

# Mid America Vascular Study Group

April 18, 2023

1 PM – 4:00 PM (CT)

Northwestern Memorial Hospital  
Arkes Pavilion-Dept of Surgery

# Meeting Attendance Credit

**Before we get started...**

**Please sign in using your Full Name (First and Last).**

**In-Person Attendees – Scan the QR code shown and sign in**

**Remote Attendees – See below instructions (#1-#3)**

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.



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

**\*\*SPECIAL NOTE: ALL ATTENDEES must have an ACTIVE PATHWAYS user account to get attendance credit!!!**

# Agenda-April 18, 2023

Time	Topic	CE Credit
1:00 pm	<p>Welcome</p> <p>Regional Data Review and Enhanced recovery for Infrainguinal Bypass -Ashley Vavra, MD, Regional Medical Leader</p> <p>Learning Objectives:</p> <ul style="list-style-type: none"> <li>• Use the VQI regional reports to establish quality improvement goals for the vascular patients (outcomes) and for their center (process).</li> <li>• Interpret and compare each centers' VQI results to regional and national benchmarked data.</li> <li>• 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.</li> <li>• 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.</li> </ul>	Yes
2:10pm	<p>Review of Long Term Follow-up Toolkit – Betsy Wymer, DNP, RN, CV-BC, SVS PSO Director of Quality</p> <p>Learning Objectives:</p> <ul style="list-style-type: none"> <li>• Use the VQI regional reports to establish quality improvement goals for the vascular patients (outcomes) and for their center (process).</li> <li>• Interpret and compare each centers' VQI results to regional and national benchmarked data.</li> <li>• 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.</li> <li>• 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.</li> </ul>	Yes
2:20 pm	<p>Quality Improvement Project: Long Term Follow-up – Stephanie Shanklin BSN, RN, Data Abstractor, Quality and Safety, OSF Healthcare</p>	Yes
2:30 pm	Break	No

# Agenda (con't)

Time	Topic	CE Credit
3:00 pm	National VQI Update-Melissa Latus, RN, PSO Clinical Project Manager Learning Objectives: <ul style="list-style-type: none"><li>• Use the VQI regional reports to establish quality improvement goals for the vascular patients (outcomes) and for their center (process).</li><li>• 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.</li></ul>	Yes
3:40 pm	AQC Update – Trissa Babrowski, M.D.	No
3:45 pm	VQC Update – Ravi Hasanadka, M.D.	No
3:50 pm	RAC Update – Kamal Gupta, M.D.	No
3:55 pm	Governing Council Update – Ashley Vavra, M.D.	No
4:00 pm	End Meeting/Evaluation/Next Meeting Discussion	No



## No Disclosures

# Appreciation and Thanks

- Ashley Vavra, MD - Regional Medical Director
- Andrew Hoel, MD – Regional Associate Medical Director
- Tracy Campin - Regional Lead Data Manager
- Jens Jorgensen, MD - SVS PSO Medical Director
- Kristopher Huffman - Director of Analytics
- Jen Correa – Marketing Manager
- Stephanie Shanklin, MSN, RN – RN Data Abstractor, OSF Healthcare
- Leka Johnson – Education & Membership Project Mgr
- Betsy Wymer – SVS PSO Director of Quality
- Melissa Latus – Clinical Operation Project Manager
- SVS PSO Staff

# Welcome and Introductions

AMITA Health Adventist Medical Center La Grange  
AMITA Health Alexian Brothers Medical Center  
AMITA Health Resurrection Medical Center  
AMITA Health Saint Joseph Medical Center Joliet  
AMITA Health St. Alexius Medical Center, Hoffman Estates  
Ascension Via Christi Hospitals Wichita  
Barnes Jewish Hospital  
Bryan Medical Center  
Capital Region Medical Center  
Carle BroMenn Medical Center  
Carle Foundation Hospital  
Centerpoint Medical Center  
CGH Medical Center  
Columbia Surgical Services, Inc.  
Cox Medical Center South  
Decatur Memorial Hospital  
Edward Hospital  
Elmhurst Memorial Hospital  
Faith Regional Health Services  
Flint Hills Heart, Vascular, Vein Clinic, LLC  
Genesis Medical Center, Davenport  
Gottlieb Memorial Hospital  
Great River Medical Center  
Javon Bea Hospital - Riverside Campus  
Kansas Heart Hospital

Lincoln - CHI Health Nebraska Heart  
Loyola University Medical Center  
MacNeal Hospital  
Memorial Hospital Belleville  
Memorial Hospital of Carbondale  
Memorial Medical Center  
Menorah Medical Center  
Mercy Hospital Springfield  
Mercy Medical Center, Cedar Rapids, Iowa  
MercyOne Des Moines Medical Center  
MercyOne Siouxland Medical Center  
Midwest Aortic & Vascular Institute, P.C.  
Midwest Institute Minimally Invasive Therapies  
Mosaic Life Care  
Nebraska Medicine  
Nebraska Methodist Hospital  
NorthShore Hospital  
Northwest Community Hospital  
Northwestern Medicine Central DuPage Hospital  
Northwestern Medicine Lake Forest Hospital  
Northwestern Memorial Hospital  
Omaha - CHI Health Creighton University Medical Center  
- Bergan Mercy  
Omaha - CHI Health Immanuel  
OSF Heart of Mary Medical Center  
OSF Saint Anthony Medical Center

OSF Saint Francis Medical Center  
OSF St. Joseph Medical Center  
Premier Vascular, LLC  
Riverside Medical Center  
Rush University Medical Center  
Saint Luke's Episcopal Presbyterian Hospital  
Saint Luke's Hospital of Kansas City  
SSM Health DePaul Hospital - St. Louis  
SSM Health Good Samaritan - Mount Vernon, IL  
SSM Health Saint Louis University Hospital  
SSM Health St. Clare Hospital - Fenton  
SSM Health St. Joseph Hospital - St. Charles  
St. John's Hospital  
St. Joseph Medical Center  
St. Luke's Methodist Hospital  
St. Mary's Hospital, Decatur, of the Hospital Sisters of the Third Order of St. Francis  
The Methodist Medical Center of Illinois  
UnityPoint Health Des Moines  
University of Chicago Medical Center  
University of Iowa Hospitals and Clinics  
University of Kansas Hospital Authority  
University of Missouri Medical Center  
Via Christi Hospital Pittsburg

- Support meaningful change to ensure delivery of high quality, high value care
- Biannual meetings:
  - Celebrate wins, identify opportunities for improvement
  - Exchange best practices and models for positive change

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 following **updates** have been implemented to enhance and improve the Spring 2023 VQI Regional Quality Report:

- Preop Smoking Report Added - A preop smoking report is now provided. This report displays center-level, regional, and VQI overall rates of current smoking at time of procedure.
- Smoking Cessation Report Added - A smoking cessation report is now provided. This report displays center-level, regional, and VQI overall rates of smoking cessation at follow up.

# Data: Birds Eye View

# Region Volume Appendix

Complete cases as of Dec 31, 2022

Report	The region must have $\geq 3$ centers with included cases for comparison to VQI overall			Risk-adjusted Outcomes		
	Included Cases	Centers with Included Cases	Centers with at least 10 Included Cases	Complete Cases	Centers with Complete Cases	Centers with at least 10 Complete Cases
Procedure Volume	8215	67	54			
Procedure Volume, All Years	62476	74	68			
Long-Term Follow-up	5314	50	42			
Discharge Medications	7530	67	54			
Preop Smoking	6393	65	52			
Smoking Cessation	1105	43	23			
TFEM CAS ASYMP: Stroke/Death	132	29	5	11		
TFEM CAS SYMP: Stroke/Death	235	27	8	22		
TCAR ASYMP: Stroke/Death	521	50	20	48		
TCAR SYMP: Stroke/Death	271	47	8	258	46	7
CEA ASYMP: Stroke/Death	685	34	21	631	34	21
CEA ASYMP: Postop LOS>1 Day	680	34	21	626	34	21
CEA SYMP: Stroke/Death	353	30	15	332	29	15
CEA SYMP: Postop LOS>1 Day	353	30	15	332	29	15
EVAR: Postop LOS>2 Days	532	20	16	448	20	15
EVAR: Sac Diameter Reporting	322	16	12			
EVAR: SVS AAA Diameter Guideline	493	20	16			
TEVAR: Sac Diameter Reporting	53	8	1			
OAAA: In-Hospital Mortality	207	12	5	195	12	5
OAAA: SVS Cell-Saver Guideline	233	12	6			
OAAA: SVS Iliac Inflow Guideline	250	12	7			
PVI CLAUD: ABI/Toe Pressure	1647	26	23			
INFRA CLTI: Major Complications	267	15	11			
SUPRA CLTI: Major Complications	44	5	1			
LEAMP: Postop Complications	78	2	2			
HDA: Primary AVF vs. Graft	179	4	4			
HDA: Ultrasound Vein Mapping	224	4	4			
HDA: Postop Complications	224	4	4			
IVCF: Filter Retrieval Reporting	70	3	2			

The region must have at  $\geq 3$  centers with  $\geq 10$  cases for regional comparison between centers

## Procedure Volume

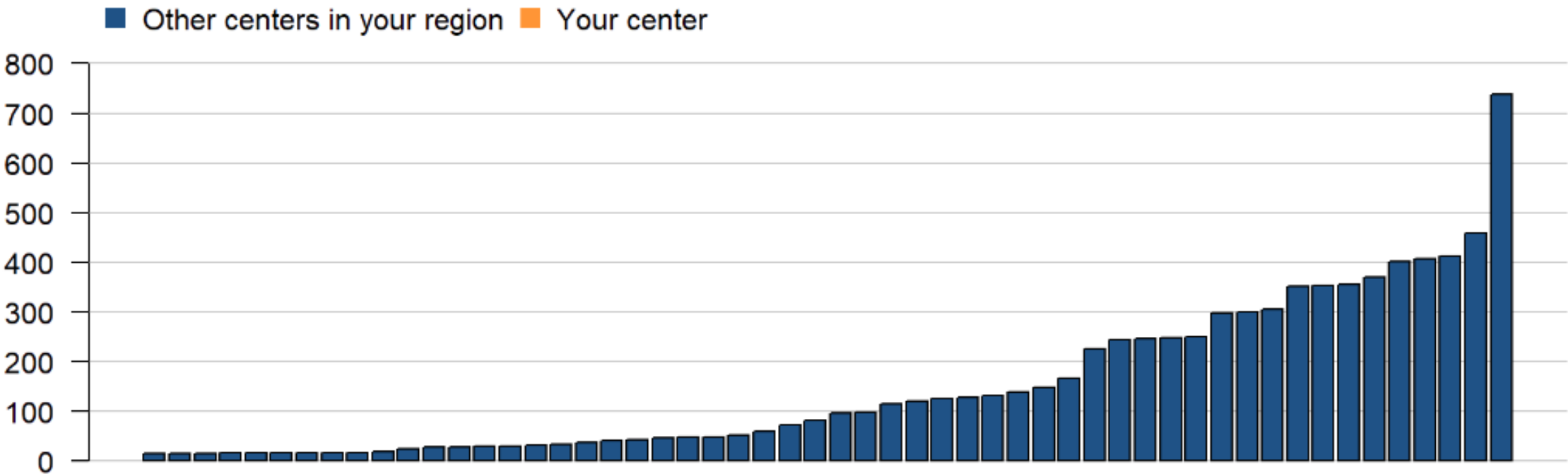
Procedures performed between January 1 and December 31, 2022

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

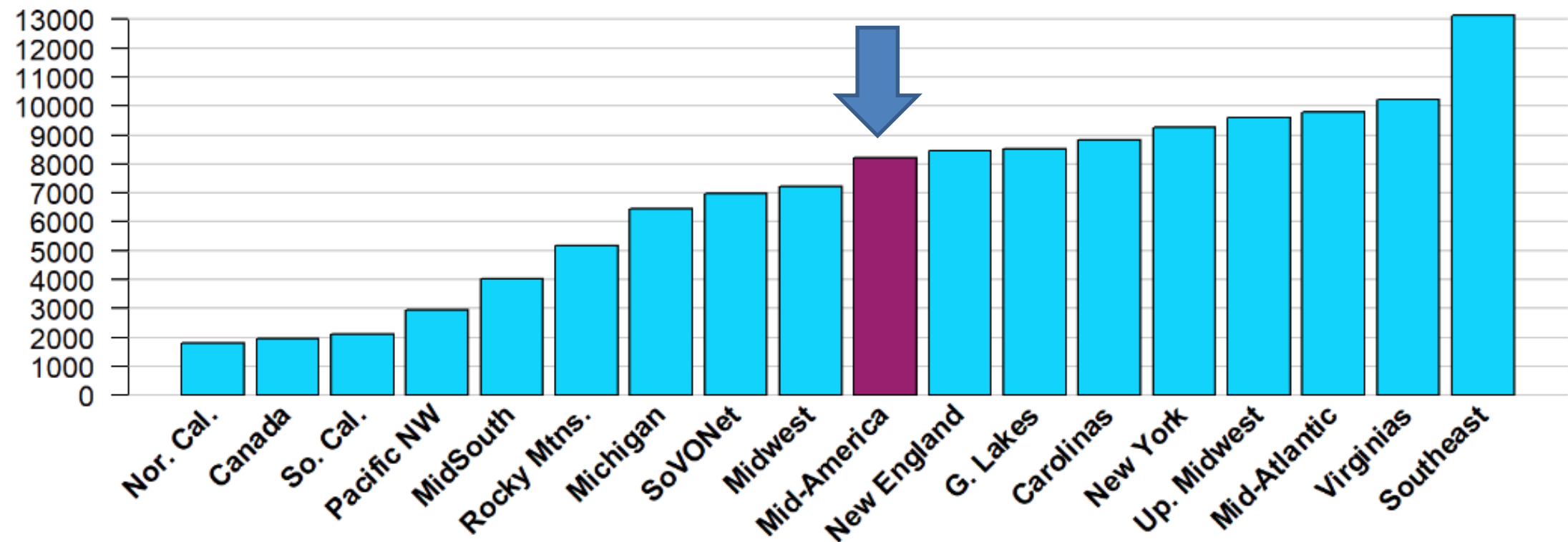
	Your Center (N)	Your Region (N)	VQI Overall (N)
CAS (TFEM CAS & TCAR)		1345	20003
CEA		1235	18006
EVAR		566	7759
HDA		224	5664
INFRA		347	6979
IVCF		NA (<3 centers)	1101
LEAMP		NA (<3 centers)	3365
OAAA		64	1339
PVI		4095	48816
SUPRA		66	2063
TEVAR		195	3665
Varicose Veins		NA (<3 centers)	6500
Overall (Jan-Dec 2022)		8215	125260
Overall (Jan-Dec 2021)		7459	126046



Procedure Volume by Center in Your Region (Jan-Dec 2022)



Procedure Volume Across VQI (Jan-Dec 2022)





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

## Procedure Volume, All Years

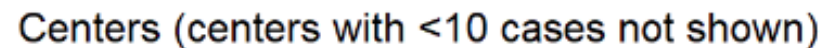
Includes all procedures with procedure date through December 31, 2022

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

	Your Center (N)	Your Region (N)	VQI Overall (N)
CAS (TFEM CAS & TCAR)		7314	88622
CEA		10527	186348
EVAR		3944	76380
HDA		3627	72316
INFRA		3548	77555
IVCF		942	17782
LEAMP		981	26942
OAAA		774	17052
PVI		22837	352693
SUPRA		1120	24831
TEVAR		1357	26757
Varicose Veins		NA (<3 centers)	58547
Overall		62476	 1025825 

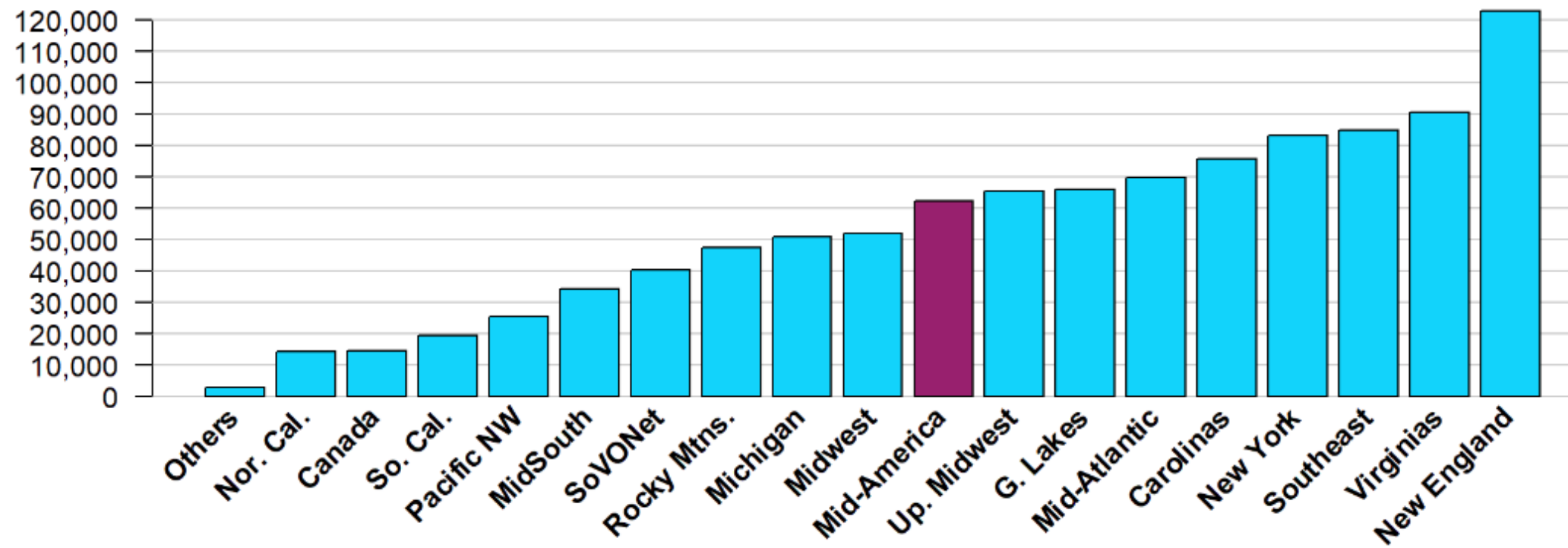
**SVS | VQI**  
In collaboration with NCDR®

■ Other centers in your region ■ Your center



SVS | Society for Vascular Surgery | American Venous Forum | fivos | Society for Vascular Medicine | VASA | SVU | SOCIETY FOR VASCULAR ULTRASOUND

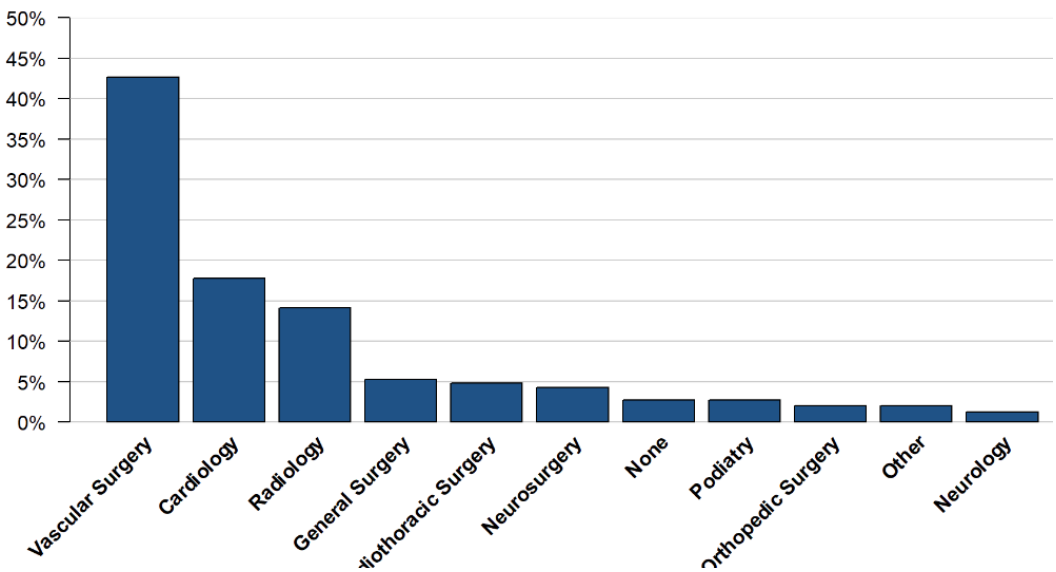
Procedure Volume Across VQI (Through Dec 2022)



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

“Others” indicates centers that do not belong to a regional group.

