medical Center
Medical University of South Carolina
Mission Hospital
New Hanover Regional Medical Center
Novant Health Forsyth Medical Center
Novant Health Matthews Medical Center
Novant Health Presbyterian Medical Center
Palmetto Health Richland
Pinehurst Surgical
Regional Medical Center, Orangeburg
Rex Hospital, Inc.
Roper St. Francis
Sanger Heart and Vascular Institute
Self Regional Health
Spartanburg Regional
Trident Medical Center
University of North Carolina Hospitals
Vidant Medical Center
Wake Forest University Baptist Health Medical Center
WakeMed Health & Hospitals-Cary Campus
WakeMed Health & Hospitals-Raleigh Campus
We realize that some of you may not be receiving all the emails that are sent by the VQI/PSO/M2S PATHWAYS.

To assist in helping you get the most updated info possible, we want to direct you to a few areas to get information:

1. VQI.org – specifically YOUR Regional Group Website! You will find the latest announcements, meeting information, contact information and much more.

2. M2S PATHWAYS – Bubble notifications when you login to the platform, as well as information in the Resources tab, can give you the very latest announcements.

3. If you are not receiving emails, consider asking your hospital IT to whitelist/allow emails from pathwayssupport@m2s.com. Mass emails via Mailchimp are sent from this email address and sending name “Vascular Quality Initiative”, “PATHWAYS”, or “SVS PSO”.

Getting Information
Spring Regional Reports

Katharine McGinigle, MD

VQI Regional Quality Report

Spring 2021

This report is patient safety work product generated within the SVS PSO, LLC, and is considered privileged and confidential.

About the Report

The VQI Regional Quality Report is produced semiannually to provide centers and regions targeted, comparative results and benchmarks for a variety of procedures, process measures, and postoperative outcomes. The report is organized into separate reports that can be quickly accessed by clicking on the report names in the table of contents on the left.

For drill-down and data feedback on your center’s cases, click on “VQI Case Appendix” in the table of contents on the left.
Important Notes

- All results are based on data entered into the VQI as of January 31, 2021. Any subsequent changes or updates to data after that date will not be reflected in this report.
- Procedure timeframes and inclusion/exclusion criteria are given at the top of each report. Cases are also excluded if outcomes are missing or not enough data was entered to determine whether the case met inclusion/exclusion criteria.
- Regions must have at least 3 centers with included cases for regional results to be displayed in tables and line charts.
- Regions must have at least 3 centers with at least 10 included cases per center for regional results to be displayed in bar charts. It is therefore possible for a region’s results to be displayed in tables and line charts, but not in bar charts.
- For risk-adjusted reports, regions must have at least 3 centers with at least 10 complete cases per center for regional results to be displayed in bar charts. It is therefore possible for a region’s results to be displayed in tables and line charts, but not in bar charts.
- In all graphics, "**" indicates a p-value <.05.
Dashboard

The dashboard provides a high-level summarization of your center’s results for each of 25 reports, and gives both regional and VQI-wide benchmarks for comparison. The “Your Center” column gives the percentage of your center’s cases with the noted outcome. Numbers in parentheses give the number of cases with the outcome and the total number of cases meeting the inclusion criteria for that report. The “Your Region” and “VQI Overall” columns give the overall, aggregate percentage of cases with the noted outcome, as well as the 25th, 50th (median), and 75th percentiles, for centers in your region and VQI, respectively ([25th|50th|75th]). Your center’s results are highlighted blue if your center is in the “best” 25th percentile for VQI Overall, and coral if your center is in the “worst” 25th percentile for VQI Overall.

For details on a particular report, click on the report name in the table of contents on the left.

Legend: Blue = “Best” 25th percentile  Coral = “Worst” 25th percentile

Note that procedure volume results are not highlighted
Dashboard Highlights

• New Colors

• New procedure groupings

• New Case Appendix with...
Dashboard Highlights

• Embedded drill-down and data feedback

VQI Case Appendix

Winter 2020

About the Appendix

The VQI Case Appendix provides embedded data feedback and drill-down for each dashboard report. Using the appendix, centers can easily identify and download cases that were reviewed or excluded from each report, as well as cases with each noted outcome.

The interactive tables below give your center’s cases (both reviewed and excluded) entered for the procedure timeframe of each report (as of 11/30/2020). Each row references a particular case and each case is referenced by a PRIMPROCID, a unique case identifier assigned to each procedure to protect patient identity. Additional data elements are included for each case to further facilitate quality improvement efforts, including procedure and patient characteristics, length-of-stay (LOS) data, discharge medication data, complication data, and other data elements related to dashboard report construction.

To download a .csv or .xlsx file containing your center’s data, click on either the “CSV” or “Excel” buttons located above each interactive table.
Dashboard Highlights

• **Embedded drill-down and data feedback**

![Dashboard Table Diagram]

- **INFRA Cases: 80**
  - # of INFRA cases in procedure timeframe
- **INFRA CLAUD (CLI) Cases Reviewed: 9 (66)**
  - # of INFRA cases included in each INFRA dashboard
- **INFRA Cases Excluded: 5**
  - # of INFRA cases not included in either INFRA dashboard (note: 5+9+66=80)

- **Show 10 rows**
- **CSV**
- **Excel**
- **Download .csv or .xlsx file of your data**

- **Change the # of rows for display**
  - (10, 25, 50, 100, 250, or 500)

- **Binary indicators for dashboard inclusion**
  - (1=yes, 0=no)

- **Use scroll bar to see additional variables**

- **Search:**

- **Returns every row containing at least 1 cell satisfying the value entered in the search bar**
  - (not incredibly useful)

- **Sort on any column by clicking the double arrows**

- **Click to page thru your cases**
  - (10, 25, 50, 100, 250, or 500)
<table>
<thead>
<tr>
<th>Procedure Group</th>
<th>Outcome</th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Procedure Volume</td>
<td>[48</td>
<td>156</td>
<td>363]</td>
</tr>
<tr>
<td></td>
<td>Procedure Volume, All Years</td>
<td>[306</td>
<td>1325</td>
<td>2737]</td>
</tr>
<tr>
<td>Multiple</td>
<td>Long-Term Follow-up</td>
<td>68.9% [69%</td>
<td>83%</td>
<td>89%]</td>
</tr>
<tr>
<td>DISC</td>
<td>Discharge Medications</td>
<td>87.8% [86%</td>
<td>93%</td>
<td>96%]</td>
</tr>
<tr>
<td>TFEM CAS ASYM</td>
<td>Stroke/Death</td>
<td>2% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td>TFEM CAS SYMP</td>
<td>Stroke/Death</td>
<td>2.7% [0%</td>
<td>0%</td>
<td>1%]</td>
</tr>
<tr>
<td>TCAR ASYM</td>
<td>Stroke/Death</td>
<td>0.4% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td>TCAR SYMP</td>
<td>Stroke/Death</td>
<td>1.7% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td>CEA ASYM</td>
<td>Stroke/Death</td>
<td>1% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td>CEA SYMP</td>
<td>Postop LOS&gt;1 Day</td>
<td>18.9% [11%</td>
<td>16%</td>
<td>27%]</td>
</tr>
<tr>
<td>EVAR</td>
<td>Stroke/Death</td>
<td>1.6% [0%</td>
<td>0%</td>
<td>3%]</td>
</tr>
<tr>
<td></td>
<td>Postop LOS&gt;1 Day</td>
<td>42.1% [32%</td>
<td>40%</td>
<td>51%]</td>
</tr>
<tr>
<td>Sac Diameter Reporting</td>
<td>Sac Diameter Reporting</td>
<td>62.9% [53%</td>
<td>76%</td>
<td>87%]</td>
</tr>
<tr>
<td>SVS Sac Size Guideline</td>
<td>SVS Sac Size Guideline</td>
<td>77.8% [65%</td>
<td>75%</td>
<td>84%]</td>
</tr>
<tr>
<td>TEVAR</td>
<td>Sac Diameter Reporting</td>
<td>44.9% [21%</td>
<td>41%</td>
<td>58%]</td>
</tr>
<tr>
<td>AAA</td>
<td>In-Hospital Mortality</td>
<td>8.5% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td>SVS Cell Saver Guideline</td>
<td>SVS Cell Saver Guideline</td>
<td>95.5% [88%</td>
<td>100%</td>
<td>100%]</td>
</tr>
<tr>
<td>SVS Iliac Inflow Guideline</td>
<td>SVS Iliac Inflow Guideline</td>
<td>95.8% [100%</td>
<td>100%</td>
<td>100%]</td>
</tr>
<tr>
<td>PVI CLAUD</td>
<td>ABI/Toe Pressure</td>
<td>84.9% [73%</td>
<td>85%</td>
<td>94%]</td>
</tr>
<tr>
<td>INFRA CLTI</td>
<td>Major Complications</td>
<td>5.9% [2%</td>
<td>5%</td>
<td>8%]</td>
</tr>
<tr>
<td>SUPRA CLTI</td>
<td>Major Complications</td>
<td>8.8% [0%</td>
<td>0%</td>
<td>13%]</td>
</tr>
<tr>
<td>LEAMP</td>
<td>Postop Complications</td>
<td>10.7% [5%</td>
<td>10%</td>
<td>17%]</td>
</tr>
<tr>
<td>HDA</td>
<td>Primary AVF vs. Graft</td>
<td>71.2% [62%</td>
<td>74%</td>
<td>86%]</td>
</tr>
<tr>
<td>IVCF</td>
<td>Filter Retrieval Reporting</td>
<td>42.2% [18%</td>
<td>41%</td>
<td>47%]</td>
</tr>
</tbody>
</table>

