Welcome: Alex Shepard, MD & Peter Henke, MD

BMC2 Data Review: Dr. Peter Henke

1. General information
   a. Total Procedures 2012-Q1/Q2 2017 = 28,704

2. CAS/ CEA Outcomes 2012-Q1/Q2 2017
   a. Combined death, stroke, & MI to 30 days
      • Q1/Q2 2017 CAS=272
      • Q1/Q2 2017 CEA=1199

3. Open Bypass (Q1/Q2 2017)
   a. AF2 most common inflow
   b. Fem-pop declining but still most common outflow
   c. Rest pain/ tissue loss most common indications for open bypass
   d. Outcomes at 30 days:
      i. Mortality stable at 3.9%
      ii. MI rate = 2.9%
      iii. Amputations = 1.6%

4. EVAR (Q1/Q2 2017)
   a. EVAR: 71.5% asymptomatic, 21.9% symptomatic, 4.4% ruptured
   b. Elective EVAR Death & Major Morbidities at 30 Days
      • Readmission = 6.1%
      • Death = 1.5%
      • Renal Failure = 0.9%
      • MI = 0.9%
      • Bleeding (≥ 4PRBCs) = 0.7%
      • Elective mortality = 1.5%, urgent/emergent= 18.2%
   c. Open AAA: 54.3% asymptomatic, 41.9% symptomatic, 22.9% ruptured
   d. Open AAA: elective mortality = 4.3%, urgent/emergent = 33.3%

5. Meds at Discharge
   a. Any antiplatelet: CEA, CAS, & open bypass = 97.8%
   b. Statin at discharge: CEA, CAS, Open bypass = 92.1%

6. Post-op MI (2017 Q1/Q2) = 1.8%

7. Post-op Transfusion
   a. All procedures: 19.3%
   b. Open bypass: 27%
   c. EVAR: 8.5%
   d. Open AAA: 41.9%
8. SSI (Q1/Q2 2017)  
   a. Overall: 10.0%  
   b. Elective Open AAA/EVAR/Bypass: 4.7%  
   c. Urgent/emergent bypass: 12.9%  
   d. 30 day readmission overall: 12.8%, 40% for SSI  
9. BMC2 partnering with Michigan “OPEN” to help identify data on opioid dependent patients. Anticipated data collection starting with 2018 procedures. Nine other CQIs have partnered with OPEN in some manner  

**National VQI update: Jim Wadzinski, VQI-PSO Ex Director**  
1. 445 centers, 46 states + Canada  
2. Total procedure volume to date: 413,905  
3. National VQI projects:  
   a. Prescribing anti platelets and statins to appropriate patients to improve their long term vascular health  
   b. Increasing follow up imaging rates at one year for EVAR patients  
4. Participation Awards: Proposed Changes  
   • Long-term F/U – Most important  
   • Meeting attendance – More important  
   • QI project involvement – Important  
   • Number of registry subscriptions – Least important  
5. M2S Pathways updates  
   a. Physician Dashboards – Starting in February, PSO will begin distributing physician-level “scorecards” for each registry  
   b. Surveillance Projects  
      • TEVAR for dissection- sites have received 941,100 in compensation for efforts thus far  
      • CREST 2 Registry and CAS registry  
      • Trans- Carotid Artery Revascularization Project - CMS collaboration to provide reimbursement if entered into VQI CAS registry & 1 yr follow up  

**Regional Data Review: Alex Shepard, MD**  
1. Membership of MVSG at 18 centers  
2. MVSG represents 4% of overall VQI numbers  
3. Vascular Surgeons make up 47% of MVSG specialties  
4. Total procedures (2003- 06/30/17) = 14,177  
5. % of procedures with > 9 Months F/U 2015 = 78%  
6. MVSG leads nation in discharge antiplatelet & statin , down to 5th in skin prep (2nd last year)  
7. 0.6% observed rate of stroke, death for CEA; in hospital death/stroke rate is 2nd best in country at 0.4%  
8. EVAR percentage of aneurysm sac diameter reporting 10% higher than VQI average at 9 – 21 months  
9. Elective CEA patients with >1 day LOS, MVSG 3rd worse in nation over 2016 and has gotten worse over time  
10. 15% of MVSG Open AAA patients with LOS > 8 days, national = 23%  
11. EVAR LOS > 2 days, MVSG = 12% , national = 15%  
12. Percentage with major complications after INFRA = 5%, National = 4.2%  
13. Elective Open AAA: Median LOS = 7, National = 7
14. PVI: Rate of any hematoma = 3.1%, National = 2.6%
15. PVI: % of claudicant with pre-procedure ABI/TBI = 93%, National = 78%
16. Report Card:
   A+ Prescribing antiplatelet/ statin on D/C
   A+ PVI: Pre- procedure ABIs in claudicants
   A+ CEA stroke/death rates
   A Reporting EVAR sac diameter at LTFU
   A PVI: using U/S guidance
   A- Chlorhexidine for infra-inguinal bypass
   A- Long-term F/U, Open AAA LOS >8 days
   B+ EVAR LOS> 2 days
   B Open AAA repair mortality
   B- Major complications after infra-inguinal bypass
   C CEA LOS > 1 day