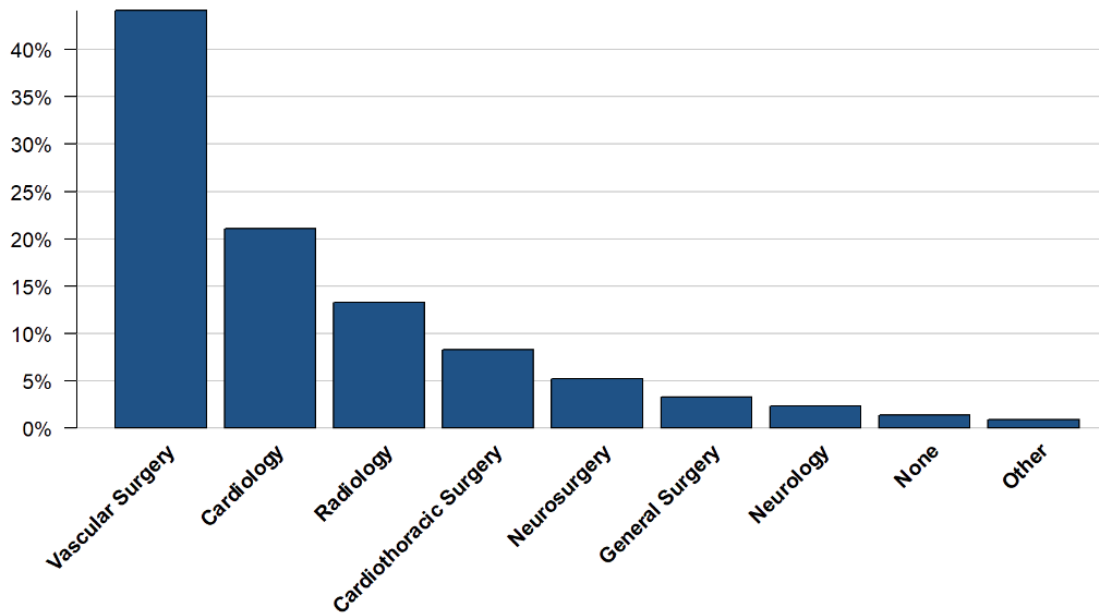
# Physician Specialties Across VQI



VQI N=6, 651 (6,185 and 5,849)

Top 3 specialties

- Vascular Surgery
- Cardiology
- Radiology



Region N=422 (447, 438)

Top 3 specialties

- Vascular Surgery
- Cardiology
- Radiology

# Module-Specific Outcomes

# Dashboard

Procedure Group	Outcome	Your Center	Your Region	VQI Overall
All	Procedure Volume	[6   17   47   197   354]	[6   20   67   211   392]	
	Procedure Volume, All Years	[19   42   228   767   3047]	[12   52   243   1230   3230]	
Multiple	Long-Term Follow-up	75.7% [0   47   78   89   99]	75.1% [0   48   77   91   97]	
	Discharge Medications	87.6% [75   87   94   100   100]	86.8% [75   83   91   97   100]	
	Preop Smoking	30.9% [13   20   27   36   41]	30% [7   17   27   36   44]	
	Smoking Cessation	23.4% [0   0   13   36   55]	25.7% [0   0   23   38   50]	
TFEM CAS ASYMP	Stroke/Death	0.8% [0   0   0   0   0]	1.7% [0   0   0   0   3]	
TFEM CAS SYMP	Stroke/Death	3.8% [0   0   0   2   21]	4.4% [0   0   0   0   12]	
TCAR ASYMP	Stroke/Death	0.8% [0   0   0   0   0]	1% [0   0   0   0   2]	
TCAR SYMP	Stroke/Death	3% [0   0   0   0   20]	2.1% [0   0   0   0   6]	
CEA ASYMP	Stroke/Death	0.6% [0   0   0   0   0]	0.8% [0   0   0   0   2]	
	Postop LOS>1 Day	24.4% [11   14   21   33   45]	21.4% [0   12   20   33   50]	
CEA SYMP	Stroke/Death	2.3% [0   0   0   4   21]	1.8% [0   0   0   0   7]	
	Postop LOS>1 Day	45.9% [11   29   47   58   76]	42.2% [0   25   39   57   75]	
EVAR	Postop LOS>2 Days	12.4% [0   6   11   18   33]	15.3% [0   7   15   21   33]	
	Sac Diameter Reporting	68.3% [3   60   67   76   93]	60.5% [1   36   64   82   89]	
	SVS AAA Diameter Guideline	76.1% [50   65   78   83   86]	75.2% [50   66   77   88   100]	
TEVAR	Sac Diameter Reporting	56.6% [35   50   50   88   100]	61.9% [0   37   57   82   100]	
OAAA	In-Hospital Mortality	3.4% [0   0   1   7   11]	4.2% [0   0   1   9   19]	
	SVS Cell-Saver Guideline	93.6% [76   88   96   100   100]	92.7% [73   89   99   100   100]	
	SVS Iliac Inflow Guideline	96.4% [88   93   100   100   100]	98.1% [93   98   100   100   100]	
PVI CLAUD	ABI/Toe Pressure	70.6% [21   57   77   90   100]	69.4% [15   50   75   90   100]	
INFRA CLTI	Major Complications	7.5% [0   3   9   10   14]	4.7% [0   0   3   7   11]	
SUPRA CLTI	Major Complications	11.4% [0   0   11   12   22]	8.2% [0   0   0   12   23]	
LEAMP	Postop Complications	NA (<3 centers)	11.3% [0   3   10   16   22]	
HDA	Primary AVF vs. Graft	88.8% [80   87   92   94   94]	81.7% [64   74   82   92   97]	
HDA	Ultrasound Vein Mapping	71% [19   48   75   89   94]	86.7% [48   81   90   97   100]	
HDA	Postop Complications	0% [0   0   0   0   0]	1.2% [0   0   0   3   4]	
IVCF	Filter Retrieval Reporting	41.4% [11   28   55   78   91]	57.1% [5   33   53   68   86]	

Legend: Blue = "Top" 25th percentile Coral = "Bottom" 25th percentile

Note that procedure volume results are not highlighted.

10<sup>th</sup>/25<sup>th</sup>/50<sup>th</sup>/75<sup>th</sup>/90<sup>th</sup> percentile



# Celebrate Positive Performance!

Discharge Medication Adherence

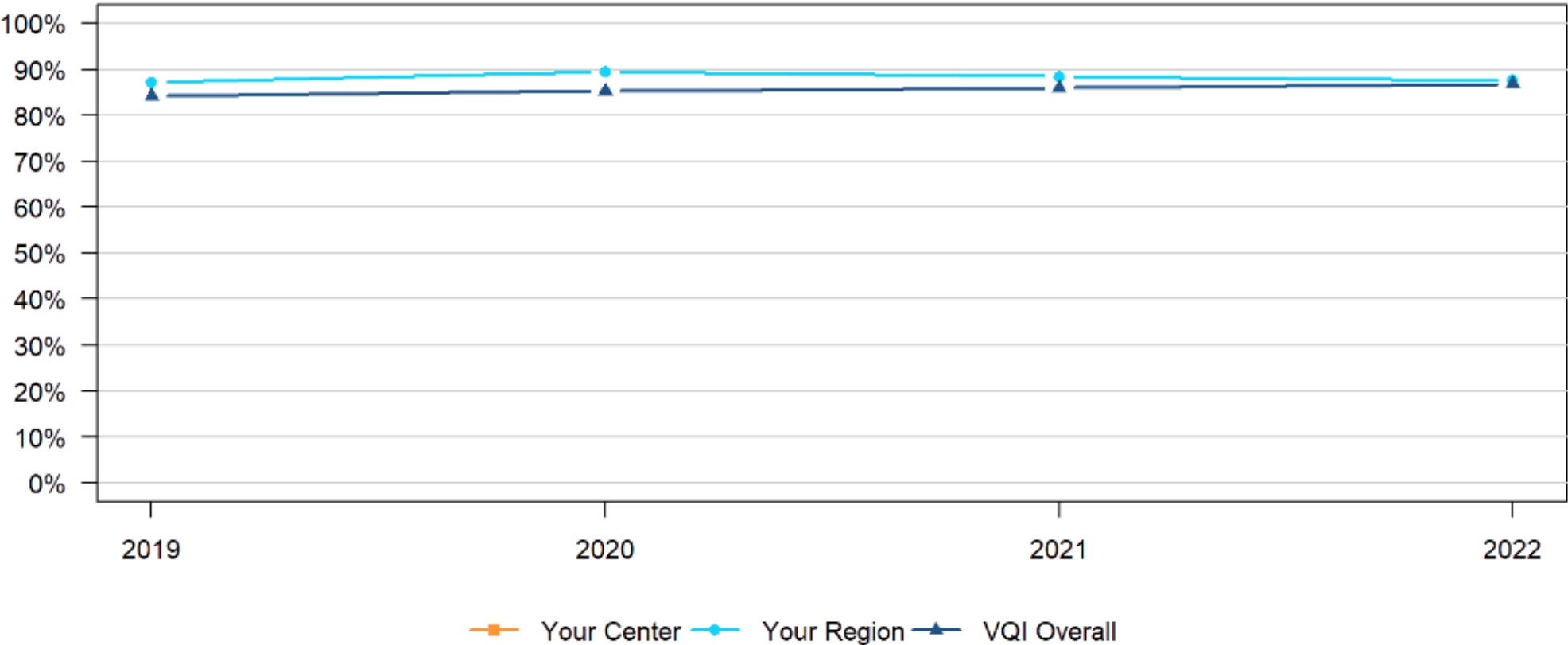
Carotid disease

Aneurysm disease

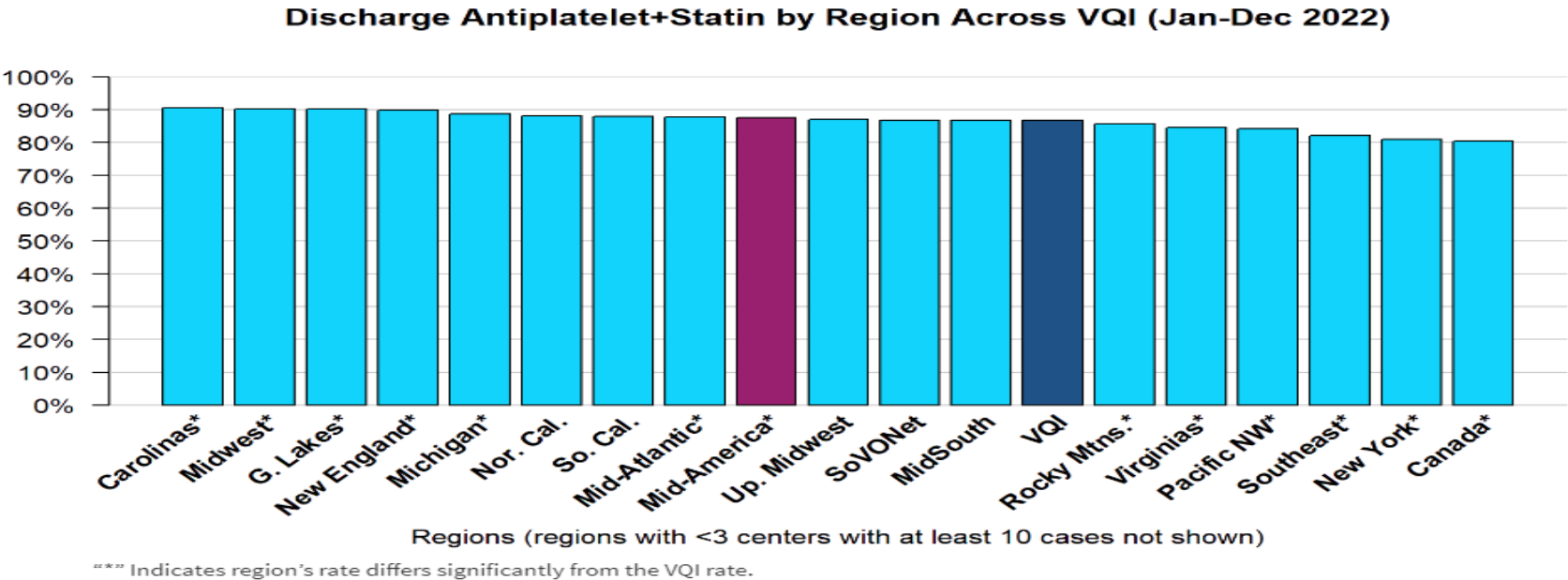
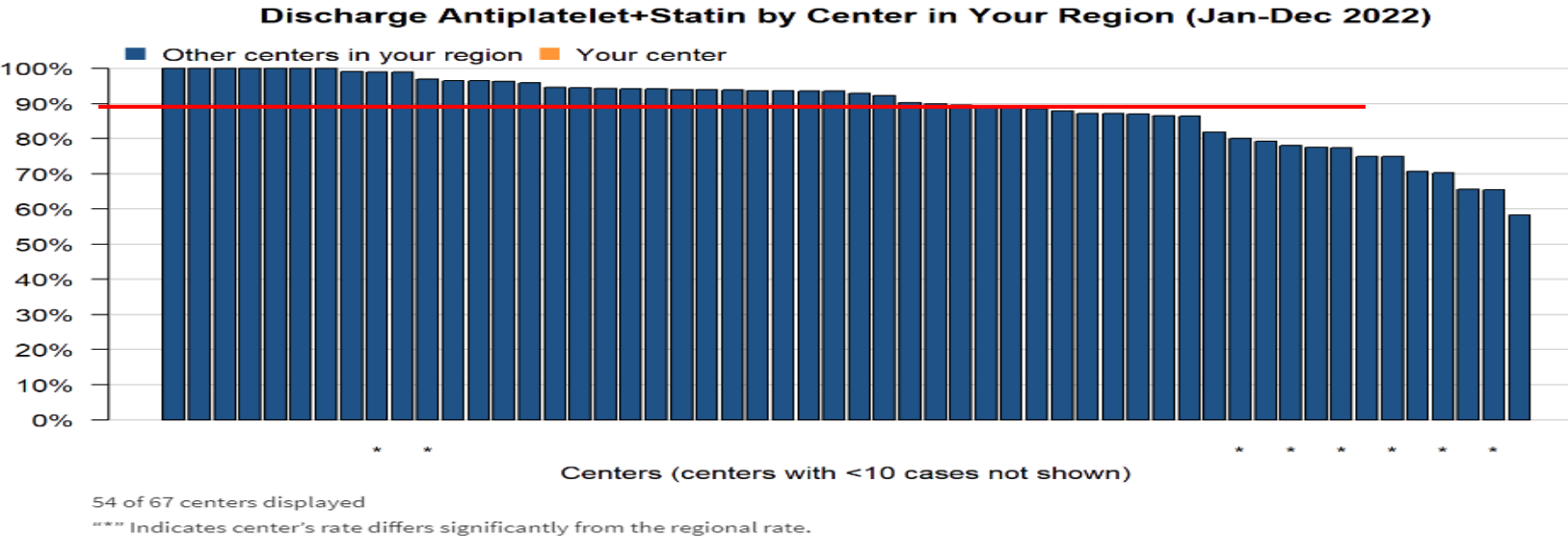
PAD – ABI/toe pressure measurement

	Number of Procedures at Your Center	Antiplatelet+Statin	Antiplatelet Only	Statin Only	Neither
Your Region Overall	7530	88%	9%	2%	1%
VQI Overall	105416	87%	8%	3%	2%

Discharge Antiplatelet+Statin by Year



# Discharge Antiplatelet & Statin by Center 2022



Procedure	Volume (complete cases)	Stroke & Death Observed	Stroke & Death Expected	LOS > 1 day Observed	LOS > 1 day Expected
TFEM CAS ASYMP	116	0%	1.8%	--	--
TFEM CAS SYMP	221	3.2%	4%	--	--
TCAR ASYMP	487	0.8%	1.0%	--	--
TCAR SYMP	258	2.3%	2.0%	--	--
CEA ASYMP	631 (626 for LOS)	0.6%	0.9%	24.4%	21.5%
CEA SYMP	332	1.8%	1.9%	45.2%	41.2%

## TFEM CAS ASYMP: Stroke/Death

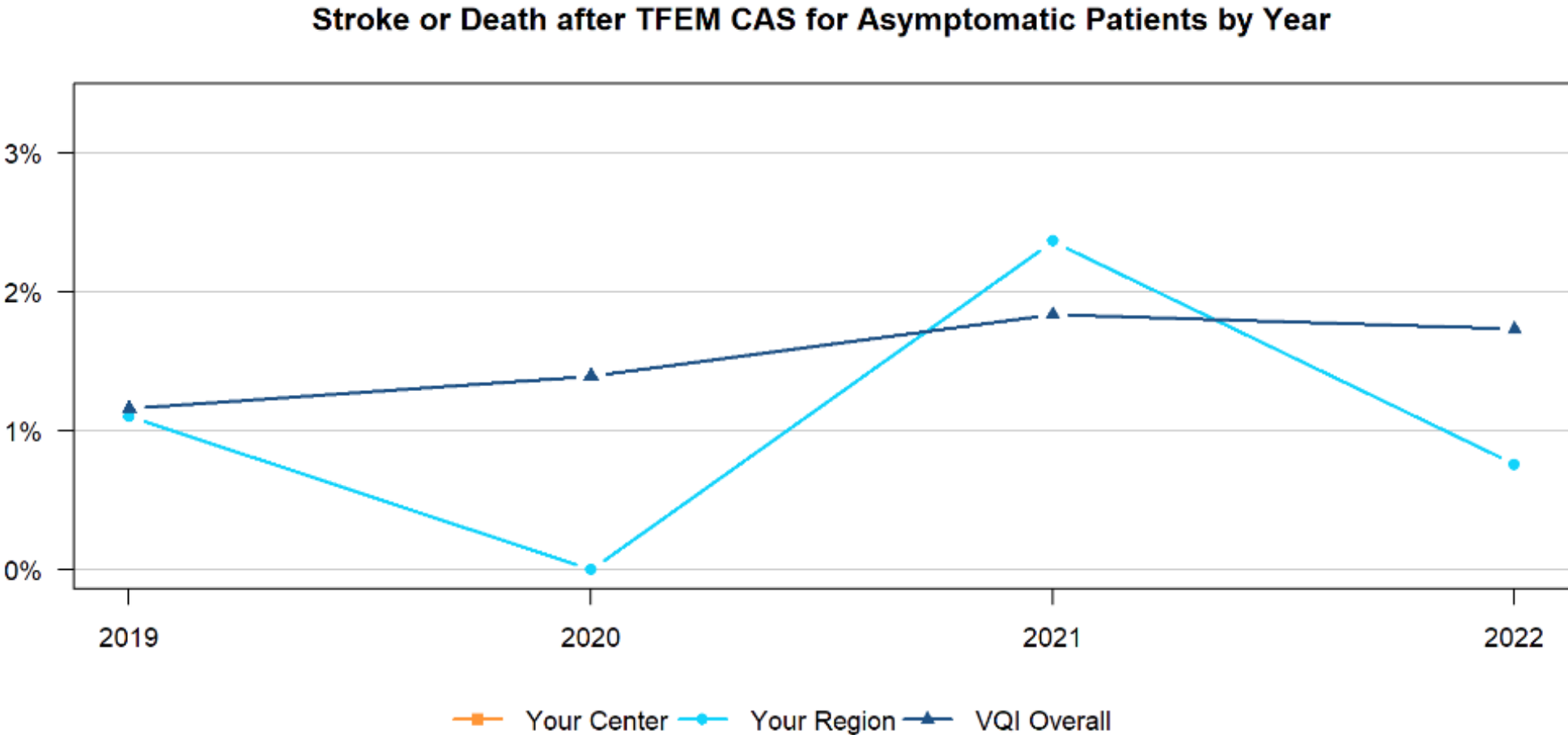
Procedures performed between January 1 and December 31, 2022

Includes Transfemoral Carotid Artery Stenting (TFEM CAS) procedures performed on asymptomatic patients. Asymptomatic patients are patients with no ipsilateral or contralateral retinal or cortical TIA or stroke within 180 days prior to surgery. Includes procedures utilizing a femoral, brachial, or radial approach. 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, brachial, or radial are also excluded.

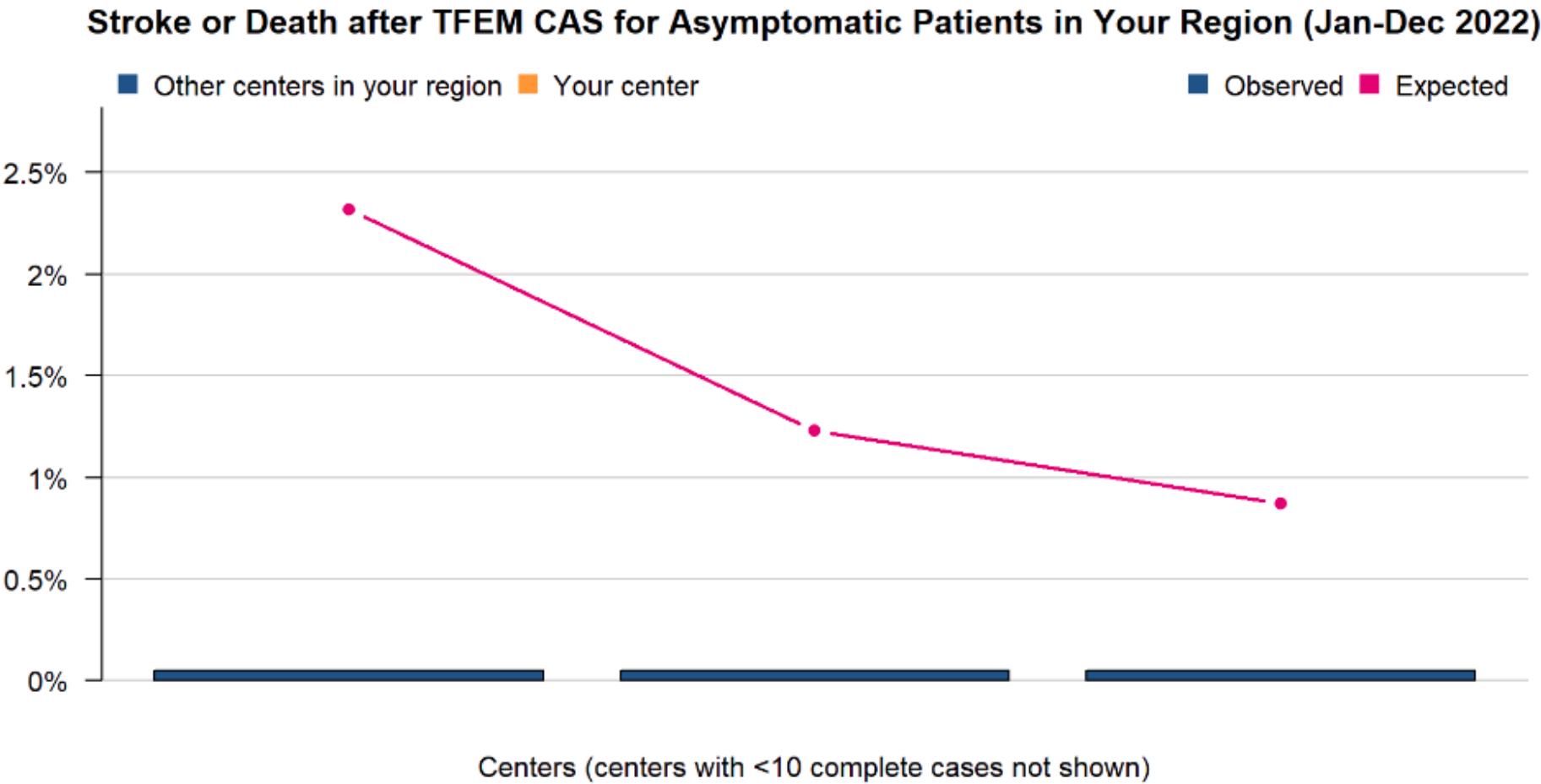
The table below gives the number of TFEM CAS procedures (performed on asymptomatic patients) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

	Your Center	Your Region	VQI Overall
Number of TFEM CAS procedures meeting inclusion criteria		132	2426
Observed rate of stroke or death among procedures meeting inclusion criteria		0.8%	1.7%
Number of procedures with complete data*		116	2202
Observed rate of stroke or death among cases with complete data		0%	1.8%
Expected rate of stroke or death among cases with complete data		1.8%	NA
P-value for comparison of observed and expected rates		0.28	NA

\*"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.