Legend: Blue = “Best” 25th percentile  Coral = “Worst” 25th percentile

Note that procedure volume results are not highlighted.
# Procedure Volume

Procedures performed between January 1 and December 31, 2020

Number of cases entered into the VQI, by registry and overall

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Your Center (N)</th>
<th>Your Region (N)</th>
<th>VQI Overall (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS (TFEM CAS &amp; TCAR)</td>
<td>677</td>
<td>11221</td>
<td></td>
</tr>
<tr>
<td>CEA</td>
<td>1271</td>
<td>15828</td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td>541</td>
<td>6473</td>
<td></td>
</tr>
<tr>
<td>HDA</td>
<td>358</td>
<td>6405</td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
<td>824</td>
<td>6797</td>
<td></td>
</tr>
<tr>
<td>IVCF</td>
<td>NA (&lt;3 centers)</td>
<td>1515</td>
<td></td>
</tr>
<tr>
<td>LEAMP</td>
<td>440</td>
<td>3192</td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td>57</td>
<td>1243</td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td>2693</td>
<td>37799</td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td>199</td>
<td>1892</td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td>280</td>
<td>2691</td>
<td></td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>NA (&lt;3 centers)</td>
<td>5938</td>
<td></td>
</tr>
<tr>
<td>Overall (Jan-Dec 2020)</td>
<td>7383</td>
<td>100994</td>
<td></td>
</tr>
<tr>
<td>Overall (Jan-Dec 2019)</td>
<td>8167</td>
<td>116809</td>
<td></td>
</tr>
</tbody>
</table>
Procedure Volume by Center in Your Region (Jan-Dec 2020)

- Other centers in your region
- Your center

Centers (centers with <10 cases not shown)

Procedure Volume Across VQI (Jan-Dec 2020)

Regions (regions with <3 centers with at least 10 cases not shown)

"Others" indicates centers that do not belong to a regional group.
## Procedure Volume, All Years

Includes all procedures with procedure date through December 31, 2020

Number of cases entered into the VQI, by registry and overall

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Your Center (N)</th>
<th>Your Region (N)</th>
<th>VQI Overall (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS (TFEM CAS &amp; TCAR)</td>
<td>3184</td>
<td>49828</td>
<td></td>
</tr>
<tr>
<td>CEA</td>
<td>12766</td>
<td>150058</td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td>5718</td>
<td>59655</td>
<td></td>
</tr>
<tr>
<td>HDA</td>
<td>1837</td>
<td>59322</td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
<td>6867</td>
<td>64165</td>
<td></td>
</tr>
<tr>
<td>IVCF</td>
<td>2393</td>
<td>19810</td>
<td></td>
</tr>
<tr>
<td>LEAMP</td>
<td>2393</td>
<td>19810</td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td>2393</td>
<td>19810</td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td>18940</td>
<td>251233</td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td>18940</td>
<td>251233</td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td>18940</td>
<td>251233</td>
<td></td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>NA (&lt;3 centers)</td>
<td>42963</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>57240</td>
<td>766290</td>
<td></td>
</tr>
</tbody>
</table>
**Procedure Volume by Center in Your Region (Through Dec 2020)**

- **Other centers in your region**
- **Your center**

**Centers (centers with <10 cases not shown)**

**Procedure Volume Across VQI (Through Dec 2020)**

**Regions (regions with <3 centers with at least 10 cases not shown)**

*Others* indicates centers that do not belong to a regional group.
Physician Specialties

Physician Specialties Across VQI (as of January 31, 2021, N=5617 Physicians)

- Vascular Surgery
- Cardiology
- Radiology
- Other
- General Surgery
- Cardiothoracic Surgery
- Neurosurgery
- None

50% 45% 40% 35% 30% 25% 20% 15% 10% 5% 0%
**Long-Term Follow-up**

Procedures performed between January 1 and December 31, 2018

Includes CAS (TFEM CAS and TCAR), CEA, EVAR, HDA, INFRA, IVCF, LEAMP, OAAA, PVI, SUPRA, and TEVAR procedures only. Excludes cases not eligible for long-term follow-up.

The table below gives the number of procedures meeting the inclusion criteria, and the percentage of those procedures with follow-up recorded between 9 and 21 months post-procedure.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS</td>
<td>427 (64%)</td>
<td>7782 (64%)</td>
<td></td>
</tr>
<tr>
<td>CEA</td>
<td>1527 (74%)</td>
<td>18807 (71%)</td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td>638 (73%)</td>
<td>7327 (72%)</td>
<td></td>
</tr>
<tr>
<td>HDA</td>
<td>342 (68%)</td>
<td>8010 (67%)</td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
<td>781 (66%)</td>
<td>7339 (72%)</td>
<td></td>
</tr>
<tr>
<td>IVCF</td>
<td>175 (61%)</td>
<td>2003 (77%)</td>
<td></td>
</tr>
<tr>
<td>LEAMP</td>
<td>445 (47%)</td>
<td>3309 (66%)</td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td>45 (58%)</td>
<td>1251 (75%)</td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td>2290 (73%)</td>
<td>34936 (70%)</td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td>232 (66%)</td>
<td>2359 (72%)</td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td>264 (61%)</td>
<td>2684 (69%)</td>
<td></td>
</tr>
<tr>
<td>Overall (Jan-Dec 2018)</td>
<td>7166 (69%)</td>
<td>95807 (70%)</td>
<td></td>
</tr>
<tr>
<td>Overall (Jan-Dec 2017)</td>
<td>6587 (79%)</td>
<td>86744 (73%)</td>
<td></td>
</tr>
</tbody>
</table>
Long-Term Follow-Up by Center in Your Region (Jan-Dec 2018)

- Other centers in your region
- Your center

Centers (centers with <10 cases not shown)

*** indicates center’s rate differs significantly from the regional rate.

Long-Term Follow-Up by Region Across VQI (Jan-Dec 2018)

Regions (regions with <3 centers with at least 10 cases not shown)

*** indicates region’s rate differs significantly from the VQI rate.
Discharge Medications

Procedures performed between January 1 and December 31, 2020
Includes CAS (TFEM CAS and TCAR), CEA, EVAR, INFRA, LEAMP, OAAA, PVI, SUPRA, and TEVAR procedures only. Antiplatelet is defined as ASA or P2Y12 inhibitor. Cases are excluded if (1) Discharge Statin = “No, for medical reason” OR (2) Both Discharge ASA = “No, for medical reason” AND Discharge P2Y12 inhibitor = “No, for medical reason” OR (3) An in-hospital death occurred.

The table below gives the number of procedures meeting the inclusion criteria, and the percentage of those procedures where patients received discharge medications.

<table>
<thead>
<tr>
<th></th>
<th>Number of Procedures at Your Center</th>
<th>Antiplatelet+Statin</th>
<th>Antiplatelet Only</th>
<th>Statin Only</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
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<td>LEAMP</td>
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<td>OAAA</td>
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<td>PVI</td>
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<td>SUPRA</td>
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<td>TEVAR</td>
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<tr>
<td>Your Center Overall</td>
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<tr>
<td>Your Region Overall</td>
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</tr>
<tr>
<td>VQI Overall</td>
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</tr>
</tbody>
</table>

The table data indicates the number of procedures and the percentage of patients receiving specific medications.
Discharge Antiplatelet+Statin by Center in Your Region (Jan-Dec 2020)

- **Other centers in your region**
- **Your center**

Centers (centers with <10 cases not shown)

*** indicates center’s rate differs significantly from the regional rate.

Discharge Antiplatelet+Statin by Region Across VQI (Jan-Dec 2020)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Regions (regions with <3 centers with at least 10 cases not shown)

- **Others**: indicates centers that do not belong to a regional group.
- *** indicates region’s rate differs significantly from the VQI rate.
Vascular Services
Performance Improvement:
Discharge Medications

“It Takes a Village”

Sheila DeBastiani, RT (R), SSGBC
Eileen Ramos, BSN, RN, HACP
# WakeMed Health & Hospitals
## Raleigh Campus
### VQI Project Charter

## Project Overview

**Problem Statement:** 87% of patients for combined registries were prescribed statins, ASA, anti-platelet therapy. Results varied between registries from 0% to 100% in the second quarter of 2019.

**Goal:** 90% (national goal)

**Scope:** Total applicable procedure volume entered into the VQI database from October-December 2019

**Deliverables:** Monthly compliance reports sent to Vascular Service Line beginning October 2019

**Resources required:** Education for all physicians and advanced practitioners writing discharge prescriptions for operators.

## Key Metrics

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Metrics:</strong></td>
<td></td>
</tr>
<tr>
<td>Verify that 90% of patients across each registry were discharged on anti-platelet and statin medication</td>
<td>Complete QI Project Charter</td>
</tr>
<tr>
<td></td>
<td>August 2019</td>
</tr>
<tr>
<td></td>
<td>Review baseline data by procedure</td>
</tr>
<tr>
<td></td>
<td>August 2019</td>
</tr>
<tr>
<td></td>
<td>Identify barriers, Root Cause Analysis</td>
</tr>
<tr>
<td></td>
<td>August 2019</td>
</tr>
<tr>
<td><strong>Process Metrics:</strong> Complete documentation for medications prescribed at discharge, to include medical contraindications for statins, ASA, and anti-platelet therapy.</td>
<td>Identify potential improvements</td>
</tr>
<tr>
<td></td>
<td>August 2019</td>
</tr>
<tr>
<td></td>
<td>Implement Changes; provide training</td>
</tr>
<tr>
<td></td>
<td>September 2019</td>
</tr>
<tr>
<td></td>
<td>Monitor changes</td>
</tr>
<tr>
<td></td>
<td>October-March 2019</td>
</tr>
</tbody>
</table>

## Team Members

<table>
<thead>
<tr>
<th>Executive Sponsor: Charles Harr, MD</th>
<th>Clinical Sponsor: Steven Kagan, MD; Joseph Salfity, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsor: Amanda Thompson, RN</td>
<td>Process Owner: Eileen Ramos</td>
</tr>
<tr>
<td>Project Leader: Sheila DeBastiani</td>
<td></td>
</tr>
<tr>
<td>Team Members: EPIC Analysts</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Nursing Unit Supervisors</td>
</tr>
<tr>
<td></td>
<td>Vascular Services APPs</td>
</tr>
</tbody>
</table>

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In collaboration with NCDR™
VQI Project Charter

Project Overview

• Problem Statement: 86% of patients for combined registries were prescribed statins, ASA, anti-platelet therapy. Results varied between registries from 0% to 100% in the second quarter of 2019.