Arterial Quality Committee report: Mitchell Weaver, MD
1. National QI projects:
   a. improving discharge antiplatelet & statin rate
   b. Improving EVAR LTFU imaging rates
2. Current ongoing work:
   a. common variables
   b. Help text updates
   c. determining variables per registry that negate the need for LTFU
   d. 30 day follow up project (variables)
   e. AQC members collaborating with SVS committee on appropriateness definitions
   f. role of VQI and other specialties with links to reimbursement

Venous Quality Committee report: Alex Shepard, MD
1. New venous stent registry will be released Mid-2018
2. Current workgroup developing an IVC filter retrieval reminder report/e-mail notification – ready 1st Q 2018
3. Varicose vein registry increasing participation
4. IVC filter registry- current workgroup developing retrieval reminder via email, ready 1st q 2018

Governing Council Update: Alex Shepard, MD
Additional Committee members to be added to the PSO Executive Committee to provide representation for community practice and office based endovascular center communities

MVSG Data: Infra-Inguinal Bypass: Alex Shepard, MD
1. 6 participating centers, study period = 2013-2016, 1070 procedures
2. Race & Ethnicity: Caucasians predominate
3. Center 4 patients had almost 10% of their patients on dialysis
4. 25% of all infra-inguinal bypasses are done for claudication
5. 18.9% of patients with prior ipsilateral Infra-inguinal bypass
6. 24.8% with prior ipsilateral PVI
7. General anesthesia favored over regional
8. Target artery: BK popliteal/ TP trunk most frequently used
9. Graft Conduit: autogenous vein infrequently used
10. Completed angio or duplex performed very infrequently : 43%
11. 3.5% post op SSI; 0.7% post op graft infection
12. 6.6 average post op LOS vs 6.1 National
13. Missing nearly 23% of long term patency data documentation

Summary:
- Timing: Dichotomy in urgency of cases- 10% urgent in 4 centers and 37% urgent in 2 centers
- Conduit: Vein only used in 55% of cases but only 65% underwent vein mapping
- Technique: Transverse incisions not necessarily associated with less SSI, endoscopic harvest vs skip incisions, completion study done < 50% of cases
- LOS: Center #2 had 2nd shortest LOS (5 days), largest no. d/c’d home, and lowest SSI during index hospitalization (1.7%), but highest SSI at 30 days and at LTFU (6.6%) – Is this the trade off?

Presentations from the Group: Infra-inguinal Bypass
1. Best techniques in open infra-inguinal bypass – Peter Wong, MD, Spectrum Health
2. Endovascular vs open revascularization: an update of the BEST-CLI Trial – Rob Molnar, MD, Michigan Vascular Center
3. Wound complications in infrainguinal bypass – Frank Davis, MD, U of M Medical Center
4. Treatment of infrainguinal bypass wound complications – a plastic surgeon’s perspective – Ken Moquin, MD, HFH
5. When is primary amputation warranted? Tim Nypaver, MD, HFH

Research Advisory committee: Nick Osborne MD
1. Research advisory committee has approved 64 research projects submitted by 26 centers.
2. Next round of proposal submission: Due Date : November 20, 2017 Meeting Dec 11 2017, Notifications sent: Dec 12, 2017 Email NICHOSBO@umich.edu for examples
3. Regional QI project Discussion:
   a. Complications/readmissions following LEB/PVI
   b. Minimizing LOS after CEA
   c. Radiation exposure during routine EVAR vs FEVAR

ADJOURN

Next Meeting: MVS Meeting, May 17th 2018, Grand Traverse Resort, Acme, MI

Executive Committee Meeting:
1. Henry Ford Allegiance welcomed into MVSG
2. Dr. Ash Mansour unanimously elected as new Medical Director