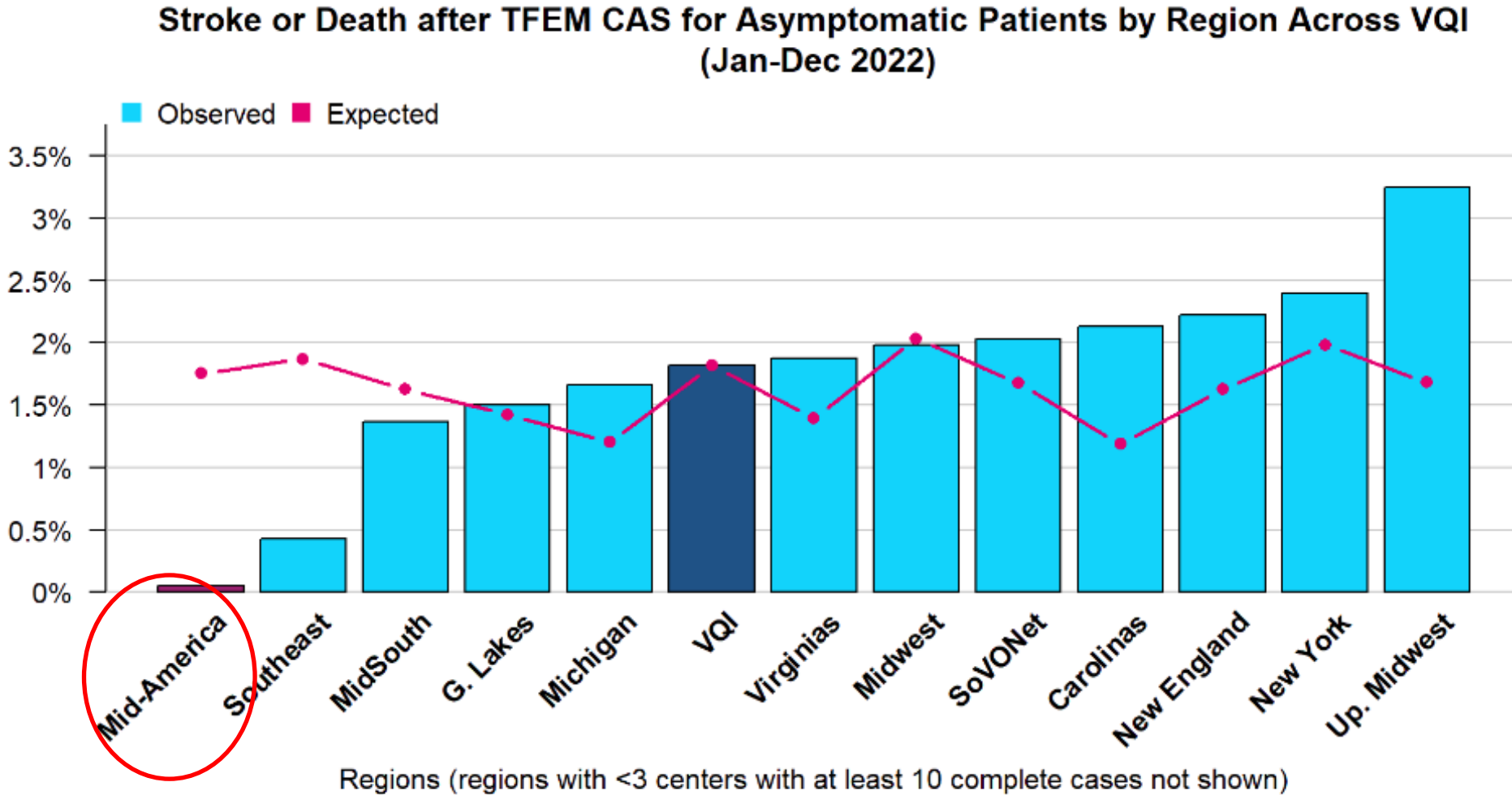


Rates shown are observed rates among cases meeting inclusion criteria.



3 of 29 centers displayed

Rates shown are among cases with complete data. “\*” Indicates center’s observed rate differs significantly from its expected rate



Rates shown are among cases with complete data. \*\*\* Indicates region's observed rate differs significantly from its expected rate



## TFEM CAS SYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2022

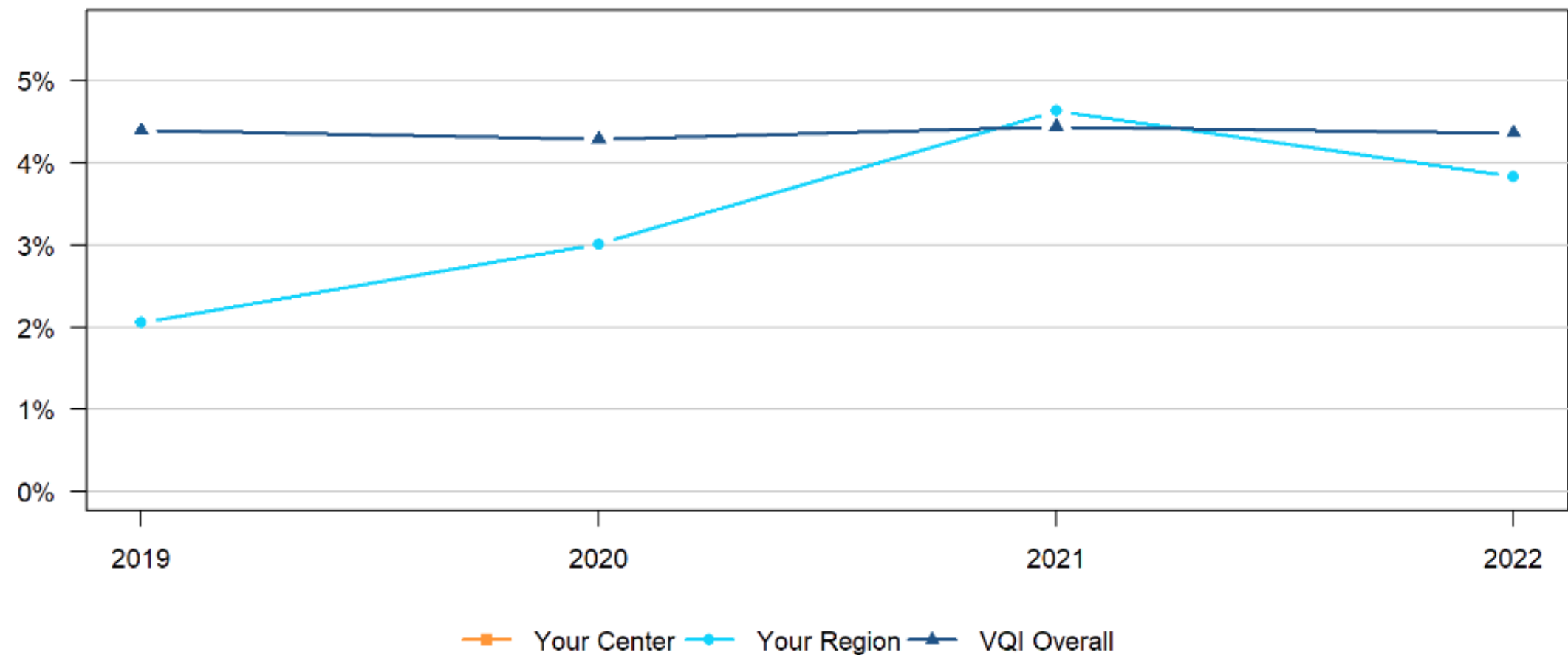
Includes Transfemoral Carotid Artery Stenting (TFEM CAS) procedures performed on symptomatic patients. Symptomatic patients are patients with an ipsilateral or contralateral retinal or cortical TIA or stroke within 180 days prior to surgery. Includes procedures utilizing a femoral, brachial, or radial approach. 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, brachial, or radial are also excluded.

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

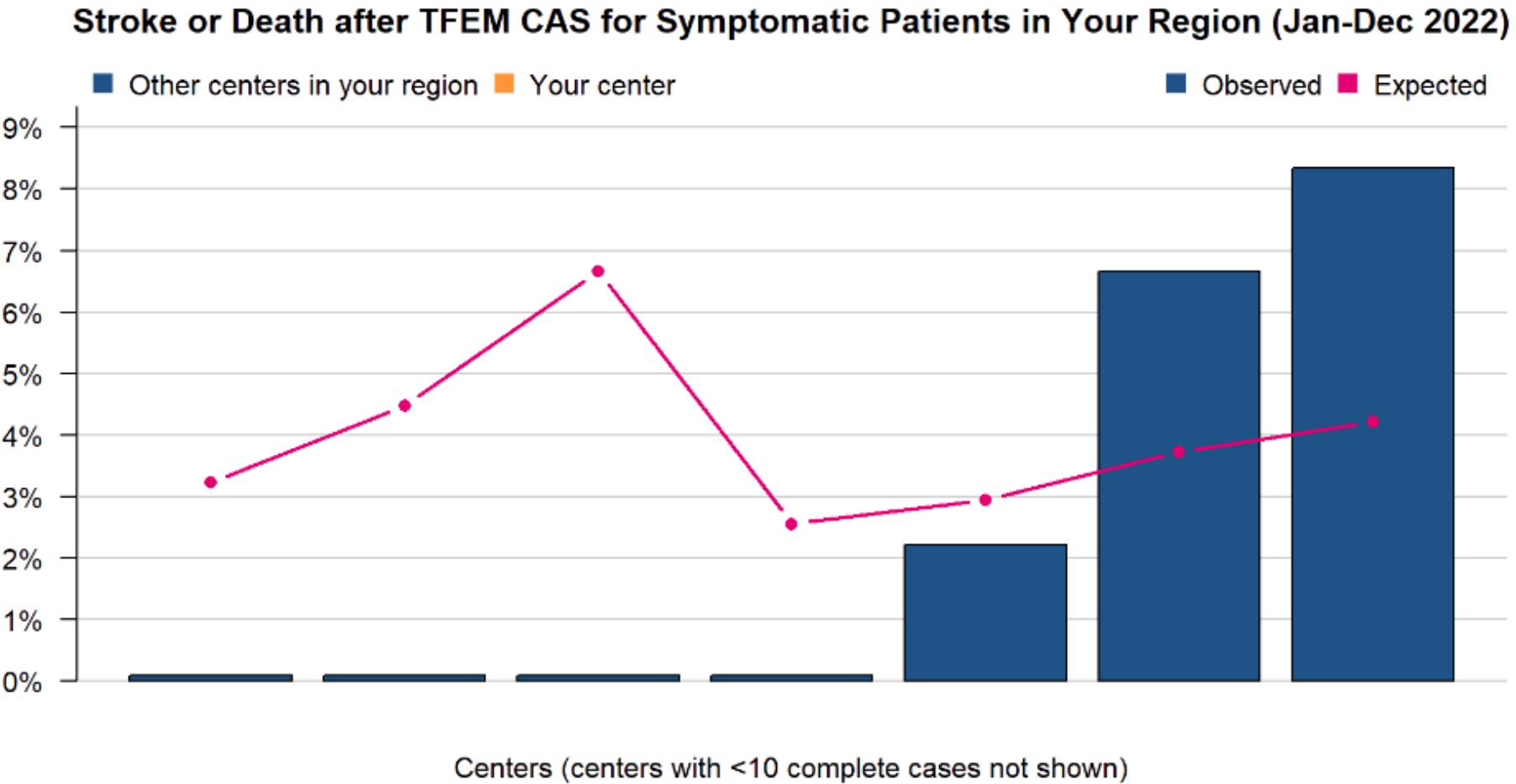
	Your Center	Your Region	VQI Overall
Number of TFEM CAS procedures meeting inclusion criteria		235	2659
Observed rate of stroke or death among procedures meeting inclusion criteria		3.8%	4.4%
Number of procedures with complete data*		221	2486
Observed rate of stroke or death among cases with complete data		3.2%	4.1%
Expected rate of stroke or death among cases with complete data		4%	NA
P-value for comparison of observed and expected rates		0.73	NA

\*"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 Symptomatic Patients by Year

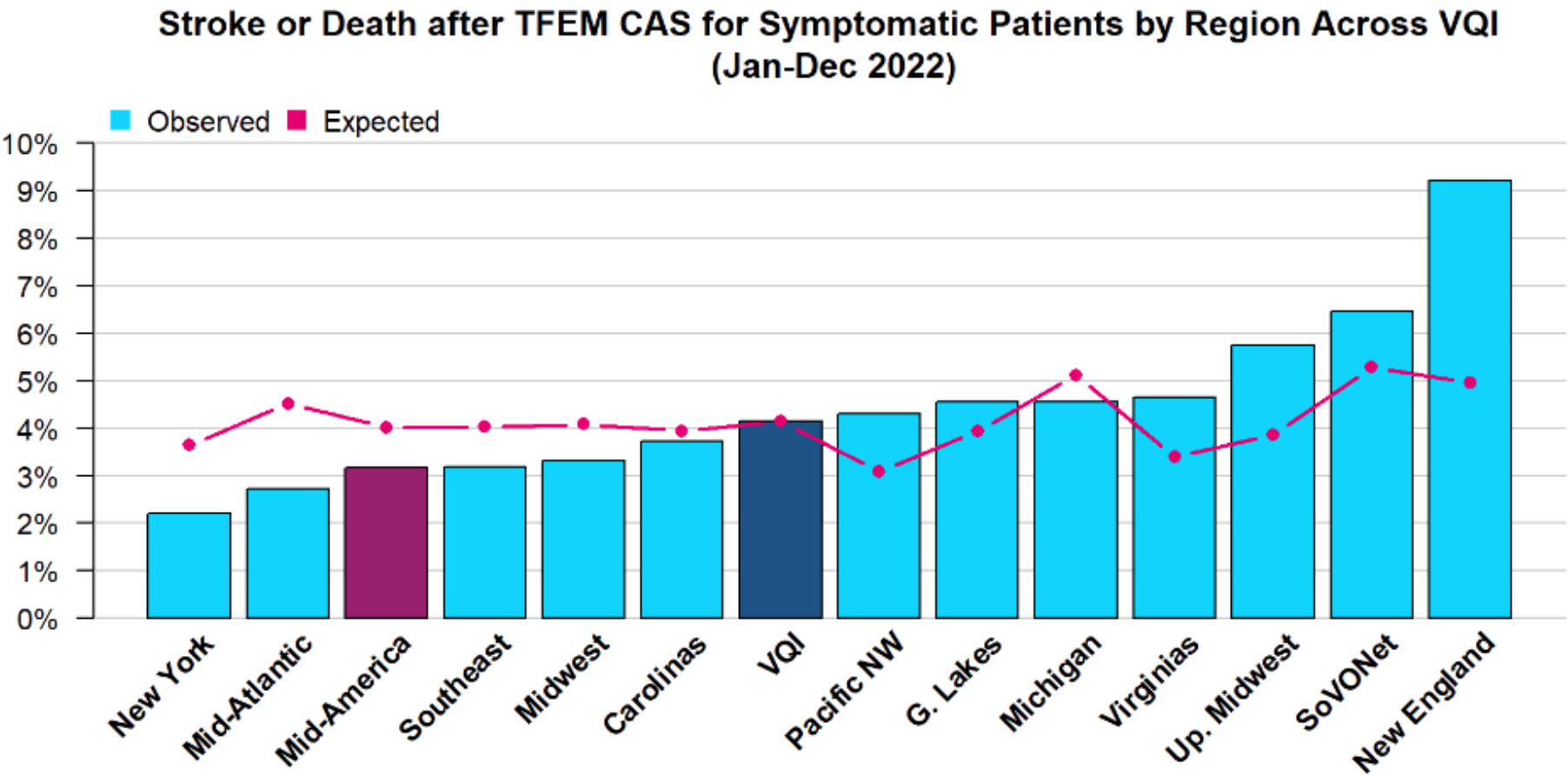


Rates shown are observed rates among cases meeting inclusion criteria.



7 of 27 centers displayed

Rates shown are among cases with complete data. \*\*\* Indicates center's observed rate differs significantly from its expected rate



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

Rates shown are among cases with complete data. \*\* Indicates region's observed rate differs significantly from its expected rate

## TCAR ASYMP: Stroke/Death

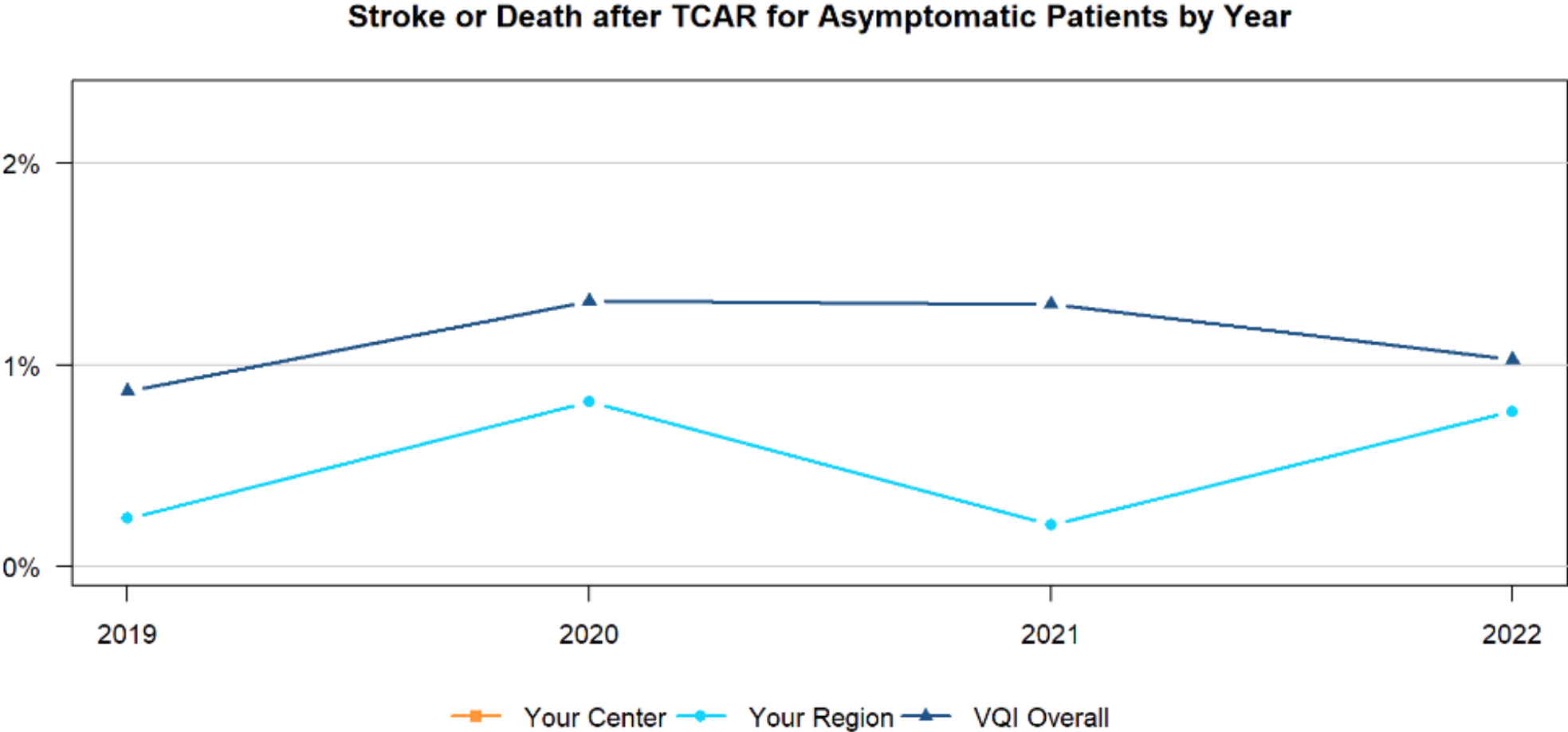
Procedures performed between January 1 and December 31, 2022

Includes TransCarotid Artery Revascularization (TCAR) procedures performed on asymptomatic patients. Asymptomatic patients are patients with 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 carotid percutaneous or carotid open are also excluded.

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

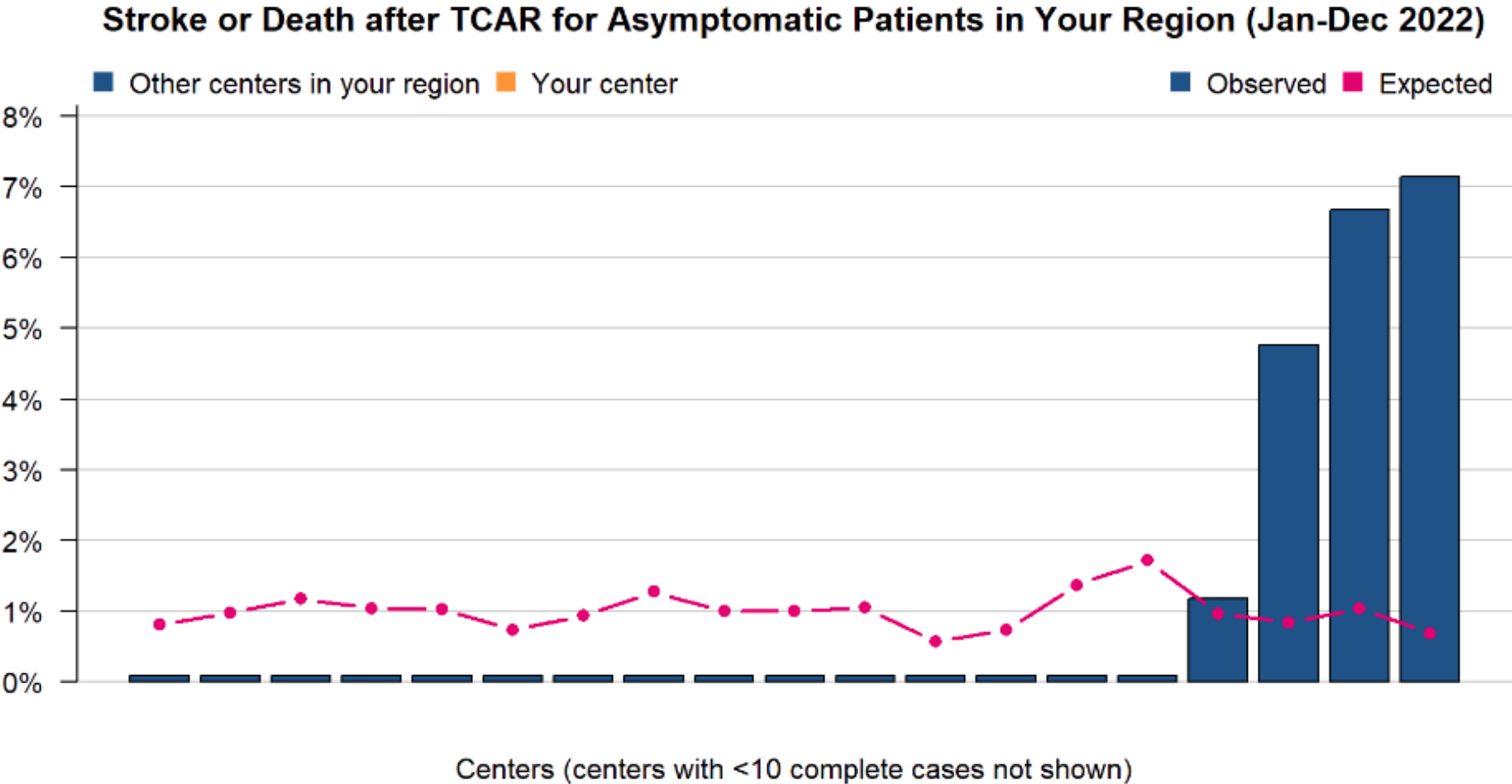
	Your Center	Your Region	VQI Overall
Number of TCAR procedures meeting inclusion criteria		521	7701
Observed rate of stroke or death among procedures meeting inclusion criteria		0.8%	1%
Number of procedures with complete data*		487	7136
Observed rate of stroke or death among cases with complete data		0.8%	1%
Expected rate of stroke or death among cases with complete data		1%	NA
P-value for comparison of observed and expected rates		1	NA

\*“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.



Rates shown are observed rates among cases meeting inclusion criteria.