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VQI Project Charter

Key Metrics

• Outcome Metrics:
  – Verify that 90% of patients across each registry were discharged on anti-platelet and statin medication

• Process Metrics:
  – Complete documentation for medications prescribed at discharge, to include medical contraindications for statins, ASA, and anti-platelet therapy.
VQI Project Charter

Milestones

• August 2019
  – Complete QI Project Charter
  – Review baseline data by procedure
  – Identify barriers, Root Cause Analysis
  – Identify potential improvements

• September 2019
  – Implement Changes; provide training

• October 2019 – March 2020
  – Monitor changes
VQI Discharge Meds 2nd Quarter 2019

%

100
90
80
70
60
50
40
30
20
10
0

1 2 3 4 5 6 7
VQI Registries
Methodology
PDSA Worksheet

Date: August 1, 2019

PDSA Coordinator: Sheila DeBastiani

FOCUS

Fully describe the problem:
The Society of Vascular Surgery best practice is to prescribe a statin and ASA/anti-platelet therapy to patients following a vascular intervention or surgery. WakeMed Raleigh reports to 7 VQI registries: EVAR, TEVAR, PVI, CEA, CAS, Infra and Supra Inguinal Bypass. Data for Quarter 2 of 2019 showed 86% of patients in the combined registries were prescribed the medications at discharge, with the range of 0-100%. The National Target Goal is 90%.

Organize a small team to facilitate the improvement: <list names>

Executive Sponsor: Charles Harr, MD; Sponsor: Amanda Thompson; Project Lead: Sheila DeBastiani; Clinical Sponsors: Steven Kagan, MD, Joseph Salfity, MD; Process Owner: Eileen Ramos

Clarify the improvement or result needed: <describe>

Improve the rate of patients prescribed a statin and ASA/anti-platelet therapy at discharge following a vascular surgery or procedure to at least 90% across all registries.

Uncover improvement ideas through brainstorming to address the problem: <list>

Educate providers on: best practices, documentation of “no, for medical reasons” if medication is contraindicated; educate APPs, Hospitalists, RNs on best practices regarding discharge medications; create letter template in EPIC to send to referring physician as a follow-up on prescribing statins at discharge; create “PASS” sticker as a reminder on the paper charts for outpatients to prescribe meds and schedule LTFU appointment; update post procedure orders.

Select one improvement idea from the list to test: <restate>

Educate providers and APPs: best practice of prescribing a statin and ASA/anti-platelet therapy at discharge and documentation in EPIC when medications are contraindicated.
PLAN

What process or change will be tested?

Will providing education to physicians and APPs on SVS recommendations for a statin and ASA/anti-platelet therapy at discharge and on documenting contraindications in EPIC when the medications are not prescribed result in reaching the National Target Goal of 90%?

Where will test occur and for how long?

The test will occur at WakeMed Raleigh for 6 months

What data will be collected? How and by whom?

The data will be collected on the number of patients prescribed both a statin and ASA/anti-platelet therapy at discharge. The documentation for "no, for medical reasons" will be monitored. The data will be collected using the VQI database by Eileen Ramos, RN.
DO – Carry Out the Plan

When did the test begin?  
October 1, 2019

How long was the idea tested?  
6 months

Who participated in the test?  
All physicians performing vascular procedures reported to the VQI registries and their designated APPs

STUDY

What was observed and were there any problems with the test?

Hospitalists sometimes write the discharge orders for vascular patients and were not aware of the SVS recommendations for discharge medications or the process put in place for documentation if the medication was not prescribed due to a contraindication. Statin at discharge is not an STS recommendation for TEVAR. WakeMed Cary, which participates in two registries, was not included in the test.

Did the tested solution result in an improvement?  Yes

What did the data show? Reference a graph if needed and provide statement of analysis if possible:

Goal of 90% was exceeded in 6 of the registries

If there was an improvement, was it worth the effort/investment?  Yes

Were there unintended side effects?  
No
What actions should be taken as a result of this PDSA?

☑ Adopt the solution as tested.  ☐ Adapt the solution and test again.  ☐ Abandon the solution and test a new idea.

What was learned from this PDSA?
Continued monitoring of data beyond the 6 month timeframe showed that the results were not sustainable. Additional education needed to be provided to other care providers.

What are the next steps to Adopt, Adapt or Abandon? Who is responsible for each step?

Adopt:
Education for hospitalists and nursing units: Sheila and Eileen
Real time review of EPIC chart at discharge with follow-up for fall outs: Eileen
Inclusion of WakeMed Cary registries in PI: Vascular Quality Team
Continue to monitor results until goal is achieved for all registries: Vascular Services Quality Team

REVIEW

PDSA results presented to Vascular Services Quality Team on (date) Quarterly Meetings

Comments:
Next Steps:

• Continue to monitor

• Utilize other “tools” in our “toolbox”
  ▪ Physician Scorecards
  ▪ Patient “Discharge PASS”
Collaboration with Cardiac & Vascular Quality:

Have You Completed Discharge CAPSS for Cardiac Patient?

- Cardiac Rehab Referral Order or instructions for when to return if patient already participating
- Aspirin
- Plavix, Brilinta or Effient (P2Y12)
- Statin
- Serum Creatinine for patients here > 24 hours

Have you completed Discharge PASS for Vascular Patient?

- P2Y12 Plavix, Brilinta, Effient or Aspirin
- Statin
- Schedule LTFU Office Visit (DRAFT)
Team Members

- Project Leader: Sheila DeBastani
- Process Owner: Eileen Ramos
- Executive Sponsor: Charles Harr, MD
- Clinical Sponsor: Steven Kagan & Joseph Salfity
- Sponsor: Amanda Thompson, RN
- Additional Support:
  - EPIC Analysts
  - Nursing Unit Supervisors
  - Pharmacy
  - Vascular APPs
https://www.vqi.org/members-login/


**TFEM CAS ASYMP: Stroke/Death**

Procedures performed between January 1 and December 31, 2020

Includes asymptomatic admissions for Transfemoral Carotid Artery Stenting (TFEM CAS) only. Asymptomatic admissions are admissions where the patient had no ipsilateral or contralateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar TIA or stroke, prior ipsilateral CAS, CAS for intracranial treatment, or any procedure involving dissection, trauma, FMD, or “Other” lesion types. Procedures with an approach other than “Femoral” are also excluded.

The table below gives the number of TFEM CAS procedures (performed on asymptomatic admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TFEM CAS procedures meeting inclusion criteria</td>
<td>51</td>
<td>1338</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>2%</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>38</td>
<td>1224</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>0%</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>1.1%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>1</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.*
Stroke or Death after TFEM CAS for Asymptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after TFEM CAS for Asymptomatic Admissions in Your Region (Jan-Dec 2020)

Other centers in your region  Your center  Observed  Expected

Centers (centers with <10 complete cases not shown)

Rates shown are among complete cases. "*" indicates center’s observed rate differs significantly from its expected rate.

Stroke or Death after TFEM CAS for Asymptomatic Admissions by Region Across VQI (Jan-Dec 2020)

Observed  Expected

Regions (regions with <3 centers with at least 10 complete cases not shown)

Rates shown are among complete cases. "*" indicates region’s observed rate differs significantly from its expected rate.
TFEM CAS SYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2020

Includes symptomatic admissions for Transfemoral Carotid Artery Stenting (TFEM CAS) only. Symptomatic admissions are admissions where the patient had an ipsilateral or contralateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar TIA or stroke, prior ipsilateral CAS, CAS for intracranial treatment, or any procedure involving dissection, trauma, FMD, or “Other” lesion types. Procedures with an approach other than “Femoral” are also excluded.

The table below gives the number of TFEM CAS procedures (performed on symptomatic admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TFEM CAS procedures meeting inclusion criteria</td>
<td>112</td>
<td>1537</td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>2.7%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>98</td>
<td>1434</td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>2%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>4.4%</td>
<td>NA</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.33</td>
<td>NA</td>
</tr>
</tbody>
</table>

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Stroke or Death after TFEM CAS for Symptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after TFEM CAS for Symptomatic Admissions in Your Region (Jan-Dec 2020)

Centers (centers with <10 complete cases not shown)

Rates shown are among complete cases. ** indicates center’s observed rate differs significantly from its expected rate.

Stroke or Death after TFEM CAS for Symptomatic Admissions by Region Across VQI
(Jan-Dec 2020)

Regions (regions with <3 centers with at least 10 complete cases not shown)

Rates shown are among complete cases. ** indicates region’s observed rate differs significantly from its expected rate.
TCAR ASYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2020

Includes asymptomatic admissions for TransCarotid Artery Revascularization (TCAR) only. Asymptomatic admissions are admissions where the patient had no ipsilateral or contralateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar TIA or stroke, prior ipsilateral CAS, CAS for intracranial treatment, or any procedure involving dissection, trauma, FMD, or “Other” lesion types.

The table below gives the number of TCAR procedures (performed on asymptomatic admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TCAR procedures meeting inclusion criteria</td>
<td>255</td>
<td>4068</td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>0.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>248</td>
<td>3864</td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>0.4%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>1.5%</td>
<td>NA</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.28</td>
<td>NA</td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.
Stroke or Death after TCAR for Asymptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after TCAR for Asymptomatic Admissions in Your Region (Jan-Dec 2020)

- Other centers in your region
- Your center
- Observed
- Expected

Centers (centers with <10 complete cases not shown)

Rates shown are among complete cases. "***" indicates center’s observed rate differs significantly from its expected rate.

Stroke or Death after TCAR for Asymptomatic Admissions by Region Across VQI (Jan-Dec 2020)

Regions (regions with <3 centers with at least 10 complete cases not shown)

Rates shown are among complete cases. "***" indicates region’s observed rate differs significantly from its expected rate.
TCAR SYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2020

Includes symptomatic admissions for TransCarotid Artery Revascularization (TCAR) only. Symptomatic admissions are admissions where the patient had an ipsilateral or contralateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebobasilar TIA or stroke, prior ipsilateral CAS, CAS for intracranial treatment, or any procedure involving dissection, trauma, FMD, or “Other” lesion types.

