Minutes

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<tr>
<th>Name</th>
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<tr>
<td>Alex Shepard</td>
<td>Medical Director</td>
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<td>Loay Kabbani</td>
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<td>Mitchell Weaver</td>
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<td>Kim Finch</td>
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<td>Peter Henke</td>
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<td>Erin Jervzal</td>
<td>Coordinator</td>
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<td>Ash Mansour</td>
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<td>Justin Simmons</td>
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<td>Graham Long</td>
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<td>Maciej Uzieblo</td>
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<td>Branka Stojkovic</td>
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<td>Jimmy Haouilou</td>
<td>Physician</td>
<td>Beaumont, GP</td>
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<td>Mike Boros</td>
<td>Physician</td>
<td>Munson</td>
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<td>John Ilgas</td>
<td>Guest Physician</td>
<td>DMC, Sinai-Grace</td>
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<td>Vern Dencklau</td>
<td>Guest Physician</td>
<td>McLaren, Port Huron</td>
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<td>John Pap</td>
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<td>Marquette General</td>
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<td>Axel Thors</td>
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<td>William Oppat</td>
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<td>Tamer Boules, MD</td>
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Attendees:

Lunch & Welcome: Peter Henke, MD / Alex Shepard, MD

BMC2 PCI-VIC Data: Henke
Dr. Henke outlined VIC data:
A. General Data
   • All major hospital in MI participate
   • CEA most common procedure
   • Low rate of open AAA repair
   • 9393 vascular surgery discharges
A. CAS vs CEA – Post-procedural CVAs about the same now – when we first started CAS much higher
B. Lower extremity bypass
   • Number of procedures about the same
   • Indication: 32.7% for claudication, 15% for ALI
   • Re-do 17%
C. AAA
   • Asymptomatic 78%, symptomatic 23%
   • Mortality for open AAA = 6.2%
   • Mortality for open RAAA – 35.6%
   • Mortality for EVAR = 1.5%
   • Mortality for urgent/emergent EVAR = 11.9%
D. MVS SSI Survey Questionnaire (26 respondents) – Summary:
   • Transverse incisions more common
   • Closure: most use 3 layers interrupted; no one used drains
   • Skin: most common sub q without glue, second subq with glue
   • Groin lymph leaks: commonly re-explore or use wound VAC; some bedrest and observe; timing to treat: 42% immediate
   • Do you use Muprosin for MRSA positive pts? 81% no
   • For wet gangrene of extremity 77% with staged control
   • 65% use same groin incision if prior surgery
   • Does the type of reconstruction affect your approach regarding treatment of lymph leak, hematoma? 70% yes
   • Some use Ligasure, or harmonic scalpel
   • Incisional wound VAC of questionable benefit
   • Obese patients advised not to sit longer than 30 minutes. Takes tension off wound for three weeks.

National VQI Update: Shepard
A. National statistics: currently 376 center now enrolled in VQI in 46 different states. Over 270,000 procedures entered as of the first of the first of October; PVI is highest volume procedure
B. First Annual VQI Meeting Wed. June 8, 2016 National Harbor, MD (SVS annual meeting).
   AM session for Data Manger, PM session for all. Beaumont Hospital is presenting their experience with decreasing CEA LOS at afternoon session.
C. Center Participation Award:
   a. Points awarded for: 1) physician and ancillary staff attendance at regional meetings; 2) long-term F/U percentage and 3) number of procedure groups the site participates in.
      Centers with LTFU less than 50% will receive mentoring from a peer advisor and a LTFU toolkit from the PSO to assist then in improving their LTFU rates.
   b. MVSG has one 3 star center, three 2 star centers, and one 1 star center
D. VQI Initiatives
   a. COPIs – planned reports for future:
      i. CEA Stroke/Death
      ii. CAS Stroke/Death
      iii. Long term imaging after EVAR
      iv. Major complications after open AAA
      v. PVI Hematoma
      vi. Amputation free survival after Infra/Supra bypass
   b. Individual physician reports now available on website
c. Vascular Medicine Registry – out by end of summer, 2016. Focus on medical management of carotid, aortic and LE PAD.
d. EPIC update – working with Epic to build CEA form that can be transferred via JSON file to M2S; should be done and ready for testing end of summer 2016. Use of this interface will result in zero data abstraction for CEA
e. EVAR COST pilot completed with MedAssets – combine cost data with clinical data to benchmark similar procedures; presentation at VAM VQI Meeting