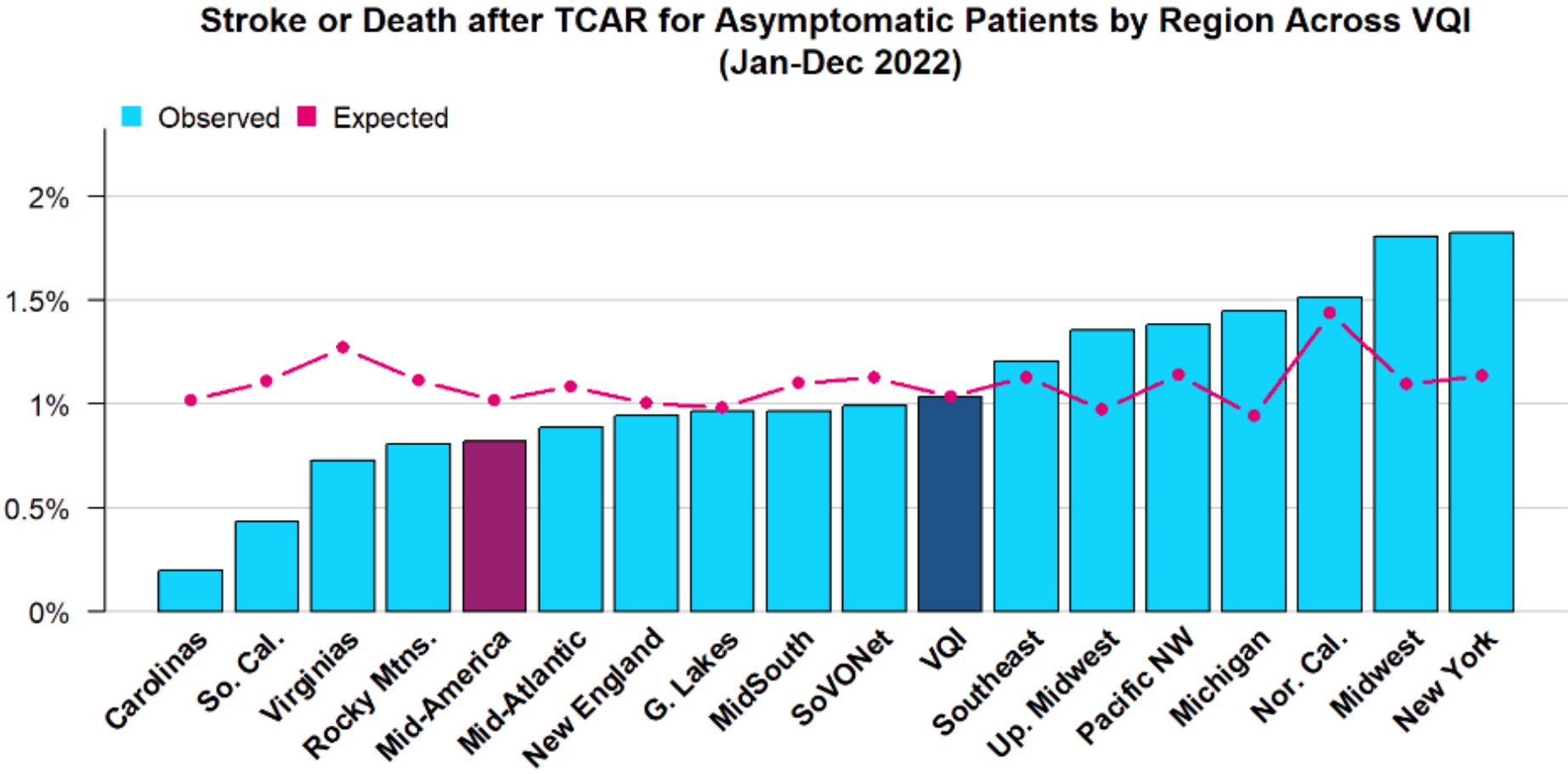
# TCAR Asymp Stroke/Death by Region 2022



19 of 50 centers displayed

Rates shown are among cases with complete data. “\*” Indicates center’s observed rate differs significantly from its expected rate





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

Rates shown are among cases with complete data. “\*” Indicates region’s observed rate differs significantly from its expected rate



## TCAR SYMP: Stroke/Death

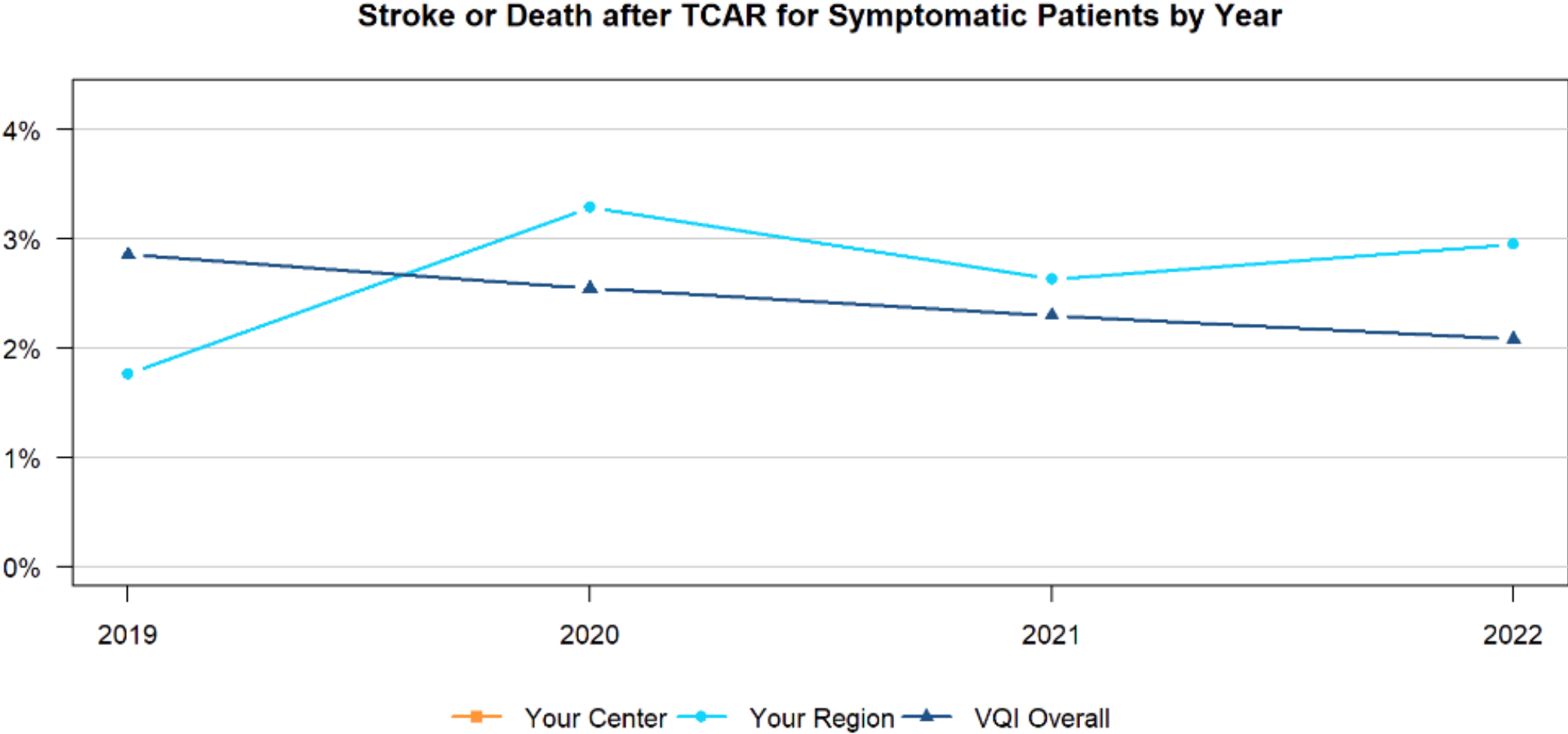
Procedures performed between January 1 and December 31, 2022

Includes TransCarotid Artery Revascularization (TCAR) procedures performed on symptomatic patients. Symptomatic patients are patients with 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 carotid percutaneous or carotid open are also excluded.

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

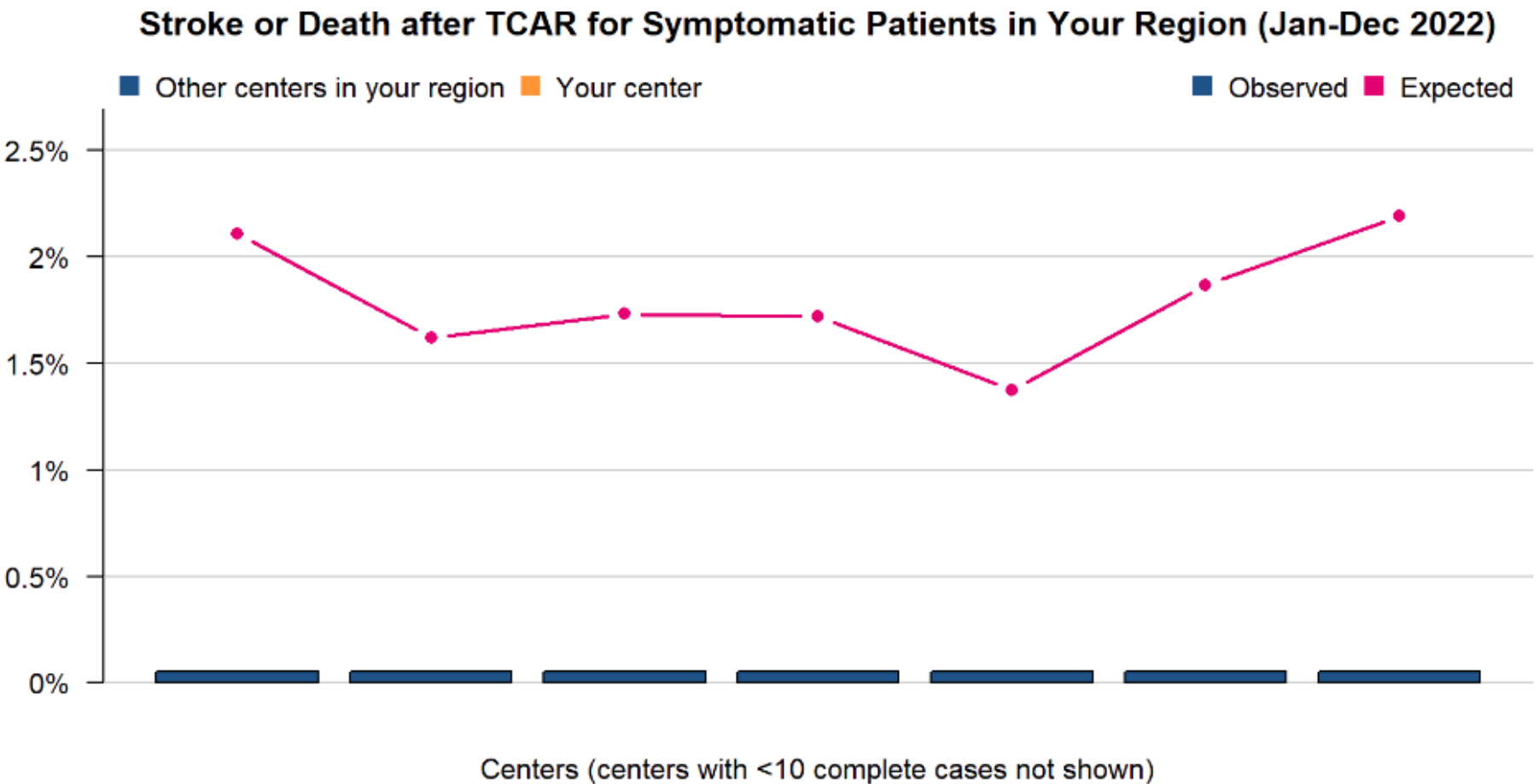
	Your Center	Your Region	VQI Overall
Number of TCAR procedures meeting inclusion criteria		271	3840
Observed rate of stroke or death among procedures meeting inclusion criteria		3%	2.1%
Number of procedures with complete data*		258	3606
Observed rate of stroke or death among cases with complete data		2.3%	2.1%
Expected rate of stroke or death among cases with complete data		2%	NA
P-value for comparison of observed and expected rates		0.66	NA

\*“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.



Rates shown are observed rates among cases meeting inclusion criteria.

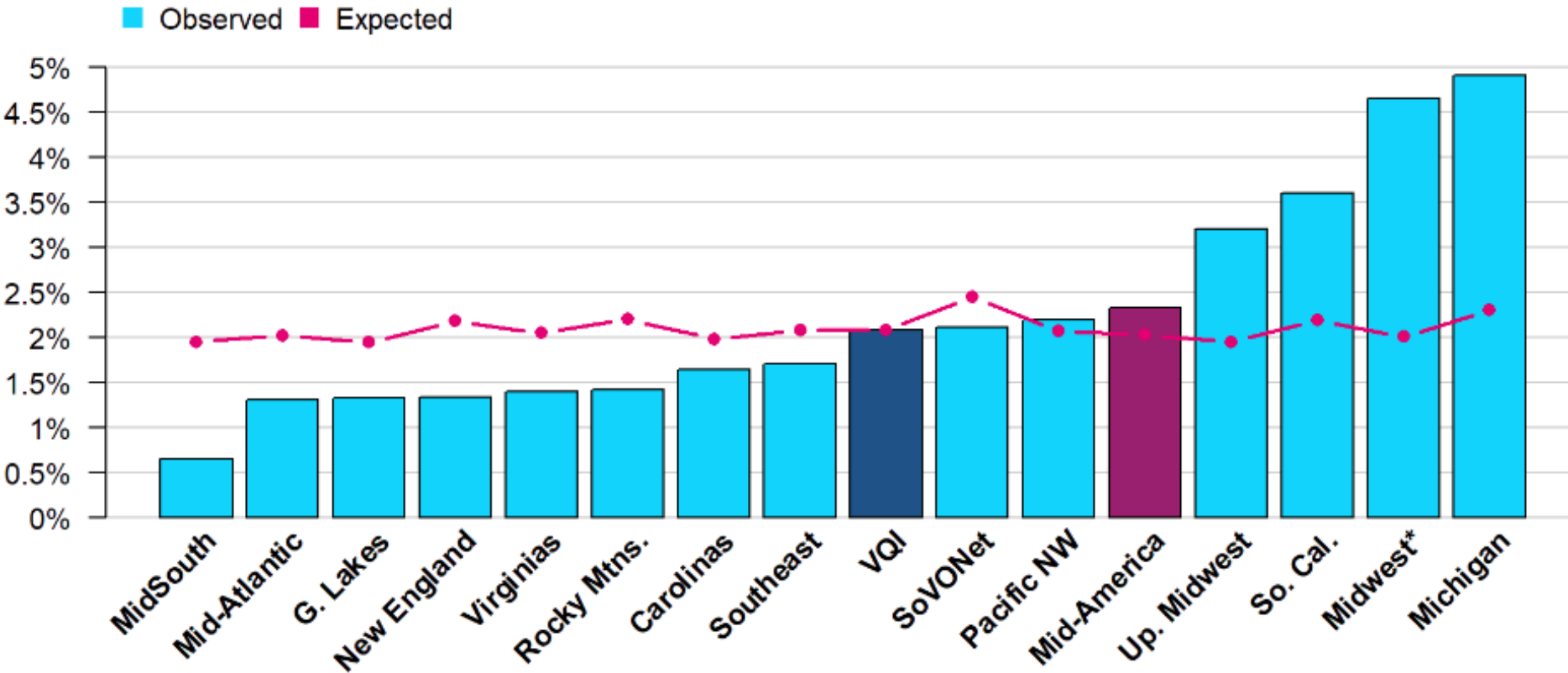
# TCAR Symp Stroke/Death by Region 2022



7 of 47 centers displayed

Rates shown are among cases with complete data. “\*” Indicates center’s observed rate differs significantly from its expected rate

Stroke or Death after TCAR for Symptomatic Patients by Region Across VQI  
(Jan-Dec 2022)



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

Rates shown are among cases with complete data. “\*” Indicates region’s observed rate differs significantly from its expected rate

## CEA ASYMP: Stroke/Death

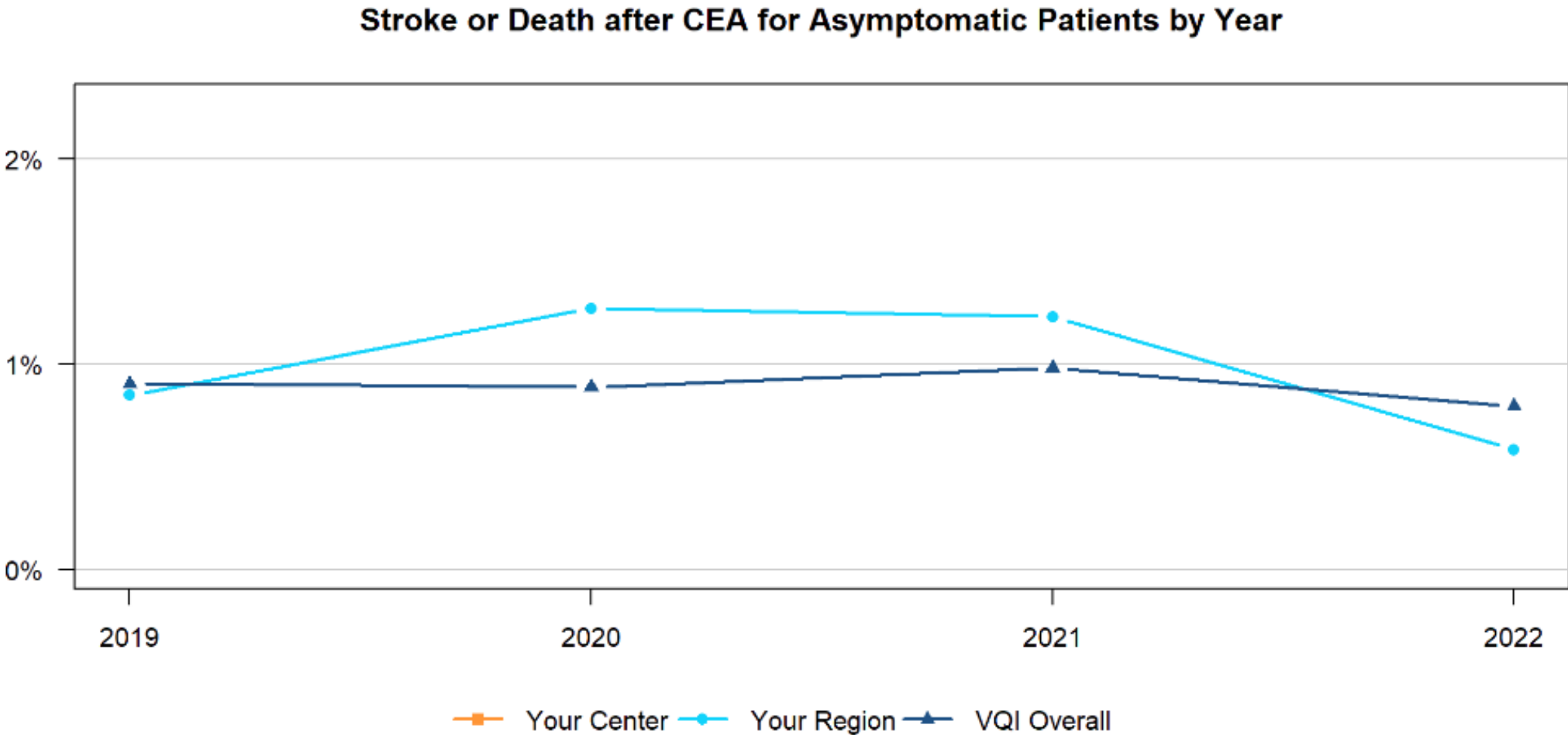
Procedures performed between January 1 and December 31, 2022

Includes Carotid Endarterectomy (CEA) procedures performed on asymptomatic patients. Asymptomatic patients are patients with 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.

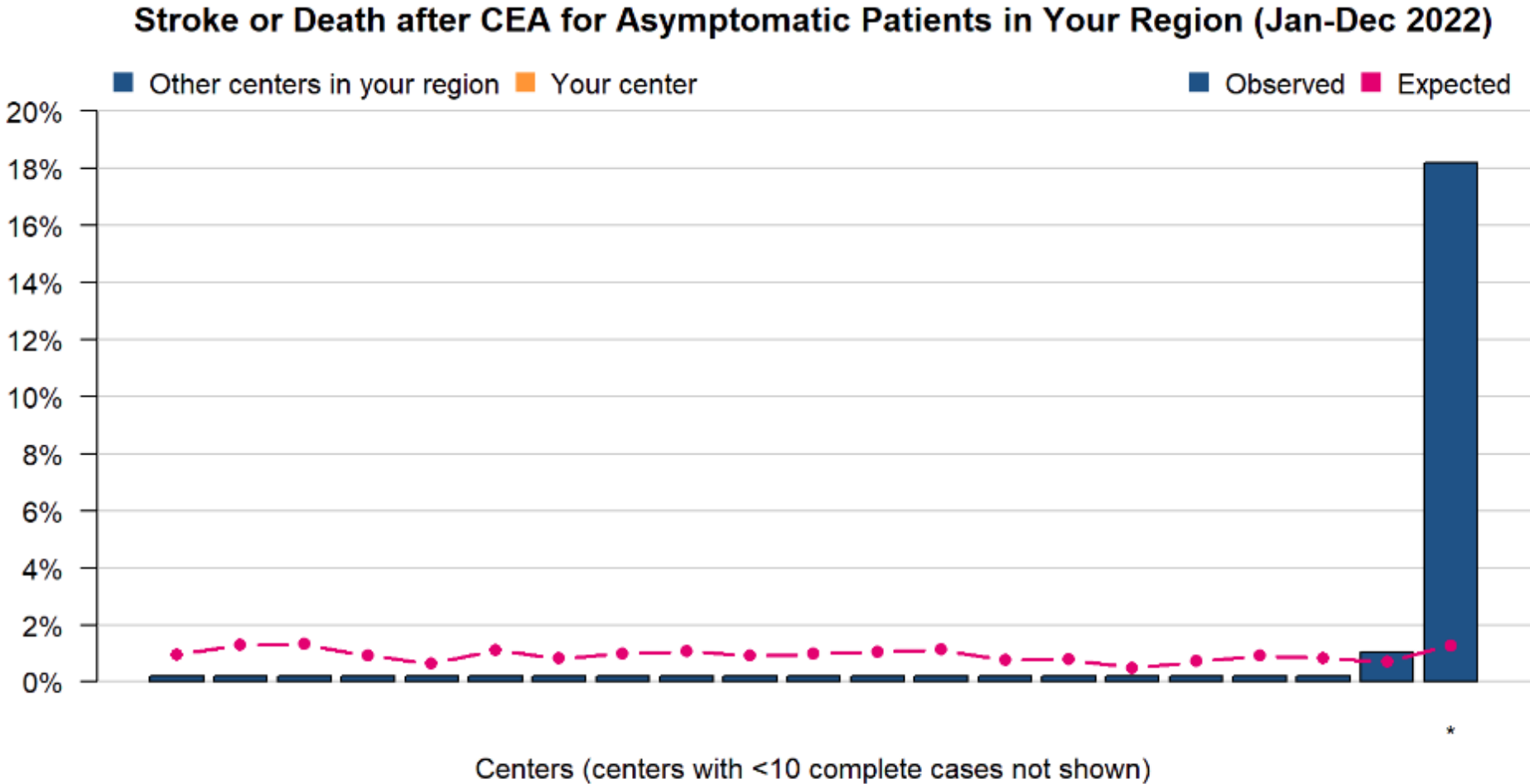
The table below gives the number of CEA procedures (performed on asymptomatic patients) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

	Your Center	Your Region	VQI Overall
Number of CEA procedures meeting inclusion criteria		685	10414
Observed rate of stroke or death among procedures meeting inclusion criteria		0.6%	0.8%
Number of procedures with complete data*		631	9733
Observed rate of stroke or death among cases with complete data		0.6%	0.8%
Expected rate of stroke or death among cases with complete data		0.9%	NA
P-value for comparison of observed and expected rates		0.67	NA

\*“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.