The table below gives the number of TCAR procedures (performed on symptomatic admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
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<th>Your Region</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of TCAR procedures meeting inclusion criteria</td>
<td>120</td>
<td></td>
<td>2138</td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>1.7%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>114</td>
<td></td>
<td>2039</td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>1.8%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>2%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>1</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.
Stroke or Death after TCAR for Symptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after TCAR for Symptomatic Admissions in Your Region (Jan-Dec 2020)

- Other centers in your region
- Your center
- Observed
- Expected

Centers (centers with <10 complete cases not shown)

Rates shown are among complete cases. "***" indicates center's observed rate differs significantly from its expected rate.

Stroke or Death after TCAR for Symptomatic Admissions by Region Across VQI (Jan-Dec 2020)

- Observed
- Expected

Regions (regions with <3 centers with at least 10 complete cases not shown)

Rates shown are among complete cases. "***" indicates region's observed rate differs significantly from its expected rate.
CEA ASYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2020

Includes asymptomatic admissions for Carotid Endarterectomy (CEA) only. Asymptomatic admissions are admissions where the patient had no ipsilateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar or non-specific TIA or stroke, prior ipsilateral CEA or CAS, or any procedure with a concomitant CABG, proximal endovascular, distal endovascular, or “Other” arterial procedure.

The table below gives the number of CEA procedures (performed on asymptomatic admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CEA procedures meeting inclusion criteria</td>
<td>732</td>
<td>8867</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>1%</td>
<td>0.9%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>673</td>
<td>8410</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>1%</td>
<td>0.9%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>1%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.85</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.
Stroke or Death after CEA for Asymptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
CEA ASYMP: Postop LOS>1 Day

Procedures performed between January 1 and December 31, 2020

Includes asymptomatic admissions for Carotid Endarterectomy (CEA) only. Asymptomatic admissions are admissions where the patient had no ipsilateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar or non-specific TIA or stroke, prior ipsilateral CEA or CAS, or any procedure with a concomitant CABG, proximal endovascular, distal endovascular, or “Other” arterial procedure. Procedures where in-hospital death occurred with postoperative LOS<=1 day are also excluded. Postoperative LOS is based on the midnight rule used for hospital billing.

The table below gives the number of CEA procedures (performed on asymptomatic admissions) meeting the inclusion criteria, and the observed and expected rates of postoperative LOS>1 Day for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CEA procedures meeting inclusion criteria</td>
<td></td>
<td></td>
<td>731</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among procedures meeting inclusion criteria</td>
<td></td>
<td></td>
<td>18.9%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td></td>
<td></td>
<td>674</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among cases with complete data</td>
<td></td>
<td></td>
<td>19.9%</td>
</tr>
<tr>
<td>Expected rate of LOS&gt;1 day among cases with complete data</td>
<td></td>
<td></td>
<td>22.9%</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td></td>
<td></td>
<td>0.06</td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.
Postop LOS>1 Day after CEA for Asymptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Postop LOS>1 Day after CEA for Asymptomatic Admissions in Your Region (Jan-Dec 2020)

Rates shown are among complete cases. "***" indicates center’s observed rate differs significantly from its expected rate.

Postop LOS>1 Day after CEA for Asymptomatic Admissions by Region Across VQI (Jan-Dec 2020)

Rates shown are among complete cases. "***" indicates region’s observed rate differs significantly from its expected rate.
CEA SYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2020

Includes symptomatic admissions for Carotid Endarterectomy (CEA) only. Symptomatic admissions are admissions where the patient had an ipsilateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar or non-specific TIA or stroke, prior ipsilateral CEA or CAS, or any procedure with a concomitant CABG, proximal endovascular, distal endovascular, or “Other” arterial procedure.

The table below gives the number of CEA procedures (performed on symptomatic admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CEA procedures meeting inclusion criteria</td>
<td>361</td>
<td>4593</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>1.9%</td>
<td>1.8%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>345</td>
<td>4416</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>2%</td>
<td>1.8%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>1.9%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.69</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.
Stroke or Death after CEA for Symptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after CEA for Symptomatic Admissions in Your Region (Jan-Dec 2020)

- Other centers in your region
- Your center
- Observed
- Expected

Rates shown are among complete cases. "***" indicates center's observed rate differs significantly from its expected rate.

Stroke or Death after CEA for Symptomatic Admissions by Region Across VQI (Jan-Dec 2020)

- Observed
- Expected

Regions (regions with <3 centers with at least 10 complete cases not shown)

Rates shown are among complete cases. "***" indicates region's observed rate differs significantly from its expected rate.
CEA SYMP: Postop LOS>1 Day

Procedures performed between January 1 and December 31, 2020

Includes symptomatic admissions for Carotid Endarterectomy (CEA) only. Symptomatic admissions are admissions where the patient had an ipsilateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar or non-specific TIA or stroke, prior ipsilateral CEA or CAS, or any procedure with a concomitant CABG, proximal endovascular, distal endovascular, or “Other” arterial procedure. Procedures where in-hospital death occurred with postoperative LOS<=1 day are also excluded. Postoperative LOS is based on the midnight rule used for hospital billing.

The table below gives the number of CEA procedures (performed on symptomatic admissions) meeting the inclusion criteria, and the observed and expected rates of postoperative LOS>1 Day for those cases.

<table>
<thead>
<tr>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CEA procedures meeting inclusion criteria</td>
<td>361</td>
<td>4592</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among procedures meeting inclusion criteria</td>
<td>42.1%</td>
<td>42.4%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>345</td>
<td>4430</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among cases with complete data</td>
<td>41.7%</td>
<td>42.3%</td>
</tr>
<tr>
<td>Expected rate of LOS&gt;1 day among cases with complete data</td>
<td>44%</td>
<td>NA</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.42</td>
<td>NA</td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.
Postop LOS>1 Day after CEA for Symptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
EVAR: Postop LOS>2 Days

Procedures performed between January 1 and December 31, 2020

Includes Endovascular AAA Repair (EVAR) procedures only. Excludes any procedure with ruptured aneurysm. Procedures where in-hospital death occurred with postoperative LOS≤2 are also excluded. Postoperative LOS is based on the midnight rule used for hospital billing.

The table below gives the number of EVAR procedures meeting the inclusion criteria, and the observed and expected rates of postoperative LOS>2 Days for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of EVAR procedures meeting inclusion criteria</td>
<td>496</td>
<td>6032</td>
<td></td>
</tr>
<tr>
<td>Observed rate of LOS&gt;2 days among procedures meeting inclusion criteria</td>
<td>17.7%</td>
<td>16.6%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>420</td>
<td>5450</td>
<td></td>
</tr>
<tr>
<td>Observed rate of LOS&gt;2 days among cases with complete data</td>
<td>19%</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of LOS&gt;2 days among cases with complete data</td>
<td>17.5%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.4</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.
Postop LOS>2 Days after EVAR by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Postop LOS > 2 Days after EVAR in Your Region (Jan-Dec 2020)

- Other centers in your region
- Your center
- Observed
- Expected

Centers (centers with <10 complete cases not shown)

Rates shown are among complete cases. "***" indicates center's observed rate differs significantly from its expected rate.

Postop LOS > 2 Days after EVAR by Region Across VQI (Jan-Dec 2020)

- Observed
- Expected

Regions (regions with <3 centers with at least 10 complete cases not shown)

Rates shown are among complete cases. "***" indicates region's observed rate differs significantly from its expected rate.
**EVAR: Sac Diameter Reporting**

Procedures performed between January 1 and December 31, 2018

Includes Endovascular AAA Repair (EVAR) procedures only. Excludes patients who were converted to open or died within 21 months of surgery.

The table below gives the number of EVAR procedures meeting the inclusion criteria, and the percentage of those procedures where a sac diameter was reported between 9 and 21 months post-procedure.

<table>
<thead>
<tr>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of EVAR procedures meeting inclusion criteria</td>
<td>588</td>
<td>6782</td>
</tr>
<tr>
<td>Percentage with sac diameter reported between 9 and 21 months post-procedure</td>
<td>62.9%</td>
<td>59.3%</td>
</tr>
</tbody>
</table>
EVAR Sac Diameter Reporting in Your Region (Jan-Dec 2018)

EVAR Sac Diameter Reporting Unblinding Legend for Your Region

<table>
<thead>
<tr>
<th>Index</th>
<th>Medical Center Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Novant Health Forsyth Medical Center</td>
</tr>
<tr>
<td>2</td>
<td>Alamance Regional Medical Center</td>
</tr>
<tr>
<td>3</td>
<td>Vidant Medical Center</td>
</tr>
<tr>
<td>4</td>
<td>McLeod Regional Medical Center</td>
</tr>
<tr>
<td>5</td>
<td>Mission Hospital</td>
</tr>
<tr>
<td>6</td>
<td>WakeMed Health &amp; Hospitals-Raleigh Campus</td>
</tr>
<tr>
<td>7</td>
<td>Palmetto Health Richland</td>
</tr>
<tr>
<td>8</td>
<td>Roper St. Francis</td>
</tr>
<tr>
<td>9</td>
<td>Cone Health</td>
</tr>
<tr>
<td>10</td>
<td>Novant Health Presbyterian Medical Center</td>
</tr>
<tr>
<td>11</td>
<td>Wake Forest University Baptist Health Medical Center</td>
</tr>
<tr>
<td>12</td>
<td>Self Regional Health</td>
</tr>
<tr>
<td>13</td>
<td>Sanger Heart and Vascular Institute</td>
</tr>
<tr>
<td>14</td>
<td>Spartanburg Regional</td>
</tr>
<tr>
<td>15</td>
<td>Trident Medical Center</td>
</tr>
<tr>
<td>16</td>
<td>Medical University of South Carolina Hospital</td>
</tr>
<tr>
<td>17</td>
<td>Duke University Medical Center</td>
</tr>
</tbody>
</table>

** Indicates center's rate differs significantly from the regional rate.
EVAR Sac Diameter Reporting by Region Across VQI (Jan-Dec 2018)

Regions (regions with <3 centers with at least 10 cases not shown)

*** Indicates region’s rate differs significantly from the VQI rate.
Moving The Needle

National Quality Initiative – EVAR Sac Diameter Report

• Wide Variation in Compliance – VQI Mean 58.6% (22-89%)
• Little improvement since inception in 2016

“It is the obligation of the operating surgeon to stress the need for lifelong surveillance and integrate discussions about LTFU into all stages of AAA EVAR care to ensure that their patients achieve optimal outcomes.” – Salvatore Scali, MD, Professor of Surgery, University of Florida.