f. Regulatory Update
g. Post-Approval Device Surveillance in VQI

E. M2S acquired by Medstreaming another health IT company with a major presence in the cardiac cath lab

Regional Data Review: Shepard

A. 69 participating physicians, 9663 cases through 4/31/15.
B. Regional Reports
   1. 1 year follow rates – MVSG has excellent LTFU
      Unanimous vote of membership to identify LTFU by center at future meetings
   2. ASA and statin at discharge – MVSG is best in country
   3. Chlohexidine for skin prep – 3rd highest in the country
   4. Reporting of AAA sac shrinkage after EVAR at one year =80% (above average)
   5. Percent of PVI through femoral approach using US – NA for MVSG
   6. CEA in hospital stroke/death – MVSG lower than VQI average
   7. CAS in hospital stroke/death – MVSG lower than VQI average
   8. CEA LOS > 1 day - primary, isolated, elective procedures – MVSG at VQI average
   9. In-hospital death, amputation, graft thrombosis after infragenual bypass for CLI – one of the lowest in the country
   10. Open AAA repair - in hospital death for non-ruptured – MVSG higher than VQI average
   11. Open AAA LOS ≥ 8 days non-ruptured cases – MVSG 2nd highest in VQI!
   12. EVAR LOS > 2 days - non-ruptured cases – MVSG 3rd highest in VQI!

C. Suprainguinal Bypass: MVSG Results
   1. Significant variability in selection of procedures – AF2 vs extra-anatomic
   2. Aortofemoral Bypass
      • Mortality = 2%
      • Indications: Claudication = 58%, CLI = 30%, ALI = 7%
      • Technique: Significant variability in choice of grafts, end-to-end vs end-to-side proximal anastomosis
      • Timing: 85% Elective, 15% Urgent/emergent
      • Prior Inflow = 30% (8% bypass, 21% PTA)
      • Morbidity: 4% MI, 11% Respiratory, 6% Renal, 7% Wound
      • LTFU: 1% occlusion, 3% amputation
   3. Femoral-femoral Bypass
      • Mortality = 0.5%
      • Indications: Claudication = 40%, CLI = 23%, ALI = 16%
      • Timing: 63% Elective, 37% Urgent/emergent
      • Prior Inflow = 34% (17% bypass, 17% PTA)
      • Morbidity: 1.4% MI, 3% Wound
      • LTFU: 0% occlusion, 0% amputation
   4. Axillofemoral Bypass
      • Mortality = 2%
      • Indications: Claudication = 15%, CLI = 32%, ALI = 42%
      • Timing: 37% Elective, 63% Urgent/emergent
      • Prior Inflow = 44% (27% bypass, 17% PTA)
      • Morbidity: 0% MI, 1.2% Respiratory, 7% Renal, 3% Wound
      • LTFU: 4% occlusion, 8% amputation
• 9.9% of patients in national data set have occluded graft at D/C!

D. Possible research topics:
   1. Examining variability in choice of SI bypass type
   2. Examining variability in techniques
   3. 10% graft occlusion rate at time of D/C in axillofemoral bypasses

Arterial Quality Committee Report: Shepard (for Shanley)
A. Roles of the Module/Registry Committees
B. Statistical audits
C. Develop new PVI Registry
D. National QI Projects
   1. Statin/AP therapy
   2. Follow-up imaging after EVAR
   3. Appropriateness of care

Venous Quality Committee Report: Shepard (for Lin)
A. IVC filter registry: 4740 procedures at 56 centers
B. Varicose Vein Registry: 3456 procedures

A. Retool PSO organizational structure – diffusion of responsibility to registry Committees, succession planning
B. New Communication Committee
C. Maximizing the value of the VQI for key groups (including COPI reports and other registry reports)
D. Expand industry contracting
E. Make us the go-to Vascular quality organization for CMS and FDA
F. Audit Subcommittee Report:
   a. Trying to link patients in VQI to their respective Medicare claims for long-term outcomes (e.g. stroke, amputation, need for further procedures).
   b. In the near future, VQI participants will be able to link to clinical-claims datasets to evaluate for long-term effectiveness

Presentations from the Group
1. Aortofemoral bypass: Optimal techniques – Maciej Uzieblo, MD, Beaumont Hospital
2. Aortoiliac stenting is the best treatment for aortoiliac occlusive disease – Tamer Boules, MD, Providence Hospital
3. Aortofemoral bypass is still the best treatment for aortoiliac occlusive disease – Mitchell Weaver, MD, Henry Ford Hospital
4. Groin lymphatic complications – How to avoid them and what to do if they occur: A review of the literature – Justin Simmons, D.O., Spectrum Health

Research Advisory Committee Report: All
A. Discussion about ideas for research studies
B. Research requests
C. Approved project list on line

Discussion – Group
   Proposed topics for next meeting: Reducing LOS after most common procedures

Meeting adjourned

Next Meeting: November 10th 2016, Hotel Baronette, Novi, MI in Conjunction with MVS Meeting
Submitted by Alex Shepard