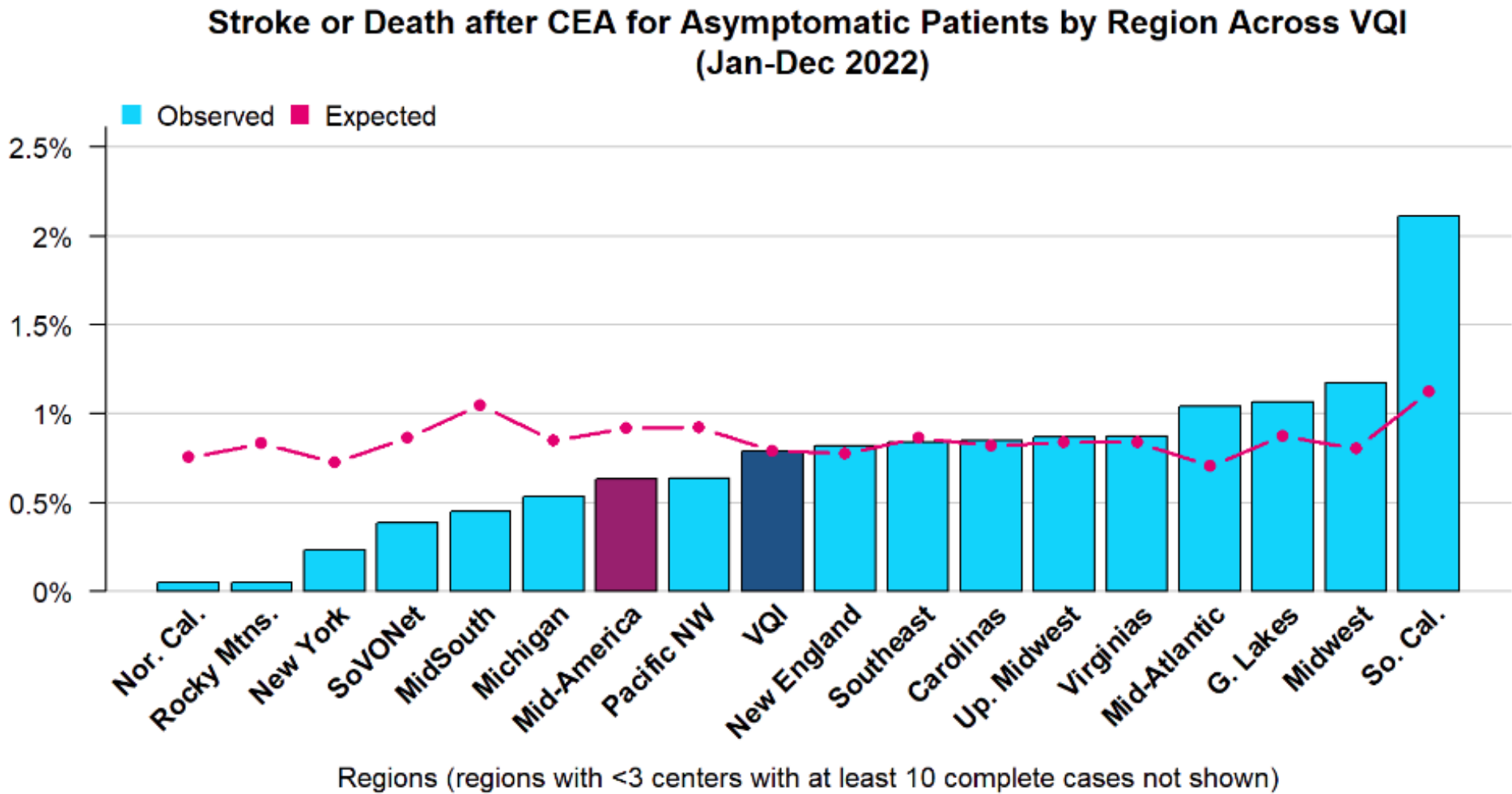


Rates shown are observed rates among cases meeting inclusion criteria.



21 of 34 centers displayed

Rates shown are among cases with complete data. \*\* \* \*\* Indicates center's observed rate differs significantly from its expected rate



Rates shown are among cases with complete data. \*\*\* Indicates region's observed rate differs significantly from its expected rate



## CEA SYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2022

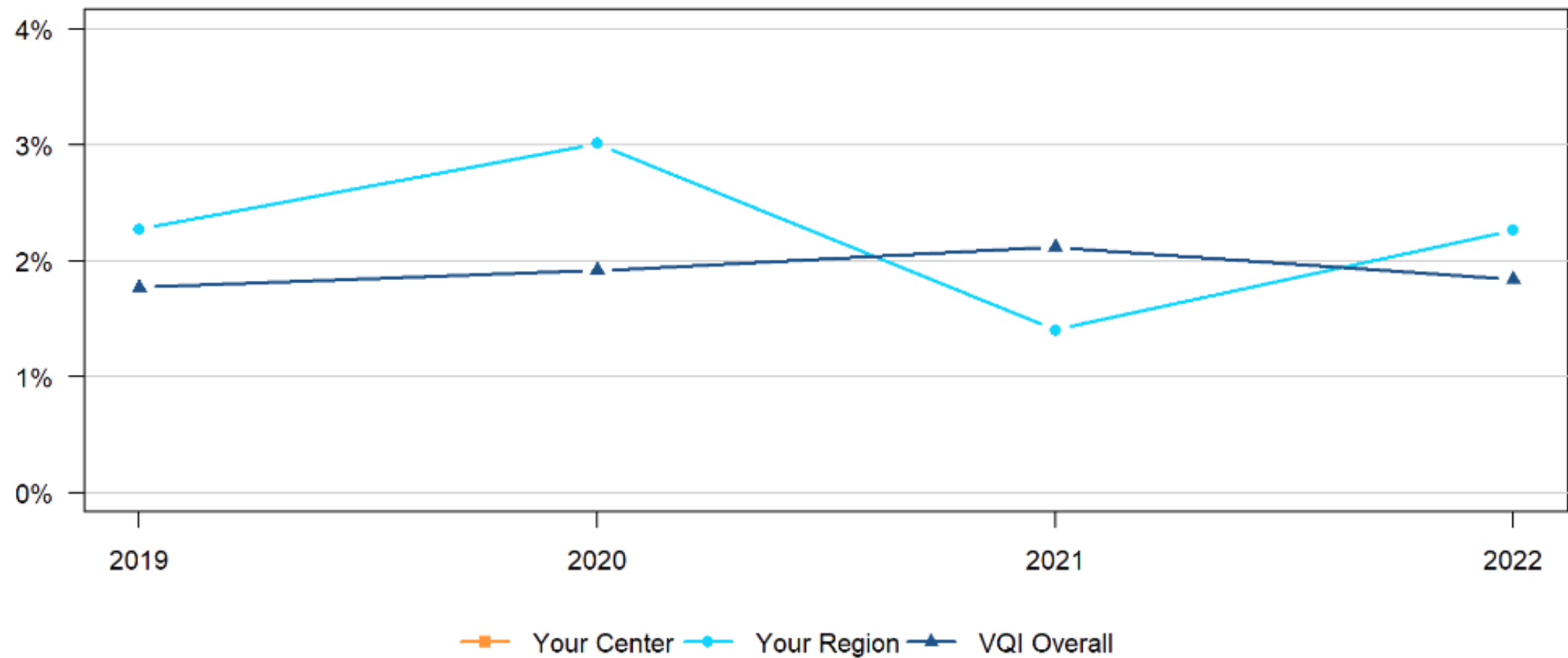
Includes Carotid Endarterectomy (CEA) procedures performed on symptomatic patients. Symptomatic patients are patients with an ipsilateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar or non-specific TIA or stroke, prior ipsilateral 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 patients) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

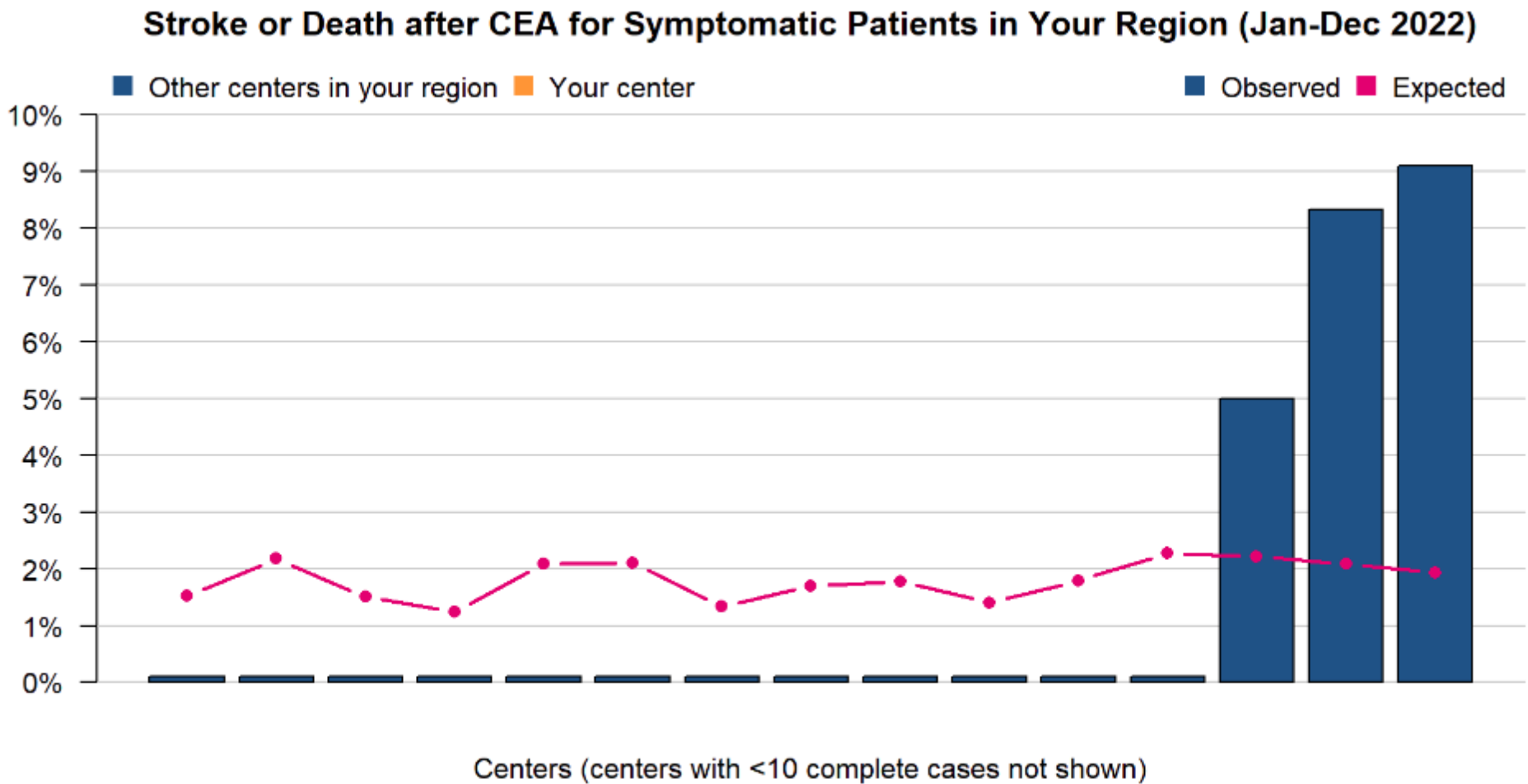
	Your Center	Your Region	VQI Overall
Number of CEA procedures meeting inclusion criteria		353	5043
Observed rate of stroke or death among procedures meeting inclusion criteria		2.3%	1.8%
Number of procedures with complete data*		332	4830
Observed rate of stroke or death among cases with complete data		1.8%	1.8%
Expected rate of stroke or death among cases with complete data		1.9%	NA
P-value for comparison of observed and expected rates		1	NA

\*“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 Patients by Year

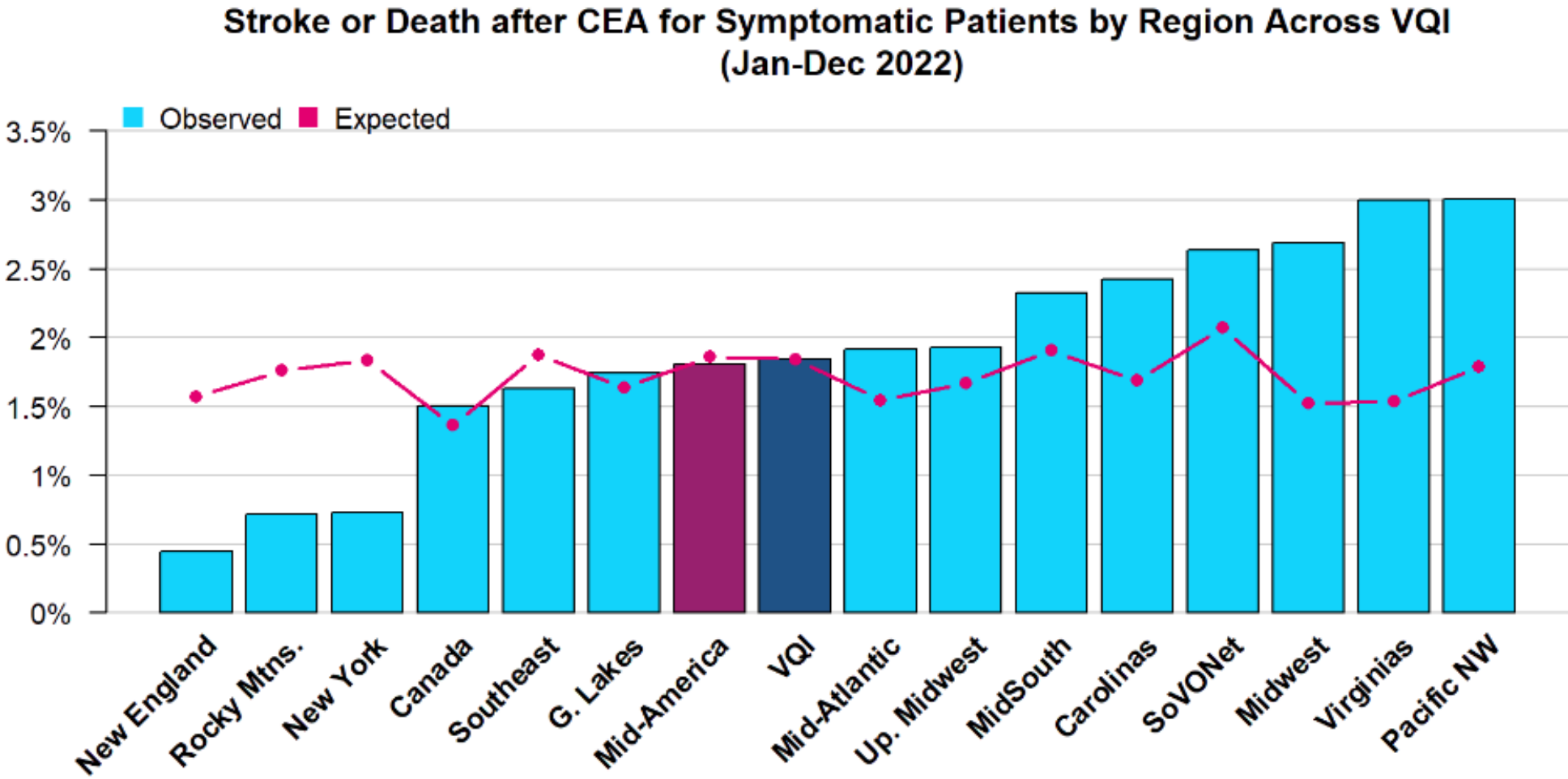


Rates shown are observed rates among cases meeting inclusion criteria.



15 of 30 centers displayed

Rates shown are among cases with complete data. \*\*\*\* Indicates center's observed rate differs significantly from its expected rate



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

Rates shown are among cases with complete data. “\*” Indicates region’s observed rate differs significantly from its expected rate

## CEA ASYMP: Postop LOS>1 Day

Procedures performed between January 1 and December 31, 2022

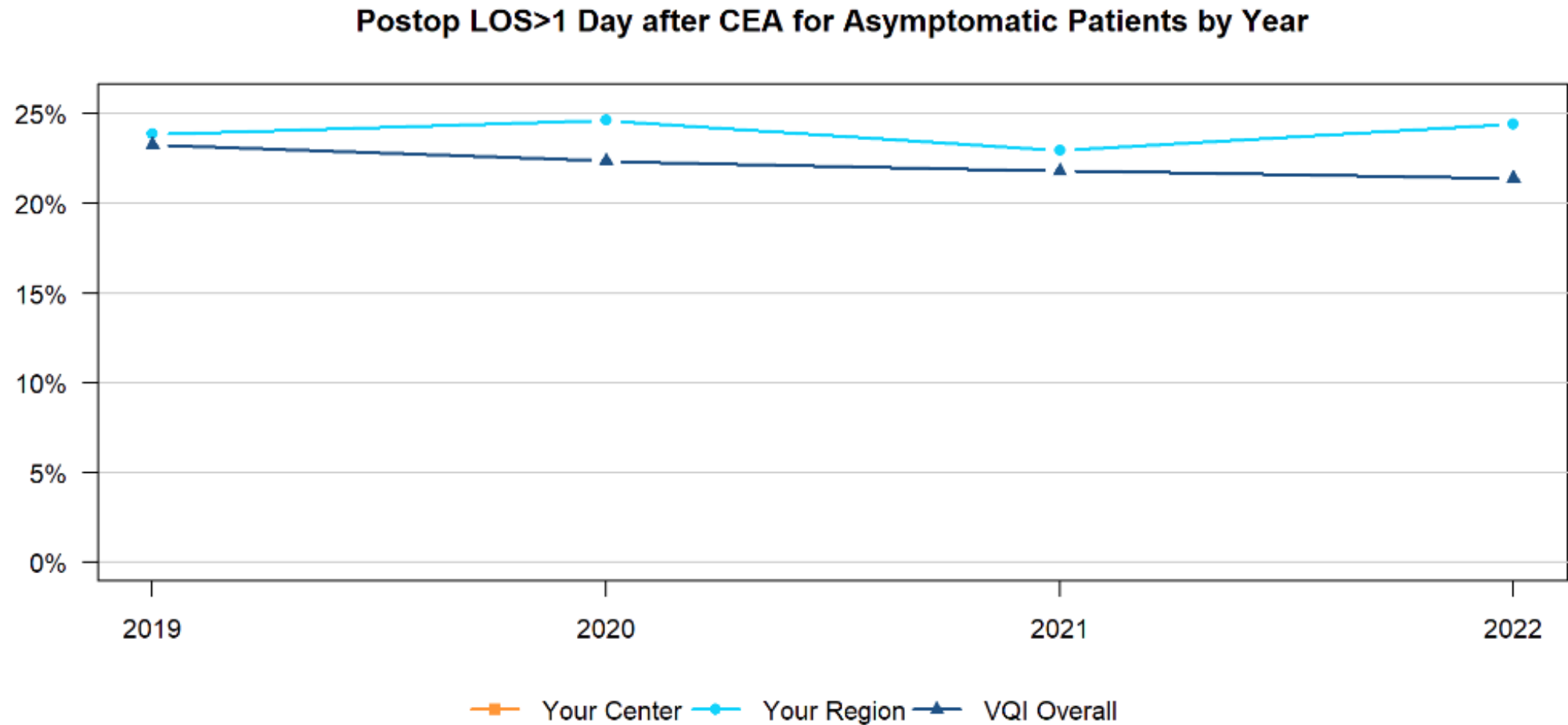
Includes Carotid Endarterectomy (CEA) procedures performed on asymptomatic patients. Asymptomatic patients are patients with no ipsilateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar or non-specific TIA or stroke, prior ipsilateral 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, or procedures with an unrelated return to the OR, 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 patients) meeting the inclusion criteria, and the observed and expected rates of postoperative LOS > 1 Day for those cases.