Barriers to Reporting

• No LTFU; patient lost to evaluation
• Patient Factors
  ▪ No Need, “Feeling Well”
  ▪ Unaware of importance of LTFU and imaging
  ▪ Moved/phone disconnected
  ▪ Lost insurance
  ▪ Too far to travel/inconvenient parking
Other Barriers

- Dictated Patient Visit with “AAA sac unchanged” or “No endoleak or size increase”
- Imaging not available at time of visit
- Center not wanting to use Radiology report information

Discussion

Suggestions for improvement:

- Center unblinding at Regional meetings ➔ Peer competition
- Biannual Physician Report sent with PRIMPROCID information
- GC Update Report from each Regional Medical Director to maintain awareness
- “Best Practice” Webinar made available for low performing centers
- Make Sac Diameter size notation at every patient encounter
EVAR: SVS Sac Size Guideline

Procedures performed between January 1 and December 31, 2020

Includes Endovascular AAA Repair (EVAR) procedures only. Excludes any non-elective procedure. SVS sac size guideline is ≥5 cm for Women and ≥5.5cm for men. If the patient has any iliac aneurysm, the guideline is considered met regardless of AAA diameter.

The table below gives the number of EVAR procedures meeting the inclusion criteria, and the percentage of those procedures meeting the SVS sac size guideline.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of EVAR procedures meeting inclusion criteria</td>
<td>433</td>
<td>5357</td>
<td></td>
</tr>
<tr>
<td>Percentage meeting SVS sac size guideline</td>
<td>77.8%</td>
<td>74.2%</td>
<td></td>
</tr>
</tbody>
</table>
TEVAR: Sac Diameter Reporting

Procedures performed between January 1 and December 31, 2018

Includes Thoracic Endovascular Aortic Repair (TEVAR) procedures for aneurysm or aneurysm from dissection only. Excludes cases where no aortic device was implanted or patients who were converted to open or died within 21 months of surgery.

The table below gives the number of TEVAR procedures meeting the inclusion criteria, and the percentage of those procedures where a sac diameter was reported between 9 and 21 months post-procedure.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TEVAR procedures meeting inclusion criteria</td>
<td>136</td>
<td>1454</td>
<td></td>
</tr>
<tr>
<td>Percentage with sac diameter reported between 9 and 21 months post-procedure</td>
<td>44.9%</td>
<td>59.8%</td>
<td></td>
</tr>
</tbody>
</table>
TEVAR Sac Diameter Reporting in Your Region (Jan-Dec 2018)

*** Indicates center’s rate differs significantly from the regional rate.

TEVAR Sac Diameter Reporting by Region Across VQI (Jan-Dec 2018)

*** Indicates region’s rate differs significantly from the VQI rate.
OAAA: In-Hospital Mortality

Procedures performed between January 1 and December 31, 2020
Includes Open AAA (OAAA) procedures only. Excludes any patient with a ruptured aneurysm.

The table below gives the number of OAAA procedures meeting the inclusion criteria, and the observed and expected rates of in-hospital death for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of OAAA procedures meeting inclusion criteria</td>
<td>47</td>
<td>1044</td>
<td></td>
</tr>
<tr>
<td>Observed rate of In-Hospital Mortality among procedures meeting inclusion criteria</td>
<td>8.5%</td>
<td>4.6%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>41</td>
<td>977</td>
<td></td>
</tr>
<tr>
<td>Observed rate of In-Hospital Mortality among cases with complete data</td>
<td>7.3%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of In-Hospital Mortality among cases with complete data</td>
<td>4.5%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.43</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.
In-Hospital Death after OAAA by Year

Rates shown are observed rates among cases meeting inclusion criteria.
In-Hospital Death after OAAA in Your Region (Jan-Dec 2020)

Rates shown are among complete cases. "**" indicates center’s observed rate differs significantly from its expected rate.

In-Hospital Death after OAAA by Region Across VQI (Jan-Dec 2020)

Regions (regions with <3 centers with at least 10 complete cases not shown).

Rates shown are among complete cases. "***" indicates region’s observed rate differs significantly from its expected rate.
OAAA: SVS Cell-Saver Guideline

Procedures performed between January 1 and December 31, 2020
Includes Open AAA (OAAA) procedures only. Excludes any patient with EBL≤500 ml. SVS cell-saver guideline is met if cell salvage or ultrafiltration device was used.

The table below gives the number of OAAA procedures meeting the inclusion criteria, and the percentage of those procedures meeting the SVS cell-saver guideline.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of OAAA procedures meeting inclusion criteria</td>
<td></td>
<td>44</td>
<td>1063</td>
</tr>
<tr>
<td>Percentage meeting SVS cell-saver guideline</td>
<td></td>
<td>95.5%</td>
<td>92.5%</td>
</tr>
</tbody>
</table>
OAAA Cell-Saver Guideline in Your Region (Jan-Dec 2020)

- Other centers in your region
- Your center

Centers (centers with <10 cases not shown)

*** Indicates center’s rate differs significantly from the regional rate.

OAAA Cell-Saver Guideline by Region Across VQI (Jan-Dec 2020)

- Southeast
- New England*
- VQI
- G. Lakes
- Canada*

Regions (regions with <3 centers with at least 10 cases not shown)

*** Indicates region’s rate differs significantly from the VQI rate.
**OAAA: SVS Iliac Inflow Guideline**

Procedures performed between January 1 and December 31, 2020

Includes Open AAA (OAAA) procedures only. SVS iliac inflow guideline is met if preservation of flow was maintained to at least one internal iliac artery.

The table below gives the number of OAAA procedures meeting the inclusion criteria, and the percentage of those procedures meeting the SVS iliac inflow guideline.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of OAAA procedures meeting inclusion criteria</td>
<td></td>
<td>48</td>
<td>1176</td>
</tr>
<tr>
<td>Percentage meeting SVS iliac inflow guideline</td>
<td></td>
<td>95.8%</td>
<td>98.1%</td>
</tr>
</tbody>
</table>
OAAA Iliac Inflow Guideline in Your Region (Jan-Dec 2020)

Centers (centers with <10 cases not shown)

**Indicates center's rate differs significantly from the regional rate.

OAAA Iliac Inflow Guideline by Region Across VQI (Jan-Dec 2020)

Regions (regions with <3 centers with at least 10 cases not shown)

**Indicates region's rate differs significantly from the VQI rate.
PVI CLAUD: ABI/Toe Pressure

Procedures performed between January 1 and December 31, 2020

Includes Peripheral Vascular Intervention (PVI) procedures for mild, moderate, or severe claudication only. “ABI/Toe Pressure Assessment” indicates at least one ABI or toe pressure assessment was made prior to PVI for the side of the procedure, or on both sides for bilateral and aortic procedures.

The table below gives the number of PVI procedures meeting the inclusion criteria, and the percentage of those procedures in which an ABI or toe pressure was assessed prior to PVI.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PVI procedures meeting inclusion criteria</td>
<td>976</td>
<td>12455</td>
<td></td>
</tr>
<tr>
<td>Percentage with ABI/toe pressure assessment</td>
<td>84.9%</td>
<td>74.5%</td>
<td></td>
</tr>
</tbody>
</table>
INFRA CLTI: Major Complications

Procedures performed between January 1 and December 31, 2020

Includes Infrainguinal Bypass (INFRA) procedures for rest pain, tissue loss, or acute ischemia. Major complications are defined as in-hospital death, ipsilateral BK or AK amputation, or graft occlusion.

The table below gives the number of INFRA procedures meeting the inclusion criteria, and the percentage of those procedures that resulted in in-hospital death, ipsilateral BK or AK amputation, or graft occlusion.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of INFRA procedures meeting inclusion criteria</td>
<td></td>
<td>648</td>
<td>5212</td>
</tr>
<tr>
<td>Percentage with major complications</td>
<td></td>
<td>5.9%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>
Major Complications after INFRA for CLTI by Year

- Your Center
- Your Region
- VQI Overall
SUPRA CLTI: Major Complications

Procedures performed between January 1 and December 31, 2020
Includes Suprainguinal Bypass (SUPRA) procedures for rest pain, tissue loss, or acute ischemia. Major complications are defined as in-hospital death, ipsilateral BK or AK amputation, or graft occlusion.

The table below gives the number of SUPRA procedures meeting the inclusion criteria, and the percentage of those procedures that resulted in in-hospital death, ipsilateral BK or AK amputation, or graft occlusion.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of SUPRA procedures meeting inclusion criteria</td>
<td>137</td>
<td>1177</td>
<td></td>
</tr>
<tr>
<td>Percentage with major complications</td>
<td>8.8%</td>
<td>7.4%</td>
<td></td>
</tr>
</tbody>
</table>
LEAMP: Postop Complications

Procedures performed between January 1 and December 31, 2020
Includes Lower-Extremity Amputation (LEAMP) procedures only. Postoperative complications are defined as myocardial infarction, dysrhythmia, congestive heart failure, surgical site infection, renal complication, or respiratory complication.

The table below gives the number of LEAMP procedures meeting the inclusion criteria, and the percentage of those procedures that resulted in a postoperative complication.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of LEAMP procedures meeting inclusion criteria     438</td>
<td>3184</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage with postoperative complications               10.7%</td>
<td>10.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Postop Complications after LEAMP by Year

- Your Center
- Your Region
- VQI Overall

Year: 2017, 2018, 2019, 2020

Complication Rate: 0%, 5%, 10%
Postop Complications after LEAMP in Your Region (Jan-Dec 2020)

- Other centers in your region
- Your center

*** Indicates center’s rate differs significantly from the regional rate.

Postop Complications after LEAMP by Region Across VQI (Jan-Dec 2020)

- Rocky Mtns
- Mid-America
- Virginia
- Southeast
- New York
- Up Midwest
- VQI
- Carolinas
- New England

*** Indicates region’s rate differs significantly from the VQI rate.
HDA: Primary AVF vs. Graft

Procedures performed between January 1 and December 31, 2020
Includes Hemodialysis Access (HDA) procedures only. Excludes procedures where Access Type = Endo AVF or patients with a previous access procedure in the same arm.