	Your Center	Your Region	VQI Overall
Number of CEA procedures meeting inclusion criteria		680	10381
Observed rate of LOS > 1 day among procedures meeting inclusion criteria		24.4%	21.4%
Number of procedures with complete data*		626	9702
Observed rate of LOS > 1 day among cases with complete data		24.4%	21.2%
Expected rate of LOS > 1 day among cases with complete data		21.5%	NA
P-value for comparison of observed and expected rates		0.07	NA

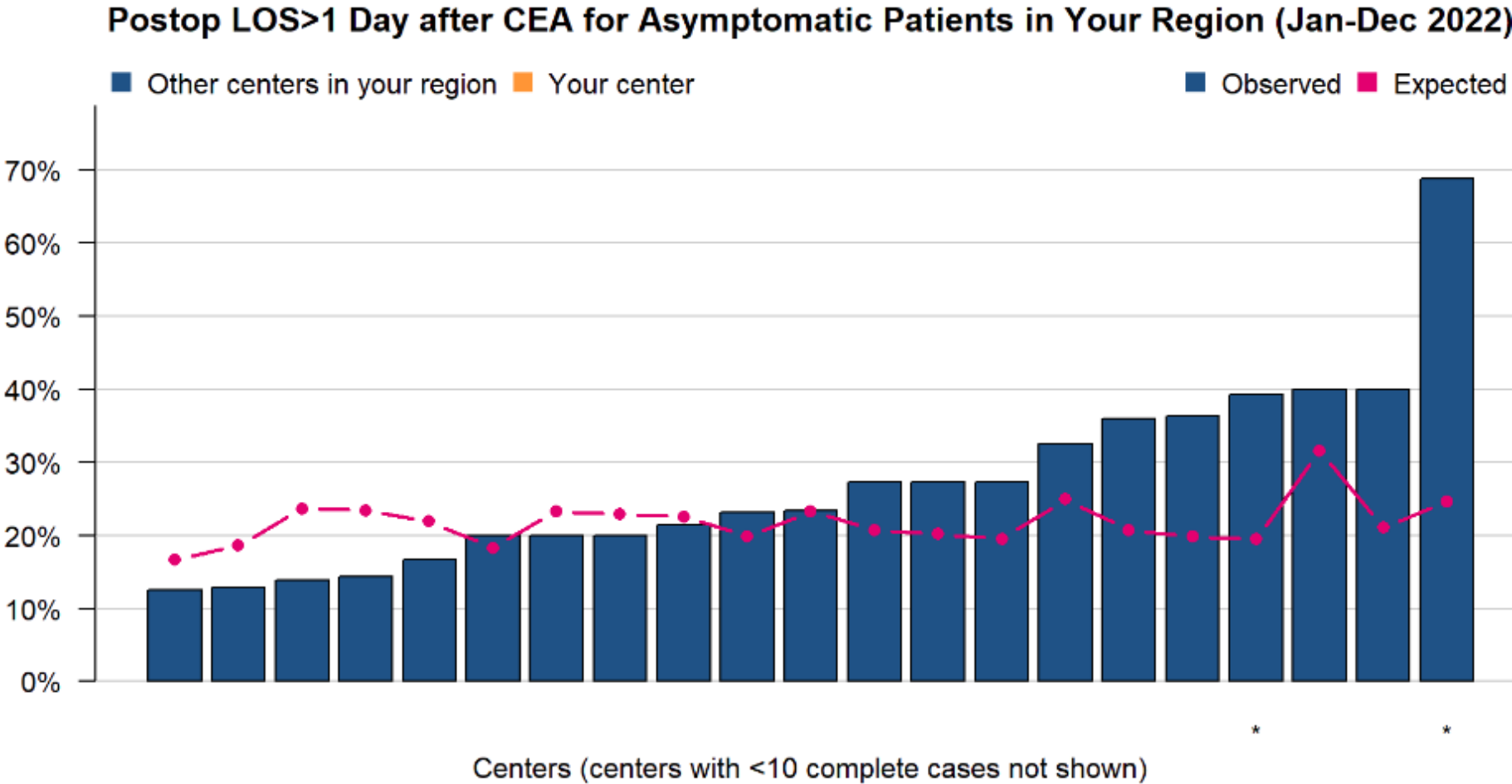
\*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.

# CEA Asympt Post-Op LOS > 1 Day by Year



Rates shown are observed rates among cases meeting inclusion criteria.

# CEA Asympt Post-Op LOS > 1 Day Region

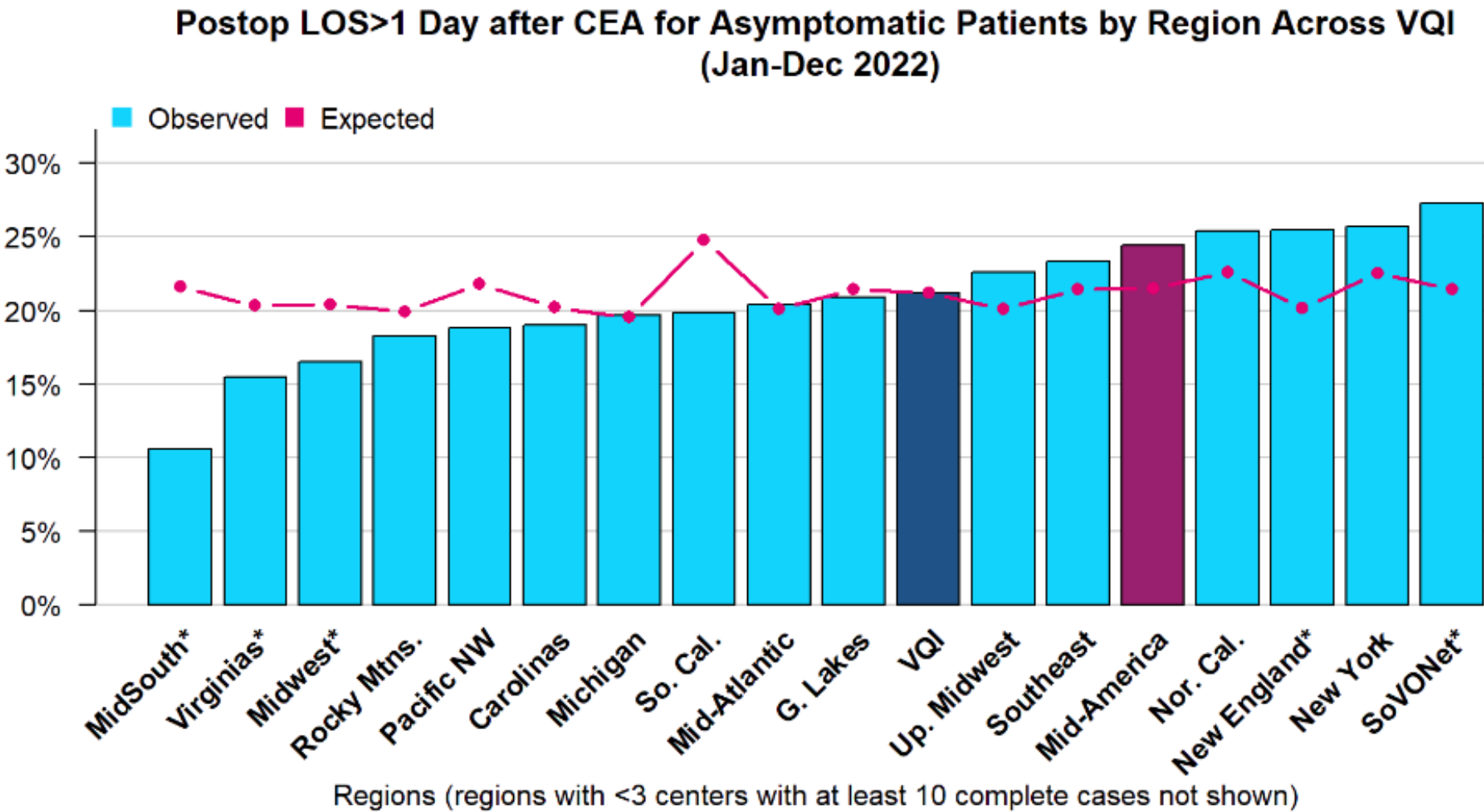


21 of 34 centers displayed

Rates shown are among cases with complete data. “\*” Indicates center’s observed rate differs significantly from its expected rate



# CEA Asympt Post-Op LOS > 1 Day All VQI



Rates shown are among cases with complete data. \*\* 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, 2022

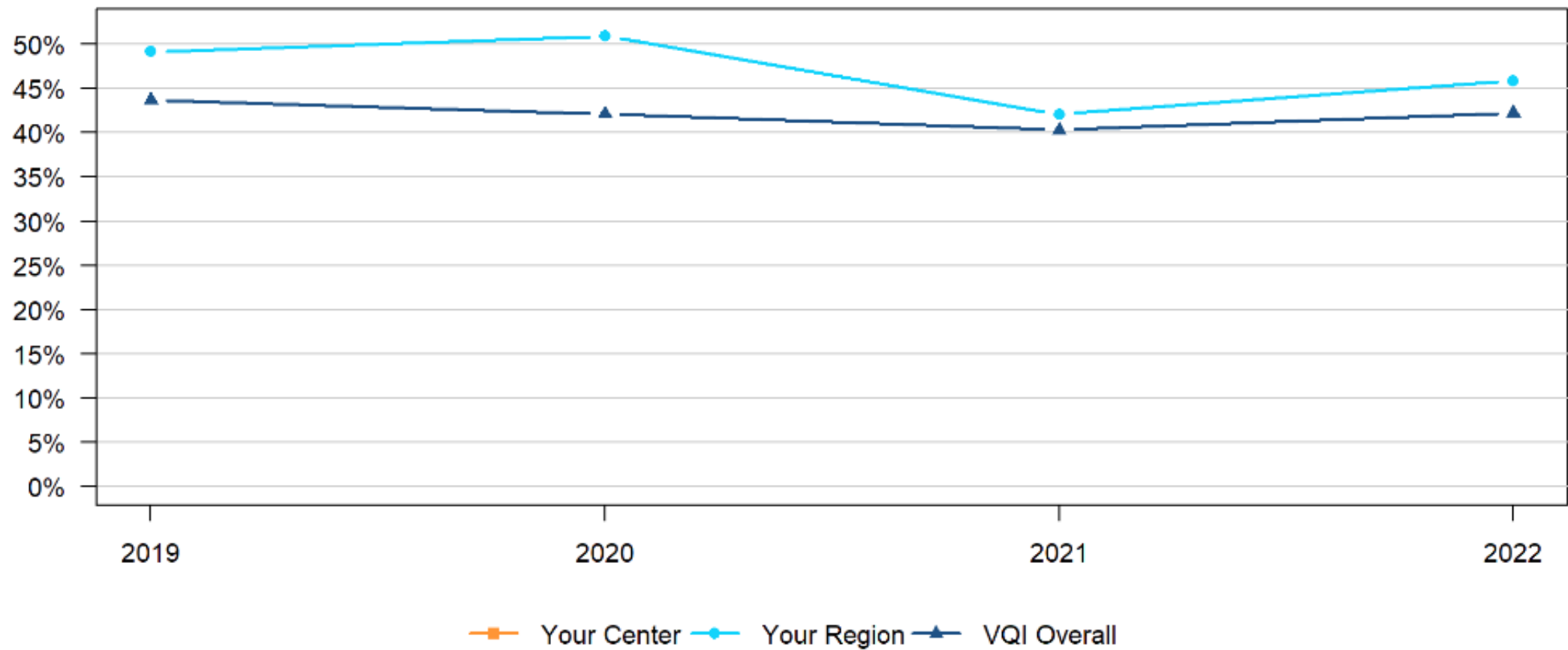
Includes Carotid Endarterectomy (CEA) procedures performed on symptomatic patients. Symptomatic patients are patients with an ipsilateral retinal or cortical TIA or stroke within 180 days prior to surgery. Excludes any patient with prior vertebrobasilar or non-specific TIA or stroke, prior ipsilateral 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, or procedures with an unrelated return to the OR, 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 patients) meeting the inclusion criteria, and the observed and expected rates of postoperative LOS>1 Day for those cases.

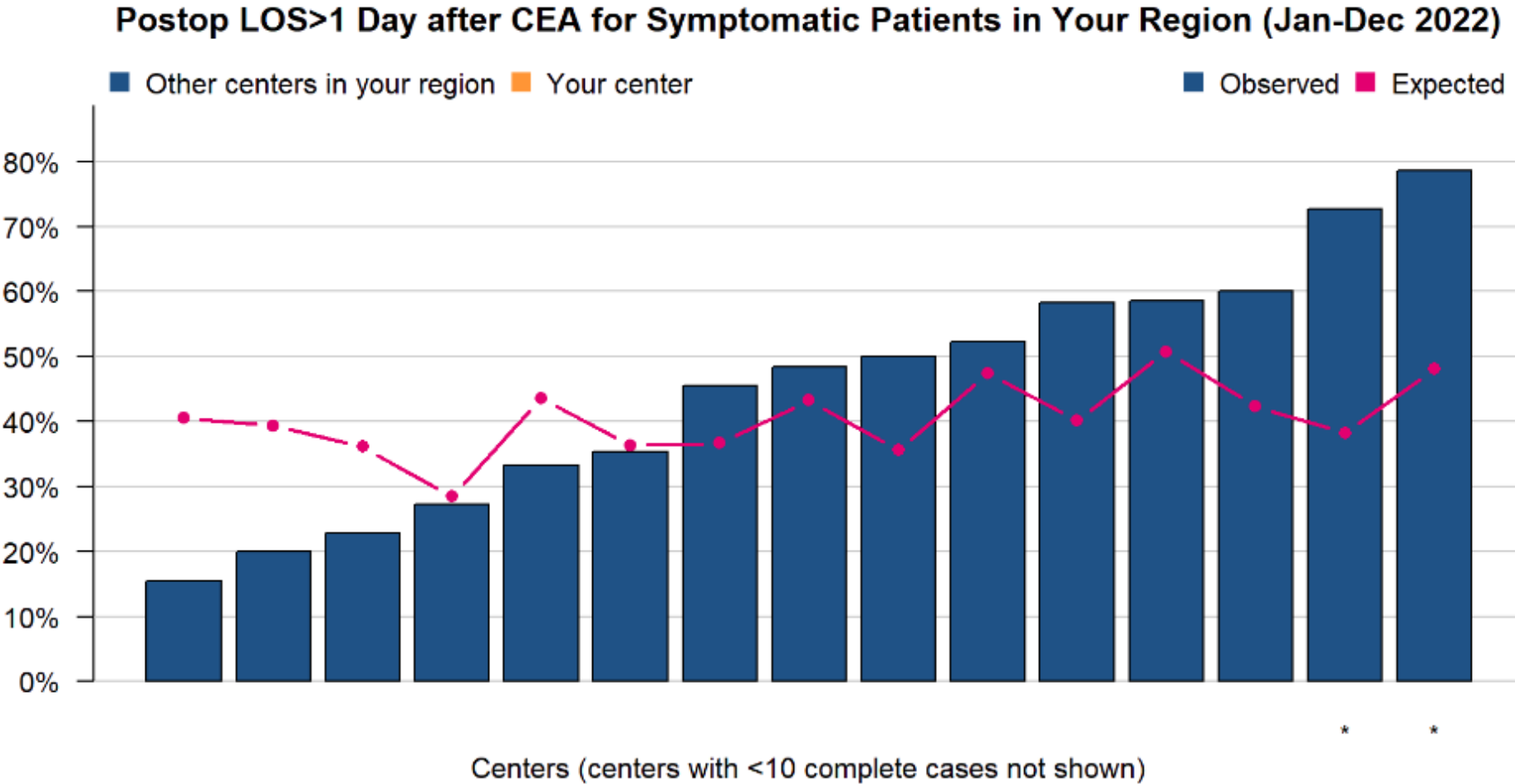
	Your Center	Your Region	VQI Overall
Number of CEA procedures meeting inclusion criteria		353	5018
Observed rate of LOS>1 day among procedures meeting inclusion criteria		45.9%	42.2%
Number of procedures with complete data*		332	4804
Observed rate of LOS>1 day among cases with complete data		45.2%	41.9%
Expected rate of LOS>1 day among cases with complete data		41.2%	NA
P-value for comparison of observed and expected rates		0.15	NA

\*“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 Patients by Year

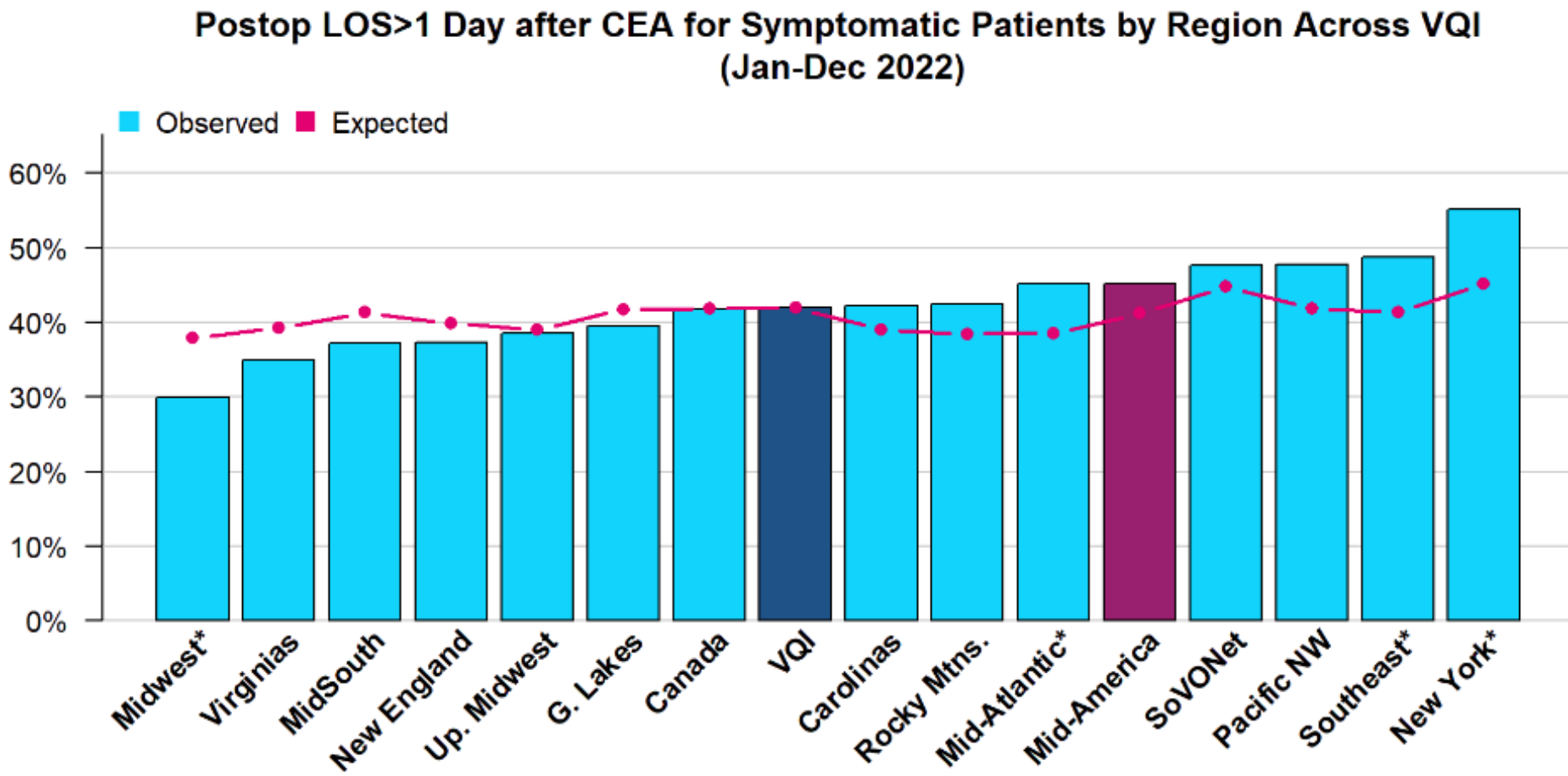


Rates shown are observed rates among cases meeting inclusion criteria.



15 of 30 centers displayed

Rates shown are among cases with complete data. “\*” Indicates center’s observed rate differs significantly from its expected rate



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

Rates shown are among cases with complete data. "\*" Indicates region's observed rate differs significantly from its expected rate

## EVAR: Postop LOS>2 Days

Procedures performed between January 1 and December 31, 2022

Includes Endovascular AAA Repair (EVAR) procedures. Excludes any procedure with ruptured aneurysm

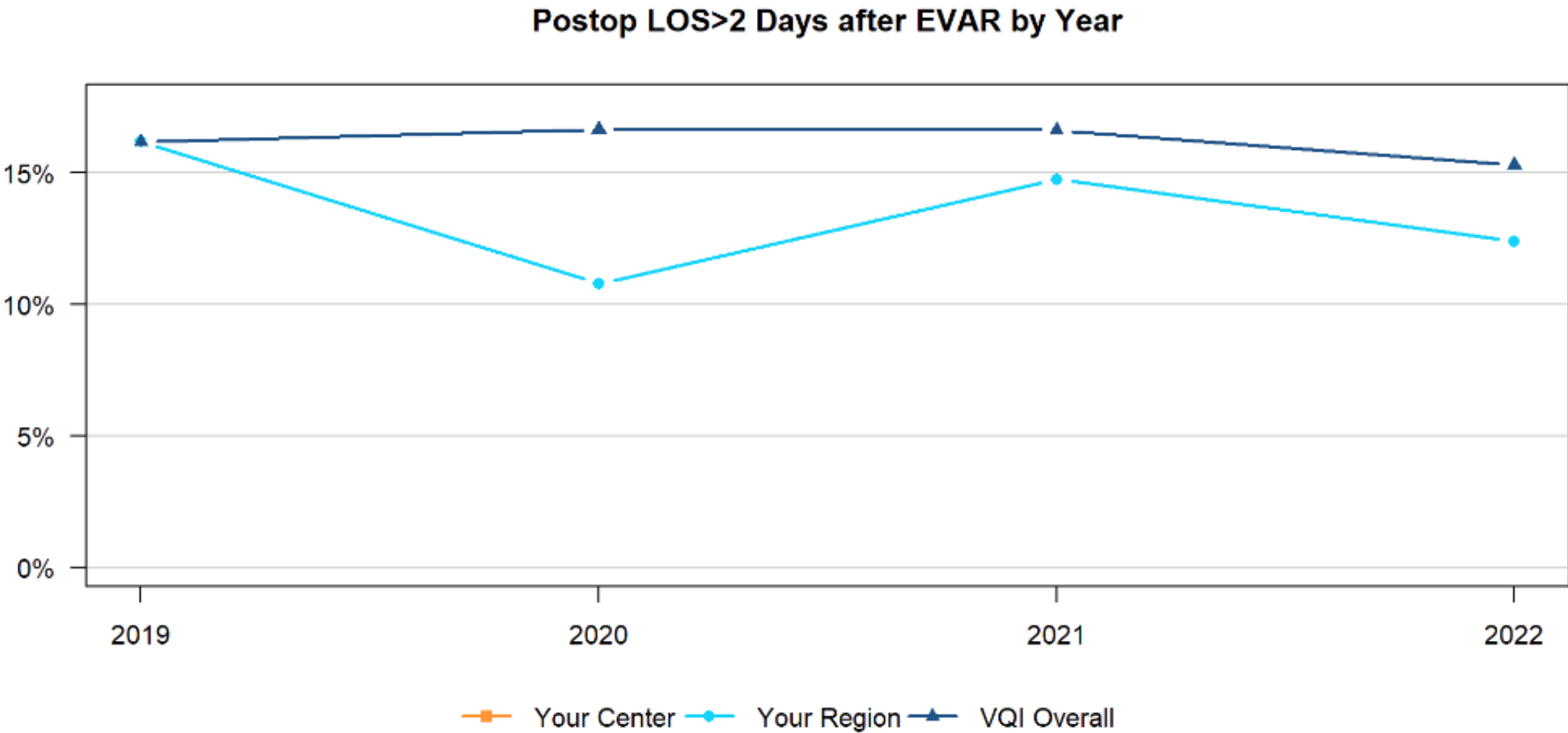
Procedures where in-hospital death occurred with postoperative LOS ≤ 2 days are also excluded. Postoperative LOS is based on the midnight rule used for hospital billing.

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.