The table below gives the number of HDA procedures meeting the inclusion criteria, and the percentage of those procedures that were primary AVF.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of HDA procedures meeting inclusion criteria</td>
<td></td>
<td>281</td>
<td>5069</td>
</tr>
<tr>
<td>Percentage with primary AVF</td>
<td></td>
<td>71.2%</td>
<td>81.7%</td>
</tr>
</tbody>
</table>
IVCF: Filter Retrieval Reporting

Procedures performed between January 1 and December 31, 2018

Includes Inferior Vena Cava Filter (IVCF) procedures only. Excludes filters with permanent planned duration, patients who have died since discharge, or patients where no follow-up was possible.

The table below gives the number of procedures meeting the inclusion criteria, and the percentage of those procedures in which the filter was reported as retrieved (or retrieval was attempted) at any time post-procedure. Because follow-up is critical for assessing filter retrieval, cases meeting the inclusion criteria are broken down into those with follow-up records (at least 1 follow-up record) and those without follow-up records.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of IVCF procedures meeting inclusion criteria</td>
<td>128</td>
<td>1224</td>
<td></td>
</tr>
<tr>
<td>Number without follow-up records</td>
<td>38</td>
<td>145</td>
<td></td>
</tr>
<tr>
<td>Number with follow-up records</td>
<td>90</td>
<td>1079</td>
<td></td>
</tr>
<tr>
<td>Percentage with Filter Retrieval, or Attempt at Retrieval</td>
<td>42.2%</td>
<td>59.7%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because No Follow-up Records Created</td>
<td>29.7%</td>
<td>11.8%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Not Clinically Indicated</td>
<td>16.4%</td>
<td>18.8%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Patient Declined</td>
<td>3.9%</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Lost to Follow-Up</td>
<td>3.1%</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Deemed Too Late for Removal</td>
<td>0%</td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Planned Later Removal</td>
<td>5.5%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because No Reason Given</td>
<td>2.3%</td>
<td>1.1%</td>
<td></td>
</tr>
</tbody>
</table>
**IVC Filter Retrieval Reporting in Your Region (Jan-Dec 2018)**

- Other centers in your region
- Your center

**Centers (centers with <10 cases not shown)**

"*" indicates center's rate differs significantly from the regional rate.

**IVC Filter Retrieval Reporting by Region Across VQI (Jan-Dec 2018)**

- Mid-America*
- VQI
- Virginias
- New York
- Carolinas*
- Southeast*

Regions (regions with <3 centers with at least 10 cases not shown)

"*" indicates region's rate differs significantly from the VQI rate.
Regional Improvement Projects

- Katharine McGinigle, MD
- Thomas Todoran, MD
- Maureen Sheehan, MD
- Elizabeth Genovese, MD
National VQI Update:
Jim Wadzinski
Deputy Executive Director, SVS PSO
Number of Participating Centers

Location of VQI Participating Centers

784 VQI Centers
783 centers in North America
1 center in Singapore
VQI Regional Quality Groups

18 Regional Quality Groups
VQI Procedure Volume

Total Procedures Captured (as of 3/1/2021) 800,030

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral Vascular Intervention</td>
<td>264,170</td>
</tr>
<tr>
<td>Carotid Endarterectomy</td>
<td>153,662</td>
</tr>
<tr>
<td>Infra-Inguinal Bypass</td>
<td>66,858</td>
</tr>
<tr>
<td>Endovascular AAA Repair</td>
<td>62,262</td>
</tr>
<tr>
<td>Hemodialysis Access</td>
<td>62,252</td>
</tr>
<tr>
<td>Carotid Artery Stent</td>
<td>52,728</td>
</tr>
<tr>
<td>Varicose Vein</td>
<td>44,970</td>
</tr>
<tr>
<td>Supra-Inguinal Bypass</td>
<td>21,629</td>
</tr>
<tr>
<td>Lower Extremity Amputations</td>
<td>20,547</td>
</tr>
<tr>
<td>Thoracic and Complex EVAR</td>
<td>20,624</td>
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<tr>
<td>IVC Filter</td>
<td>15,486</td>
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<tr>
<td>Open AAA Repair</td>
<td>14,762</td>
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<tr>
<td>Vascular Medicine Consult</td>
<td>55</td>
</tr>
<tr>
<td>Venous Stent</td>
<td>25</td>
</tr>
</tbody>
</table>

VQI Total Procedure Volume

Total Procedure Volume tab reflects net procedures added to the registry for the month.
Trainee engagement:

- VQI wants to help medical students, residents and fellows learn about quality improvement
Trainee engagement:

Plans –

- Invite students and trainees to regional and national meetings
- Engage students and trainees in quality improvement projects
- Participate in presentations and publications
- VQI intern program (in development)
Trainee engagement:

- What are your ideas?
Update on PSO Diversity Committee

VQI Members call for volunteers early 2021:

• 19 Applicants

• VQI Representatives
  – Dr. Leila Mureebe – Chair
  – Dr. Carla Moreiro – Vice-Chair
  – Dr. Samantha Minc
  – Dr. Patricia Fernandez
  – Dr. Mina Boutros
  – Dr. Rafael Malgor
Update on PSO Diversity Committee

• Awaiting appointments from
  - SVS DEI Committee
  - AVF
  - ACC

• Broad representation
  - Years in practice
  - Region
  - Gender
  - Race
FDA Safety Notifications

• As a Patient Safety Organization, we feel compelled to share Safety Notifications with VQI Members
• FDA will contact the SVS PSO with Safety Notifications it wants us to communicate
• Safety Notifications will appear in both the PSO and SVS newsletters
• All Safety Notifications are posted to the VQI and SVS Websites

https://www.vqi.org/resources/fda-communication/
The 2021 VQI Annual Meeting has been moved to August!

Important Dates and Times for the 2021 VQI Annual Meeting at VAM

August 17, 2021 12PM – 6:30PM* Pacific Time
August 18, 2021 8AM – 5PM Pacific Time
*Poster Presentation and Networking Reception – Tuesday, August 17th at 5:00PM to 6:30PM

We are hopeful that we will be able to have an in-person meeting at the San Diego Convention Center. In the event we are unable to meet live, we will transition to on-line presentation.
ACC and SVS Join Forces

Now Is The Time

- ACC and SVS began 2021 with a united vascular registry - creating a single resource focused on improving care and outcomes of patients with vascular disease.

- ACC PVI registry participants who have not yet joined the SVS VQI, may contact the SVS VQI account team by emailing vqi@m2s.com, or by calling 603-298-6717, to begin enrollment.
Ongoing Collaboration

ACC NCDR will have **representation** on all VQI Councils and Committees
COVID-19 Update

• COVID-19 Variable insertion into registries (Sept. 2020)
• Two JVS Publications (JVS & JVSVL) on registry volumes
• AHRQ PSO Presentation on VQI Response
• International Registry submission for June issue *Seminars in Vascular Surgery*
• Initial Outcomes Review of COVID-19 effect in registries
• Collaboration with Vascular Surgery COVID-19 Collaborative (VASCC) on LTFU in participating centers
My Peripheral Arterial Disease: a VQI Pilot of Patient Reported Outcomes for PAD

• The Society for Vascular Surgery Vascular Quality Initiative is seeking practices to participate in My PAD, a pilot program for the collection of patient reported outcomes (PRO) on patients undergoing endovascular treatment for peripheral arterial disease (PAD).

• The VQI recognizes that traditional outcomes such as patency and reintervention may not fully capture the quality of care or the experience of PAD patients. There is a long overdue need to learn and measure the patient’s perspective.

• **Must be in the PVI registry and have greater than 70% follow up! Not too late to join the Pilot!!**
**PAD Patient Reported Outcomes (PROs)**

**Highlights**

- Outpatient peripheral vascular interventions (PVI) for claudication or chronic limb threatening ischemia
- Collect VascuQoL-6 and EuroQoL 5D-5L (estimated completion time 10-15 minutes)
- Collection at three time points: pre-procedure, one month and one year postoperatively
- PRO data entry options include paper forms, computer, tablet and smart phone
- Educational materials for direct from patient data entry
- PRO feedback to participating physicians
Reporting Highlights and Questions:

• New On-line Follow-up reports
  – EVAR Released - Jan 2021
  – CEA/CAS/PVI/TEVAR – To Be Released in 2021

• New Dashboard and Regional Report Drilldown

• Suggestions for “other” reports
CME/CE CREDIT FOR REGIONAL MEETINGS

SPRING 2021
### Successful Rollout

<table>
<thead>
<tr>
<th>Type of credit</th>
<th>Total of those who took survey and claimed Contact Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBON (Iowa Board of Nursing)</td>
<td>83</td>
</tr>
<tr>
<td>AMA (MD/DO)</td>
<td>75</td>
</tr>
<tr>
<td>CE (Others)</td>
<td>25</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td><strong>183</strong></td>
</tr>
<tr>
<td>Approx. time to complete eval</td>
<td>6 min</td>
</tr>
<tr>
<td>31.4% of meeting attendees</td>
<td>183/582</td>
</tr>
</tbody>
</table>
Please describe any 'pearls' or takeaway messages:

• Identifying our areas of concern by comparison to others in our region and nationally is helpful toward setting priorities
• Other facilities are experiencing the same difficulties I am with data abstraction
• Excellent Meeting
• Good collaboration and networking with peers
• How important it is for my facility, not just the doctors, to have this information from the registry
• By sharing the report with benchmarks, our organization will identify quality improvements we can work on to improve patient outcomes
• Will look into doing more patient education
Barriers

- Lack of administrative support, Patient compliance issues
- Lack of resources/equipment
- MDs to give specific measurement in their notes
- Abstractions leave little time for QI projects
- COVID, patients traveling and receiving follow up elsewhere

How will you address these barriers?

- Look in to obtaining additional administrative organization and support
- Review operational definitions and email m2support for clarification
- Educate others at my location. Continue patient education and follow-up.
- Keep as organized as possible and enter patient information ASAP
- Work with IT to create template for follow-up office visits (to include key data points)
- Show cost savings of implementation
- Better communication with PCP
Des Moines University is the continuing education provider for this activity.

The attendance roster will be cross-referenced with those applying for CME/CE. Sign in correctly.

Each participant **MUST COMPLETE BOTH** the attendance attestation and the meeting evaluation from the URL site – one form.

You will have 7 days from the date of the meeting to complete the forms and **SUBMIT**.

Approximately 14 days from the meeting, Des Moines University will email you instructions on how to access your certificate.

PSO leadership is providing continuing education credit to you at no charge!

If you do not complete and submit the online forms within 7 days, continuing education credit cannot be awarded.
Meeting Attendance Credit

**REMEMBER TO PSO:**

- **P**ut your FULL NAME in RingCentral to get credit for attendance and CME/CE credit (no exceptions will be made)
- **S**end an email to ljohnson@svspso.org with names of group members that are sharing 1 device
- **O**fficially apply for CME/CE credit by clicking this link: [https://dmu.co1.qualtrics.com/jfe/form/SV_1KXWMZ7BTN92j8G](https://dmu.co1.qualtrics.com/jfe/form/SV_1KXWMZ7BTN92j8G)

You only have **7 days** to complete forms for CME/CE Credit.

NO EMAIL WILL BE SENT AS A REMINDER OR WITH THE CME/CE LINK
Quality Improvement Update

Spring 2021
Quality Improvement Resources:

- 2021 Quarterly Webinars
  - March 2021
  - June 2021
  - September 2021
  - November/December 2021
    - Participation Award Information

- The VQI News
  - Provides updates on regulatory issues, technical updates, and crossover news from the SVS and SVN

- VQI Quality Improvement Newsletter
  - Focusing on QI processes, tools, and definitions

- VQI.org Members only pages
Update on Charters 2020 and 2021

- Fifty-eight (58) charters submitted in 2020!
  - LTFU – 14
  - D/C Medications – 17
  - Clinical – 3
  - *Documentation – 24
- *Multi-regional AAA size compliance project – 19 charter participants. 33 overall participants.
- 2021 – Twenty charters already!
- Focused phone calls are well attended – now on a quarterly schedule (Jan, April, July, Oct).
Putting VQI Data into Action
See what your colleagues are doing with QI

- Abstracts were submitted and acceptance notifications were sent out on March 1st
- Planning on an in-person meeting in San Diego
- If needed, we will once again convert the meeting into an all-virtual format
- Incorporating some aspects of virtual online learning
- Posters that were accepted for 2020 were automatically accepted into the 2021 poster session without the need to resubmit
Charters

- Charter participants become part of focused group calls
  - Interactive discussion sharing barriers and successes
  - Sharing of charters
  - Networking
  - Checking in – where are you in the process
  - Celebrating success

One on one calls, if requested
National QI project details

• Submit Project Charters and supporting documentation for presentations and posters to QI@SVSPSO.ORG or cjackson@svspso.org.

• Visit the VQI Members Only Website for sample charters, webinars, and presentations on VQI Quality Improvement Projects. www.vqi.org
2020 Participation Award Changes
MAJOR CHANGE

• Long Term Follow-Up 2018 cases
  – COVID-19 affect
  – Remove LFTU from the 2020 Participation Award – BUT...
  – Acknowledge centers that maintained, improved LTFU with a certificate

• Centers in top 25% for 2018 LTFU rates
• Statistically significant increase in LTFU rate from 2017 to 2018
Scoring 2020 (During COVID-19)

• Three categories scored, each on a 0-6 point scale:
  o LTFU – REMOVED. Separate recognition.
  o Meeting attendance (weighted 50%)
  o QI project involvement (weighted 40%)
  o Number of registry subscriptions (weighted 10%)

• The final score is calculated as follows:
  Total points = 5 x Attendance score + 4 x QIP score + 1 x Registry score
Participation Awards Program

- 2020 Participation Award results to be announced soon.
- 3 Star recipients are presented at the in-person Annual VQI meeting.
- Participation Awards began in 2016 to encourage active participation in the registries program and recognize the importance of participation.
- Participating centers can earn up to three stars based on actions that lead to better patient care – more details available at https://www.vqi.org/quality-improvement/participation-awards/
Participation Award Results - CVQG

Novant Health Forsyth Medical Center
Medical University of South Carolina Hospital
WakeMed Health & Hospitals-Raleigh Campus
WakeMed Health & Hospitals-Cary Campus

Novant Health Presbyterian Medical Center
University of North Carolina Hospitals
Self Regional Health
Mission Hospital
McLeod Regional Medical Center
Vidant Medical Center
Duke University Medical Center

Roper St. Francis
Alamance Regional Medical Center
Cone Health
Beaufort Memorial Hospital
Trident Medical Center
Palmetto Health Richland
Wake Forest University Baptist Health Medical Center
Atrium Health Pineville
Rex Hospital, Inc.

Congratulations!
Arterial Quality Council:
Thomas Todoran, MD
AQC Update:

Chair: Randy DeMartino, MD (Mayo)
Vice Chair: Jessica Simons, MD (UMASS)
Kelly Byrnes & Marguerite Marlow, Vascular Ultrasound representatives
ACC to make 2 appointments mid 2021
AQC Update:

<table>
<thead>
<tr>
<th>Preliminary Development priorities for 2021:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Infra/Supra - Jess Simons</td>
</tr>
<tr>
<td>2. OAAA - Rumi Faizer</td>
</tr>
<tr>
<td>3. Amputation - Ahmed Abou-Zamzam</td>
</tr>
</tbody>
</table>

Always looking for Volunteers to Join Registry Committees! Contact Carrie Bosela C.Bosela@svspso.org if interested!!
AQC Update:

- Clinical Appropriateness Performance Indicators (CAPI reports)
  - Aligning with SVS Guidelines
- Registry Specific Quality Improvement Initiatives
- PAD PRO’s
- COVID Interest Group and Response (CIGAR)
  - VASCC Collaboration
The Society for Vascular Surgery Patient Safety Organization® (SVS PSO) and the Society for Vascular Medicine (SVM), in collaboration with the American Heart Association® (AHA), are excited to introduce the SVS Vascular Quality Initiative’s Vascular Medicine Consult (VMC) Registry.

This Registry will target the management of NEW Outpatient Consults who are being treated medically for:

- Atherosclerotic carotid artery occlusive disease
- Abdominal Aortic aneurysm
- Peripheral lower extremity arterial disease due to atherosclerosis or true aneurysm

The Vascular Medicine Consult Registry provides a unique opportunity to look at the natural history of a disease and what factors impact the progression. The emphasis of this Registry will be medication details and dosages, risk factor and lifestyle modifications such as exercise and diet, and non-operative treatments and counseling. The value of this Registry centers on the comparative effectiveness of surgery vs. medically managing these vascular diseases.

Learn more: The Vascular Quality Initiative | Vascular Medicine Consult Registry (New) (vqi.org)
Venous Quality Council:
Maureen Sheehan, MD
Venous SVS PSO Organization

SVS PSO Venous Arm

**Governing Council**
- 4 SVS Representatives
- 2 AVF Representatives
- 18 Regional Group Representatives

**Research Advisory Council (venous RAC)**
- Chair: Nicholas Osborne

**Venous Quality Council (VQC)**
- Chair: Marc Passman
  - 3 AVF + 2 SVS Representatives
  - 18 Regional Group Representatives

**IVC Filter Committee**
- Chair: Tony Gasparis

**Varicose Vein Committee**
- Chair: Nick Osborne

**Venous Stent Committee**
- Chair: William Marston

new

[Image]

[SVS | VQI]

In collaboration with NCDR

[SVS | Society for Vascular Surgery]
[American Venous Forum]
[m2S]
[Society for Vascular Medicine]
[VASA]
[SVL | Society for Vascular Lymphedema]
Three Year Goals for VQC:

- Dedicated podium time for VQI at AVF
- Update Varicose Vein and IVC quarterly interoperative dashboards
- Create Venous Stent dashboard
- Work on LTFU dashboards for all 3 venous procedures
- Continue work C2 disease and appropriateness of care
- Continue work with United Healthcare
- Create COPI (Center Opportunity for Process Improvement) reports
- Create CAPI (Clinical Appropriateness Performance Indicators) reports
Venous Stent Inclusion/Exclusion Criteria

Inclusion Criteria:
Percutaneous (closed) and/or cut-down (open) procedures to treat patients with symptomatic venous obstructions due to chronic thrombosis and/or some venous compression disorders. Vessels included: Inferior Vena Cava, Common iliac vein, External iliac vein, Common Femoral Vein, Deep Femoral Vein, Femoral Vein, Popliteal Vein.

- Acute obstruction of the Vein;
- Chronic thrombotic obstruction= Chronic Stenosis/Obstruction of the Vein;
- Non-thrombotic stenosis/compression such as May Thurner (iliac vein compression syndrome)

Exclusion Criteria:
- Venous Stent of the Internal Iliac (hypogastric), Great Saphenous Vein, Superior vena cava, Renal Veins, Subclavian vein, Jugular vein, Innominate vein and any upper extremity veins
- Vein Diameters that are not treatable per stent sizing recommendations
- Venous Inflow or Outflow issues precluding stent placement
Join Today!!!