	Your Center	Your Region	VQI Overall
Number of EVAR procedures meeting inclusion criteria		532	7210
Observed rate of LOS > 2 days among procedures meeting inclusion criteria		12.4%	15.3%
Number of procedures with complete data*		448	6619
Observed rate of LOS > 2 days among cases with complete data		12.5%	15.1%
Expected rate of LOS > 2 days among cases with complete data		13.6%	NA
P-value for comparison of observed and expected rates		0.54	NA

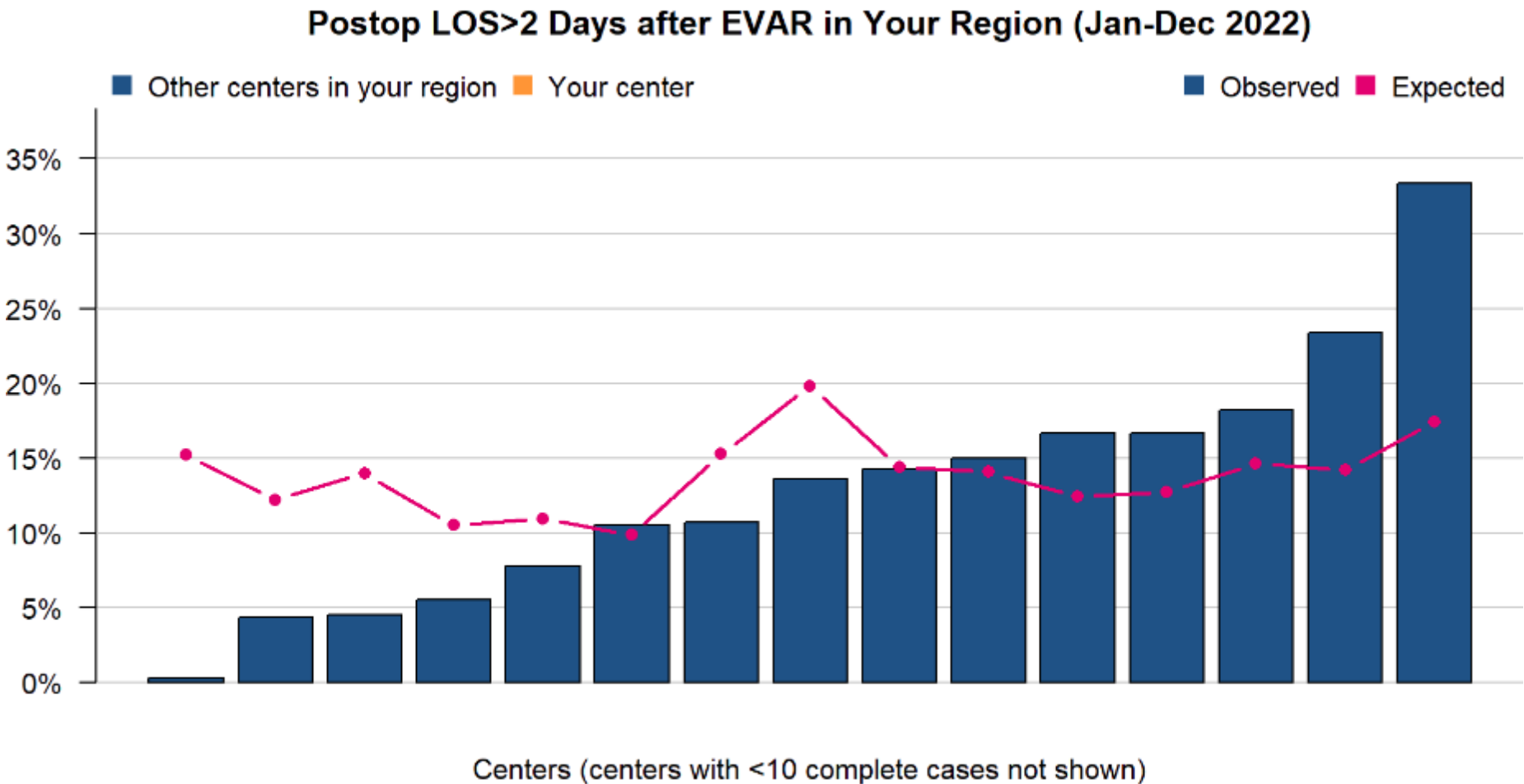
\*“Expected rate” is the rate estimated by a statistical model that accounts for patient characteristics, including age, gender, race, BMI, comorbidities, medication and stroke and vascular history. “Cases with complete data” include patients who have data on all of those factors.

# EVAR Post-Op LOS > 2 Days by Year



Rates shown are observed rates among cases meeting inclusion criteria.

# EVAR Post-Op LOS > 2 Days Region 2022

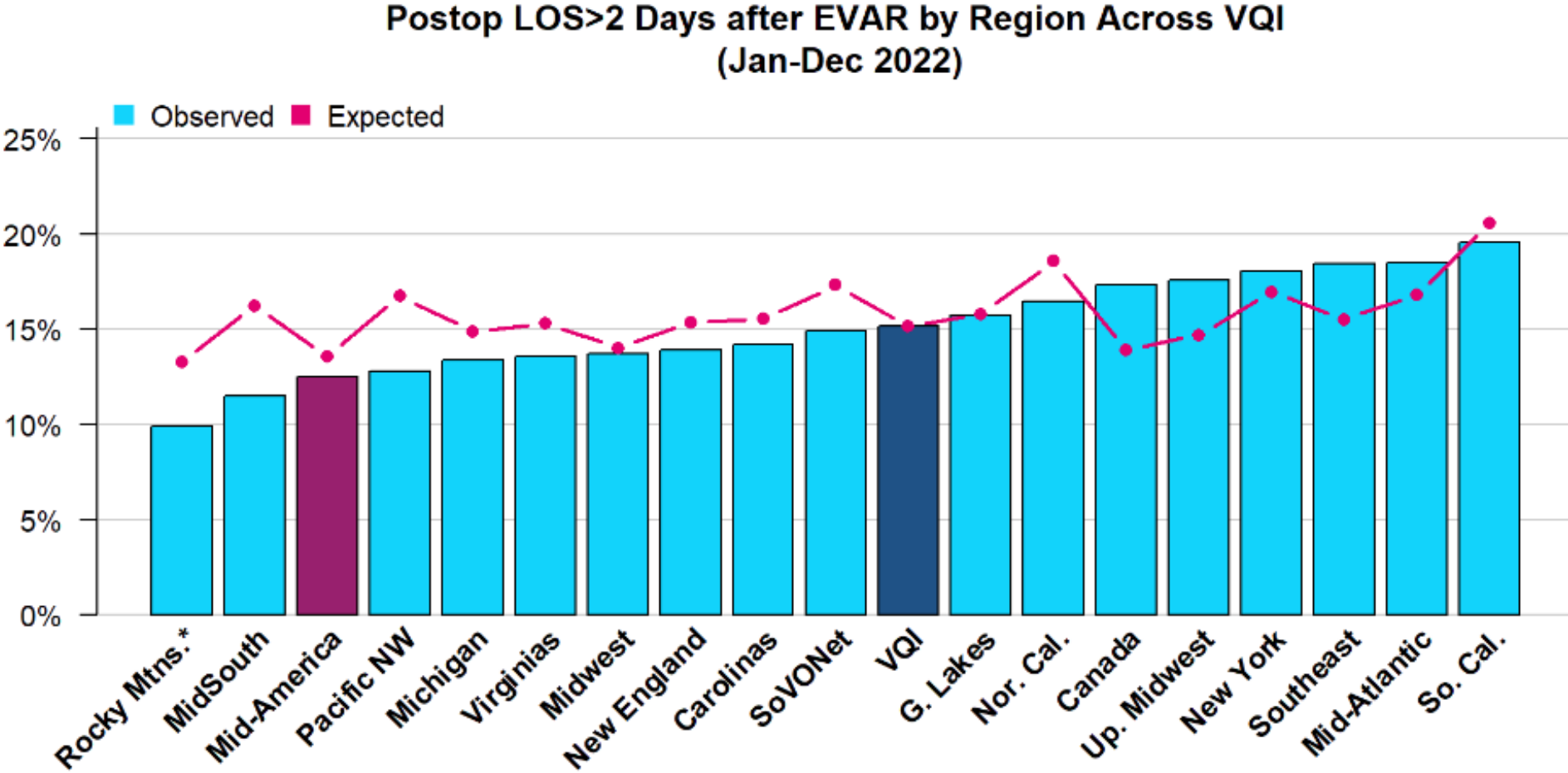


15 of 20 centers displayed

Rates shown are among cases with complete data. <sup>\*\*\*</sup> Indicates center's observed rate differs significantly from its expected rate



# EVAR Post-Op LOS > 2 Days All VQI 2022



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

Rates shown are among cases with complete data. “\*” Indicates region’s observed rate differs significantly from its expected rate



## EVAR: Sac Diameter Reporting

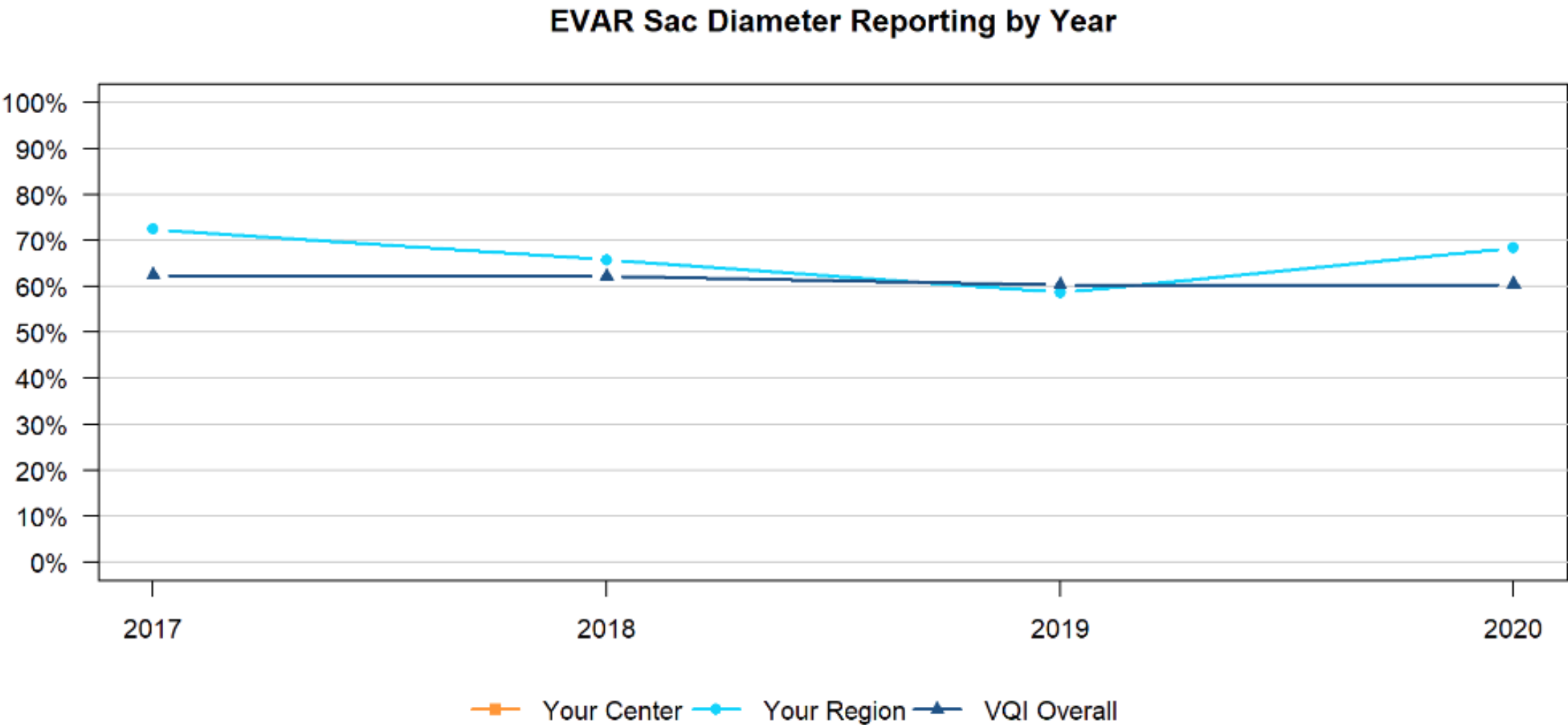
Procedures performed between January 1 and December 31, 2020

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

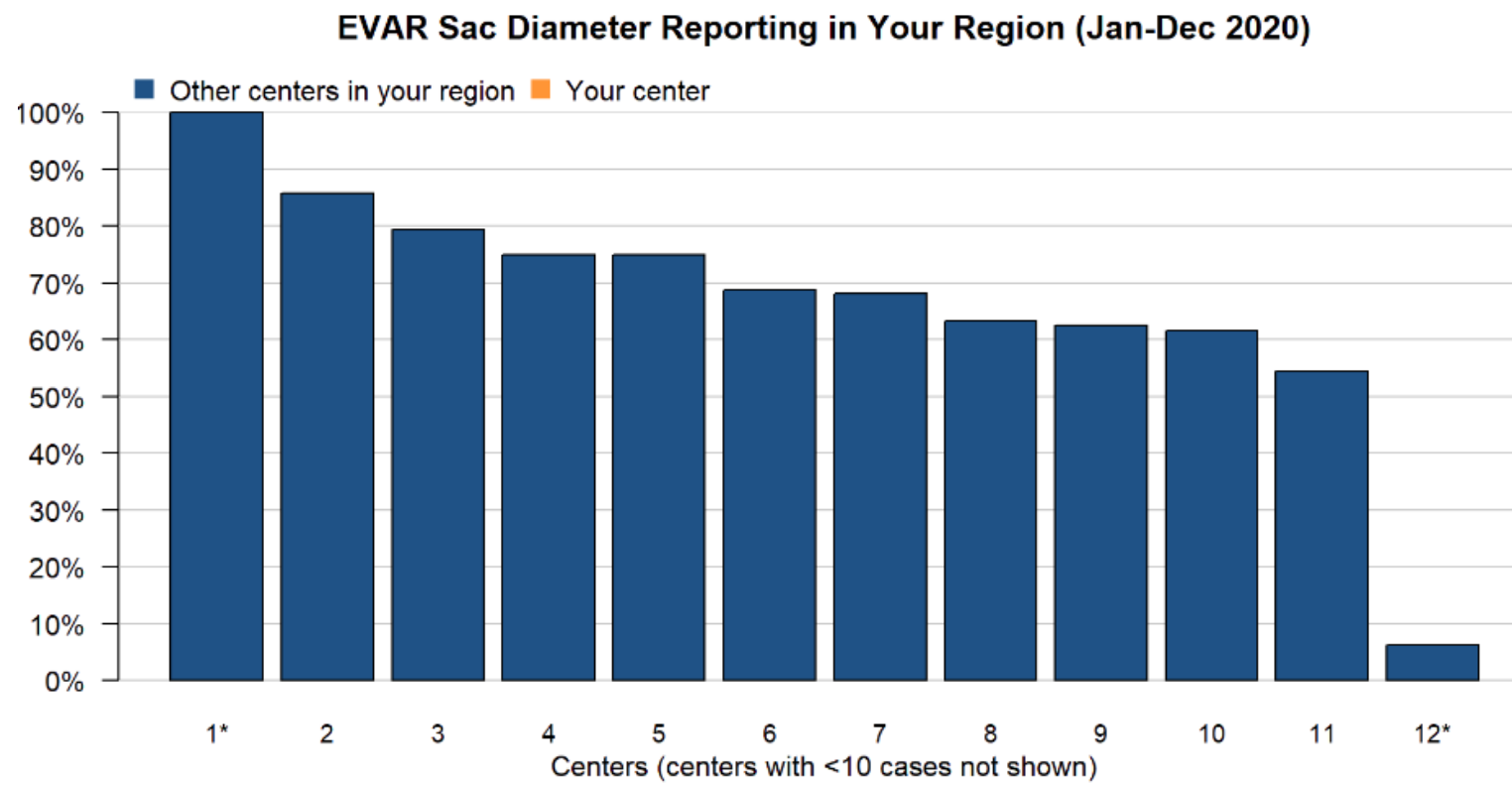
The table below gives the number of EVAR procedures meeting the inclusion criteria, and the percentage of those procedures where a sac diameter was reported between 9 and 21 months post-procedure.

	Your Center	Your Region	VQI Overall
Number of EVAR procedures meeting inclusion criteria		322	6360
Percentage with sac diameter reported between 9 and 21 months post-procedure		68.3%	60.5%

# EVAR Sac Diameter Reporting by Year



# EVAR Sac Diameter Reporting Region 2022

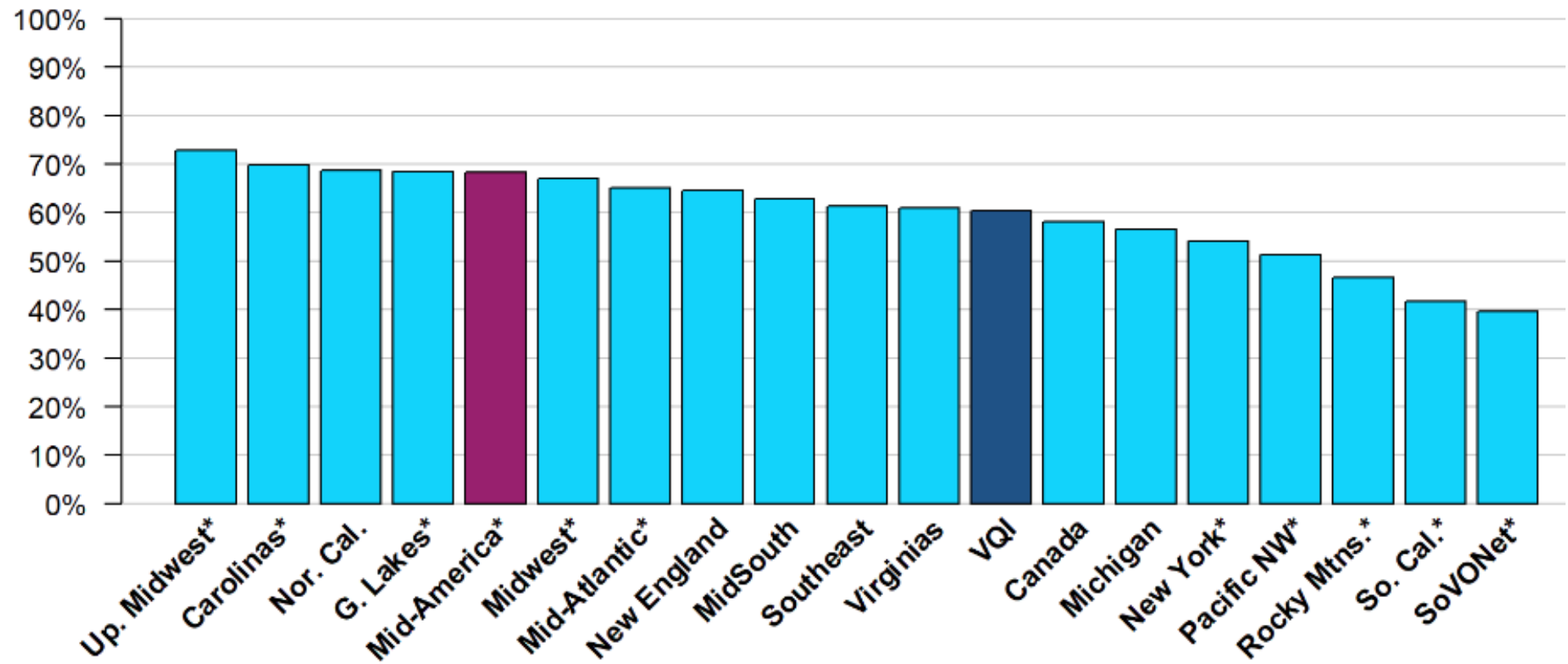


Index	Medical Center Name
1	University of Chicago Medical Center
2	NorthShore Hospital
3	OSF Saint Francis Medical Center
4	Nebraska Medicine
5	MercyOne Des Moines Medical Center
6	SSM Health St. Joseph Hospital - St. Charles
7	Northwestern Medicine Central DuPage Hospital
8	Carle Foundation Hospital
9	Northwestern Memorial Hospital
10	University of Kansas Hospital Authority
11	Saint Luke's Hospital of Kansas City
12	University of Missouri Medical Center

12 of 16 centers displayed

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

EVAR Sac Diameter Reporting 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.