- **VQI@M2S.com**
- Lots of research potential
  - Submit ideas to Venous RAC

**The Vascular Quality Initiative | National Arterial and Venous RAC Schedules (vqi.org)**
Research Advisory Council:

Elizabeth Genovese, MD
1. Review list of projects approved to avoid duplication
   https://www.vqi.org/data-analysis/rac-approved-project-search/

2. Submit proposal online:
   http://abstracts123.com/svs1/meetinglogin


4. Mortality After Paclitaxel Coated Balloon Angioplasty and Stenting of Superficial Femoral and Popliteal Artery in the Vascular Quality Initiative. Circ Cardiovasc Interv, 13(2), e008528. [https://doi.org/10.1161/circinterventions.119.008528](https://doi.org/10.1161/circinterventions.119.008528)

1. **Five-year reintervention after endovascular abdominal aortic aneurysm repair in the Vascular Quality Initiative.**
   J Vasc Surg, 71(3), 799-805.e791. [https://doi.org/10.1016/j.jvs.2019.05.057](https://doi.org/10.1016/j.jvs.2019.05.057)

2. **Drain placement confers no benefit after carotid endarterectomy in the Vascular Quality Initiative.**
   J Vasc Surg, 72(1), 204-208.e201. [https://doi.org/10.1016/j.jvs.2019.09.042](https://doi.org/10.1016/j.jvs.2019.09.042)

3. **Predictors of Underutilization of Medical Therapy in Patients Undergoing Endovascular Revascularization for Peripheral Artery Disease.** JACC Cardiovasc Interv, 13(24), 2911-2918. [https://doi.org/10.1016/j.jcin.2020.08.036](https://doi.org/10.1016/j.jcin.2020.08.036)

4. **Multivessel tibial revascularization does not improve outcomes in patients with critical limb ischemia.**
   J Vasc Surg, 71(6), 2083-2088. [https://doi.org/10.1016/j.jvs.2019.08.251](https://doi.org/10.1016/j.jvs.2019.08.251)

• Agenda for GC Meeting – April 2021
• Dr. Mureebe will discuss the formation of the SVS PSO’s new Diversity, Equity and Inclusion Committee
• Jim and Carrie will present the draft agenda for the VQI Annual Meeting and solicited ideas for additional programing
• Drs. Lemmon and Jorgensen will present the GC a proposal on a new PSO Trainee Scholarship Program
• Dr. Weaver will provide an update on progress against strategic priorities, including an update on our collaboration with ACC
M2S Updates

Spring 2021

Regional Group Meetings
VQI Technology Updates
Revised warning COVID-19 message for Follow-up Mandatory Variable

- Released on 7/29/2020
- The VQI added a temporary message about the impact of COVID-19 on LTFU completion rate calculations. The following message will display when submitting a LTFU that is missing any mandatory variable:
  - “IMPORTANT: The PSO understands that routine follow up visits may not be possible due to COVID-19 state mandates. Special considerations will be part of our LTFU calculation for 2020, please collect all of the required fields that are possible during this time.”
- As a reminder, the VQI allows phone and telehealth appointments to be used for LTFU when Face-to-Face visits are not feasible.
“Was Help Text Helpful?” feature in help text box

- Released on **7/29/2020**
- This new feature is to provide feedback regarding the current help text. For each help text field, users will have the option to indicate if the help text provided was useful or not. This information will help the VQI to identify data fields that may be unclear to members.
- The “Was this helpful?” vote up/down button will display in the bottom right corner of the help text box:
Technology Released in Q4 2020

• Across-registry revision to add Covid-19 variables and optional Patient Email
  – Released on **8/29/2020** (SUPRA, INFRA, HDA, VVR, VSR & PVI)
  – Released on **9/23/2020** (AMP, IVC, CAS, EVAR & TEVAR)
  – Added 4 procedure variables and 1 30-day and LTF follow-up variable to VQI registries to collect information about COVID-19.
  – Added an optional Patient Email variable in the procedure form to support the upcoming PRO project.
  – The procedure fields are added to the existing Procedure form tab and follow-up field to the existing 30-day and long-term Follow-up tabs. All fields are consistent across registries, and are added for all sites enrolled in the registry.
Technology Released in Q4 2020

- TEVAR Revision to align with SVS/STS guidelines
  - Released on 9/30/2020
  - Modified fields on the TEVAR form in order to become aligned with updated SVS/STS guidelines described in the article “Society for Vascular Surgery (SVS) and Society of Thoracic Surgeons (STS) reporting standards for type B aortic dissections”.
  - The overall intent of the SVS/STS is to generate more cohesive classification guidelines for both societies to follow in order to extract more granular information which would result in better reporting and research on type b aortic dissections.
  - The definition prior to this change was Type A = Zones 0-1 and Type B = Zones 2-5. The new definition is Type A = Zone 0 and Type B = Zone 1 and beyond as shown in the image to the right.
**Technology Released in Q4 2020**

- TEVAR Revision to align with SVS/STS guidelines (Cont’d)
  - Procedure Form
    - **Relation to Prior Dissection:** The existing “Relation to Prior Dissection” field received updated help text that identifies the new dissection zones and includes a new image within the help text pop-up.
    - **Entry Flow:** A new “Entry Flow” field was added above False Lumen Rx.
    - **Intestinal Ischemia and Unintentional Septal Rupture:** Intestinal Ischemia and Unintentional Septal Rupture received additions to help text.
  - Follow-up Form
    - **Entry Flow:** The new “Entry Flow” field added to the Procedure was also added to the Follow-up, dependent on the Pathology field (TEVAR_PATH) being Dissection (2).
    - **Current Endoleak?:** The dependency for this field changed to display when Pathology is Aneurysm in addition to Pathology being Dissection or Aneurysm from dissection.
    - **Intestinal Ischemia:** Similar to the Procedure, this field received additional help text.
Technology Released in Q4 2020

- Varicose Vein Registry (VVR) & Venous Stent Registry (VSR) revision for New CEAP Clinical Classification
  - Released on 11/11/2020
  - CEAP classification used for classifying venous disorders has been updated to align with the current understanding of chronic venous disease (CVD).
- New selections of C2r, C4c, and C6r were added to the current list of CEAP classifications.

<table>
<thead>
<tr>
<th>C class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C_0</td>
<td>No visible or palpable signs of venous disease</td>
</tr>
<tr>
<td>C_1</td>
<td>Telangiectasias or reticular veins</td>
</tr>
<tr>
<td>C_2</td>
<td>Varicose veins</td>
</tr>
<tr>
<td>C_2r</td>
<td>Recurrent varicose veins</td>
</tr>
<tr>
<td>C_3</td>
<td>Edema</td>
</tr>
<tr>
<td>C_4</td>
<td>Changes in skin and subcutaneous tissue secondary to CVD</td>
</tr>
<tr>
<td>C_5</td>
<td>Pigmentation or eczema</td>
</tr>
<tr>
<td>C_6</td>
<td>Lipodermatosclerosis or atrophie blanche</td>
</tr>
<tr>
<td>C_6c</td>
<td>Corona phlebectatica</td>
</tr>
<tr>
<td>C_6h</td>
<td>Healed</td>
</tr>
<tr>
<td>C_6e</td>
<td>Active venous ulcer</td>
</tr>
<tr>
<td>C_6r</td>
<td>Recurrent active venous ulcer</td>
</tr>
</tbody>
</table>
Technology Released in Q4 2020

- Vascular Medicine Consult (VMC) registry revision to add new drug category and update CAD
  - Released on 11/19/2020
  - Added a new drug category called Hemorheologic Agent (categorical field) that contains Cilostazol, Pentoxifylline and Other as Hemorheologic Types. These fields were added to Demographics, Treatment and Follow-up tabs. Dosing and Dosing Other as well as Frequency and Frequency Other will be collected for both Cilostazol and Pentoxifylline.
  - The following existing Cilostazol fields are retired from the form:
    - PRETX_CILOSTAZOL
    - TX_CILOSTAZOL
    - LTF_CILOSTAZOL
  - Added a select option, CAD asymptomatic, to the Procedure field “CAD Symptoms”.
Registry Projects
These projects are conducted within the SVS PSO and only non-identifiable data (removal of patient, center and physician information) will be provided to Medtronic/BARD/Cook/Gore or the FDA. Only standard of care practice is being evaluated. For such PSO activities, patient informed consent and Institutional Review Board review are not required.

Sites must follow their institutional guidelines.
The SVS PSO is excited to announce the reopening of the TEVAR Dissection Surveillance Project to evaluate the Cook Zenith Dissection Endovascular System. FDA approval was granted for this device after safety and effectiveness were demonstrated in pre-market studies of complicated dissection with the proviso that the efficacy of TEVAR treatment of descending aortic dissection would be more fully analyzed through post-market surveillance, as was done through VQI for the W. L. Gore and Medtronic devices after their approval.

- Patients will have 30 day, and annual visits for 5 years.
- Total reimbursement of $4,000 per patient for a patient followed annually for 5 years
TEVAR Dissection Surveillance Project

TEVAR Dissection Surveillance Project is Open for Enrollment

- 12 of the 180 required patients enrolled (11 potential cases in process)
  - Retrospective enrollment allowed- All eligible cases from December 31, 2018 (protocol FDA approval date)
- 23 of 40 sites enrolled (10 more in contracting)
  - This project is conducted within the SVS PSO and only non-identifiable data (removal of patient, center and physician information) will be provided to Cook or the FDA. Only standard of care practice is being evaluated. For such PSO activities, patient informed consent and Institutional Review Board review are not required.

For more information, please contact:

tevarproject@m2s.com
PATHWAYS Support
PATHWAYS Support Projects

Claims Validation
The 2019 Claims Validation process was launched in July 2020.
• 50% of Centers have completed validation or are in progress.
• Please reach out to PATHWAYS Support if you were notified and haven’t started and are unclear with the process.
• PATHWAYS Support is here to help you!
Plans to launch 2020 Claims Validation are currently underway...Stay tuned!

PATHWAYS Educational Webinars
• Reporting & Analytics webinar series (2 sessions) were held in November & December.
  • Visit the Resources tab in PATHWAYS to access the presentations and recordings.
• EVAR FU Aggregate Report – Excited to expand this report to additional registries in the future!
PATHWAYS Communication

We have heard feedback that due to firewall and spam filter configurations at your centers, you may not be receiving mass emails from M2S. We are excited to help our users keep up to date with new release announcements.

- A new “Release Notes” button has been added to the “Support” tab in the upper left corner to provide you with historical release announcements to help you search for updates.
Conclusion
Nominations
Meeting Evaluation/Roundtable

- What did you like about this meeting?
- What can we do better?
- Next meeting location? Need to do a post-meeting poll live v virtual.
REMEMBER TO PSO:

• **P**UT your FULL NAME in RingCentral to get credit for attendance and CME/CE credit (no exceptions will be made)

• **S**END an email to ljohnson@svspso.org with names of group members that are sharing 1 device

• **O**FFICALLY apply for CME/CE credit by clicking this link: https://dmu.co1.qualtrics.com/jfe/form/SV_1KXWMZ7BTN92j8G

You only have **7 days** to complete forms for CME/CE Credit.
NO EMAIL WILL BE SENT AS A REMINDER OR WITH THE CME/CE LINK