## EVAR: SVS AAA Diameter Guideline

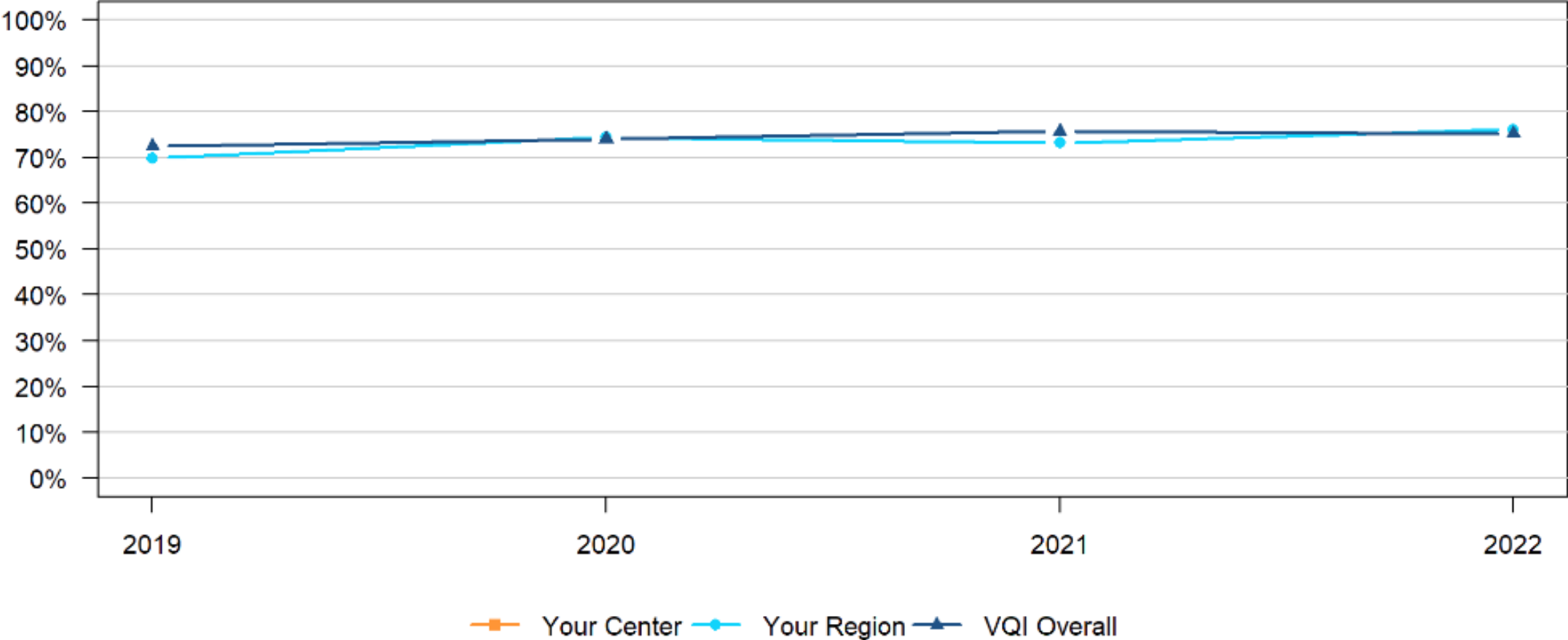
Procedures performed between January 1 and December 31, 2022

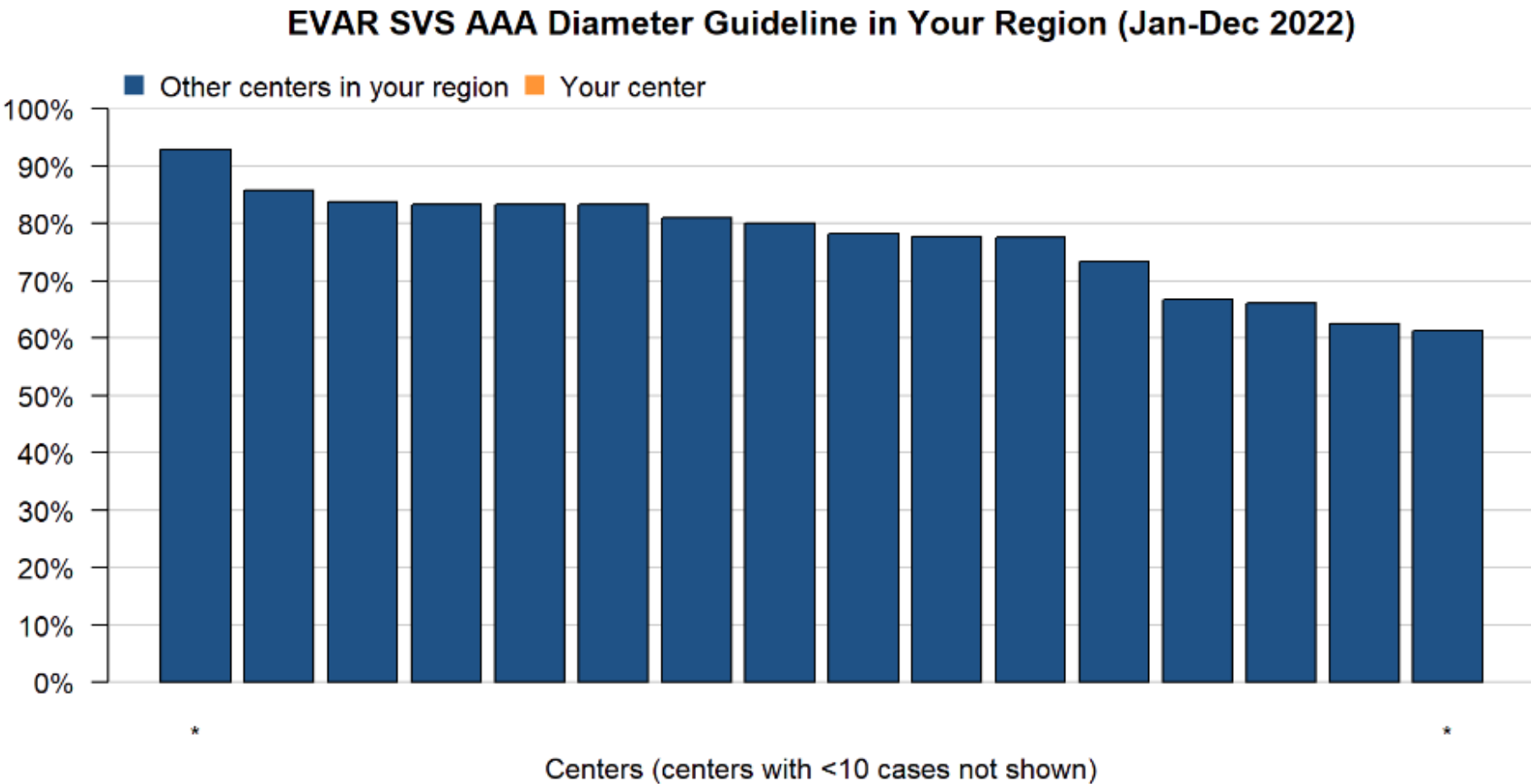
Includes Endovascular AAA Repair (EVAR) procedures. Excludes any non-elective procedure. SVS AAA diameter guideline is  $\geq 5$  cm for Women and  $\geq 5.5$ cm for men. If the patient has any iliac aneurysm, the guideline is considered met regardless of AAA diameter.

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

	Your Center	Your Region	VQI Overall
Number of EVAR procedures meeting inclusion criteria		493	6400
Percentage meeting SVS AAA diameter guideline		76.1%	75.2%

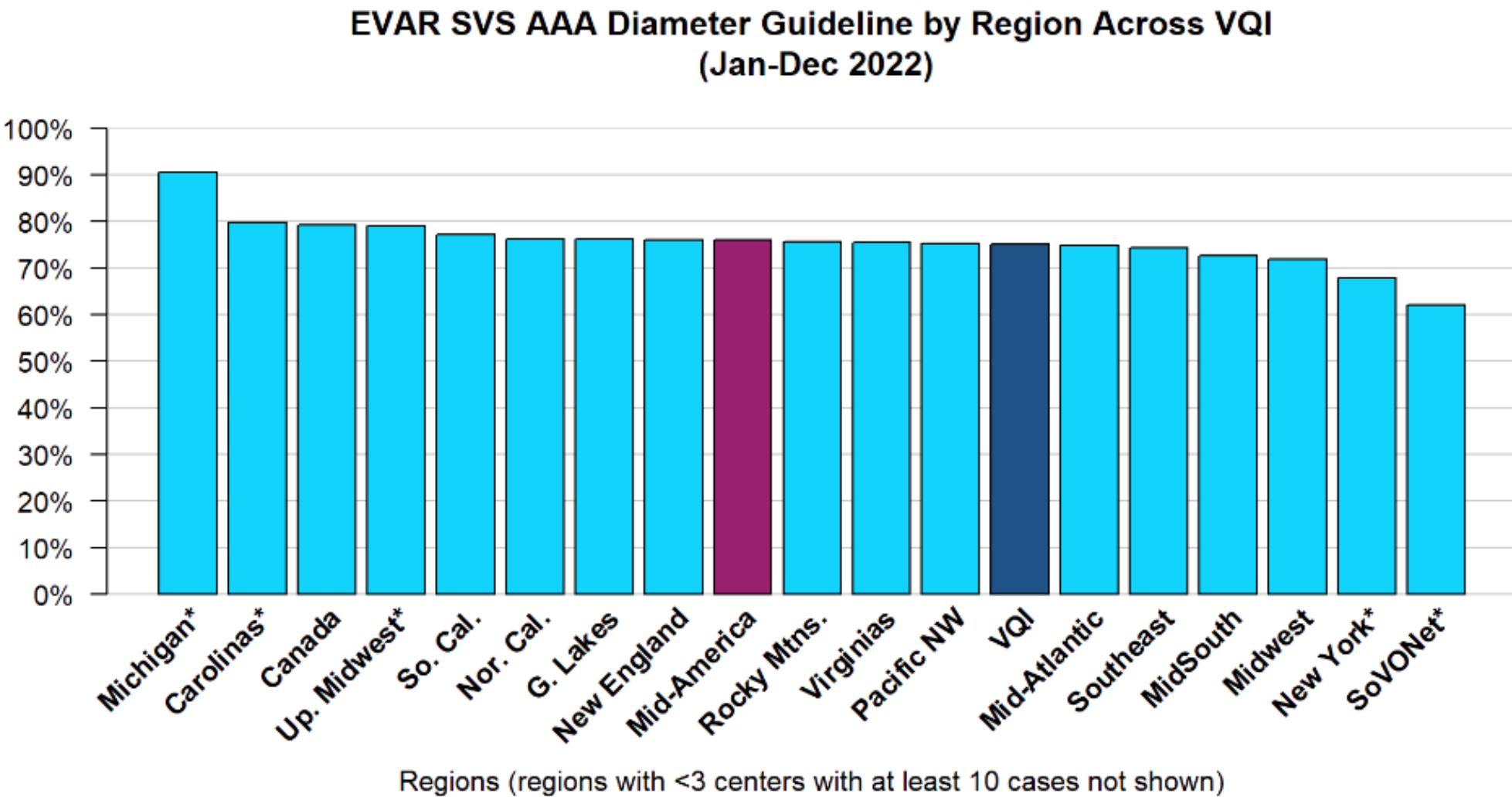
EVAR SVS AAA Diameter Guideline by Year





16 of 20 centers displayed

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



\* \* \* Indicates region's rate differs significantly from the VQI rate.



## TEVAR: Sac Diameter Reporting

Procedures performed between January 1 and December 31, 2020

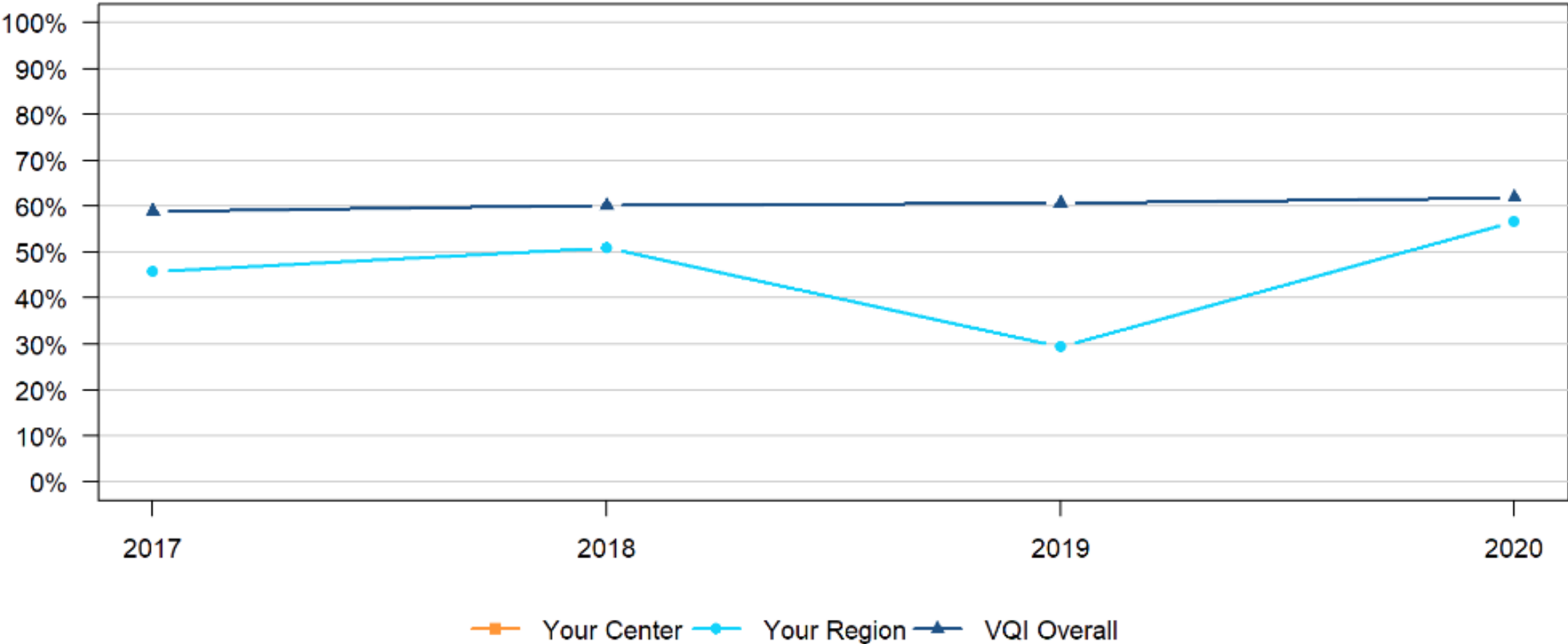
Includes Thoracic Endovascular Aortic Repair (TEVAR) procedures for aneurysm or aneurysm from dissection.  
Excludes procedures where no aortic device was implanted or patients who were converted to open or died within 21 months of surgery.

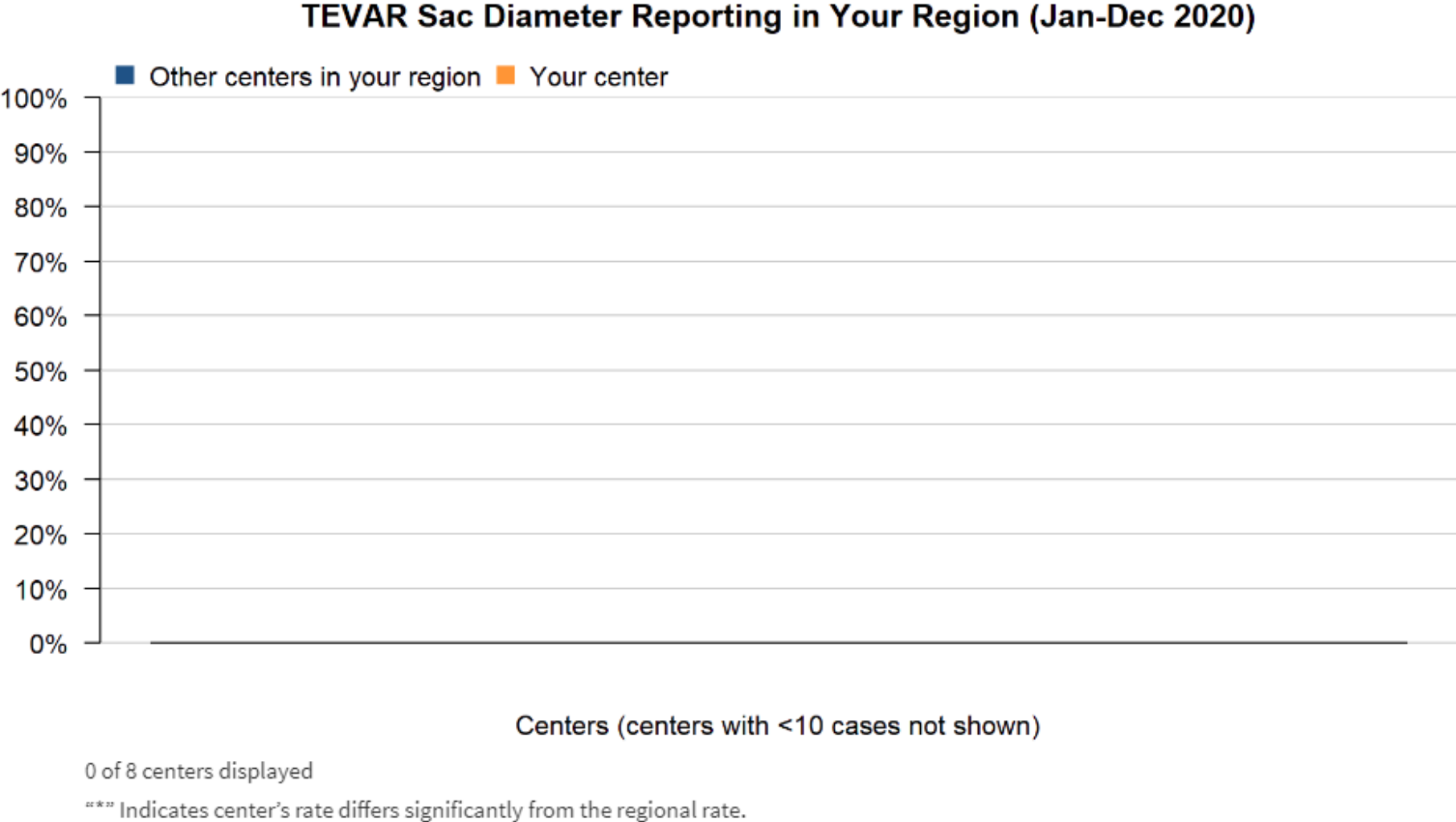
The table below gives the number of TEVAR procedures meeting the inclusion criteria, and the percentage of those procedures where a sac diameter was reported between 9 and 21 months post-procedure.

	Your Center	Your Region	VQI Overall
Number of TEVAR procedures meeting inclusion criteria		53	1427
Percentage with sac diameter reported between 9 and 21 months post-procedure		56.6%	61.9%

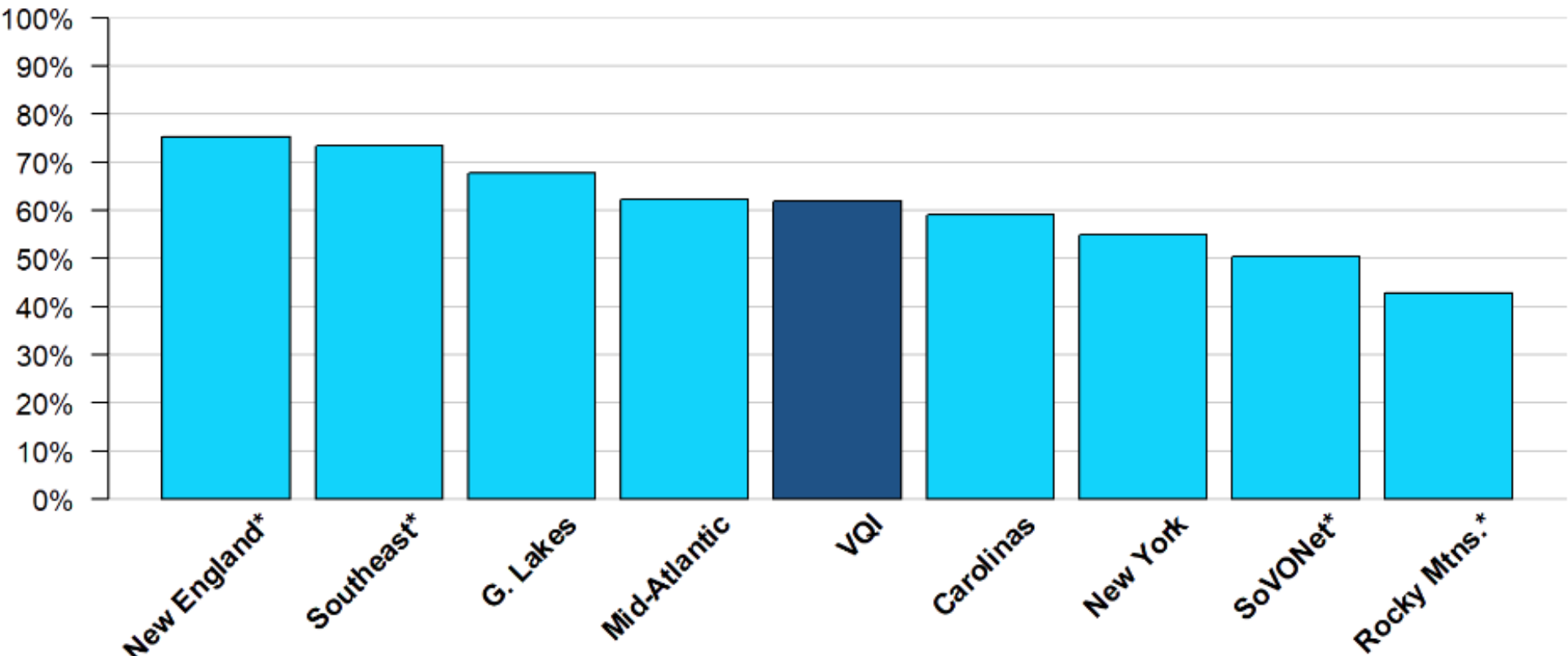
# TEVAR Sac Diameter Reporting by Year 2022

TEVAR Sac Diameter Reporting by Year





TEVAR Sac Diameter Reporting 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.

## OAAA: In-Hospital Mortality

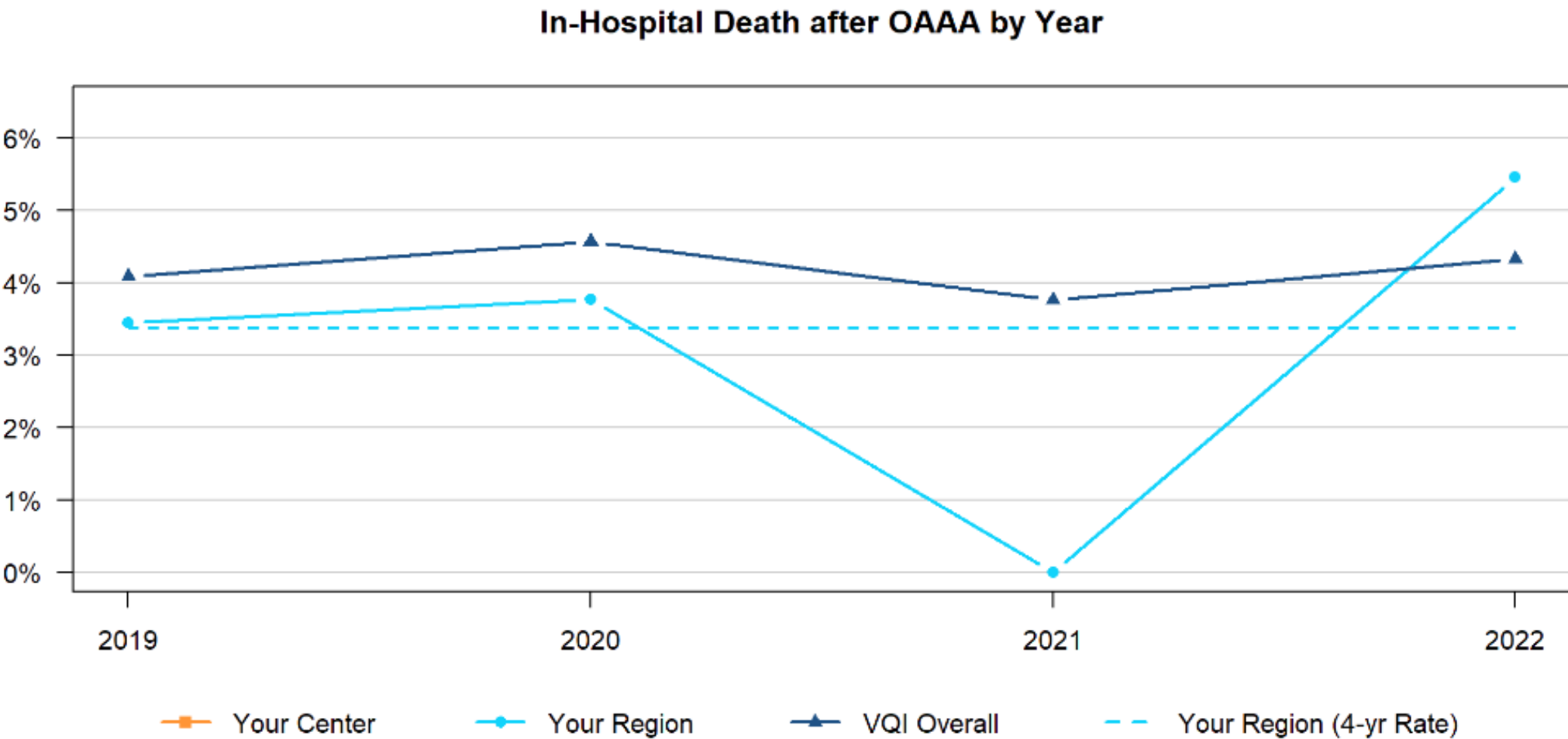
Procedures performed between January 1, 2019 and December 31, 2022

Includes Open AAA (OAAA) procedures. Excludes any patient with a ruptured aneurysm.

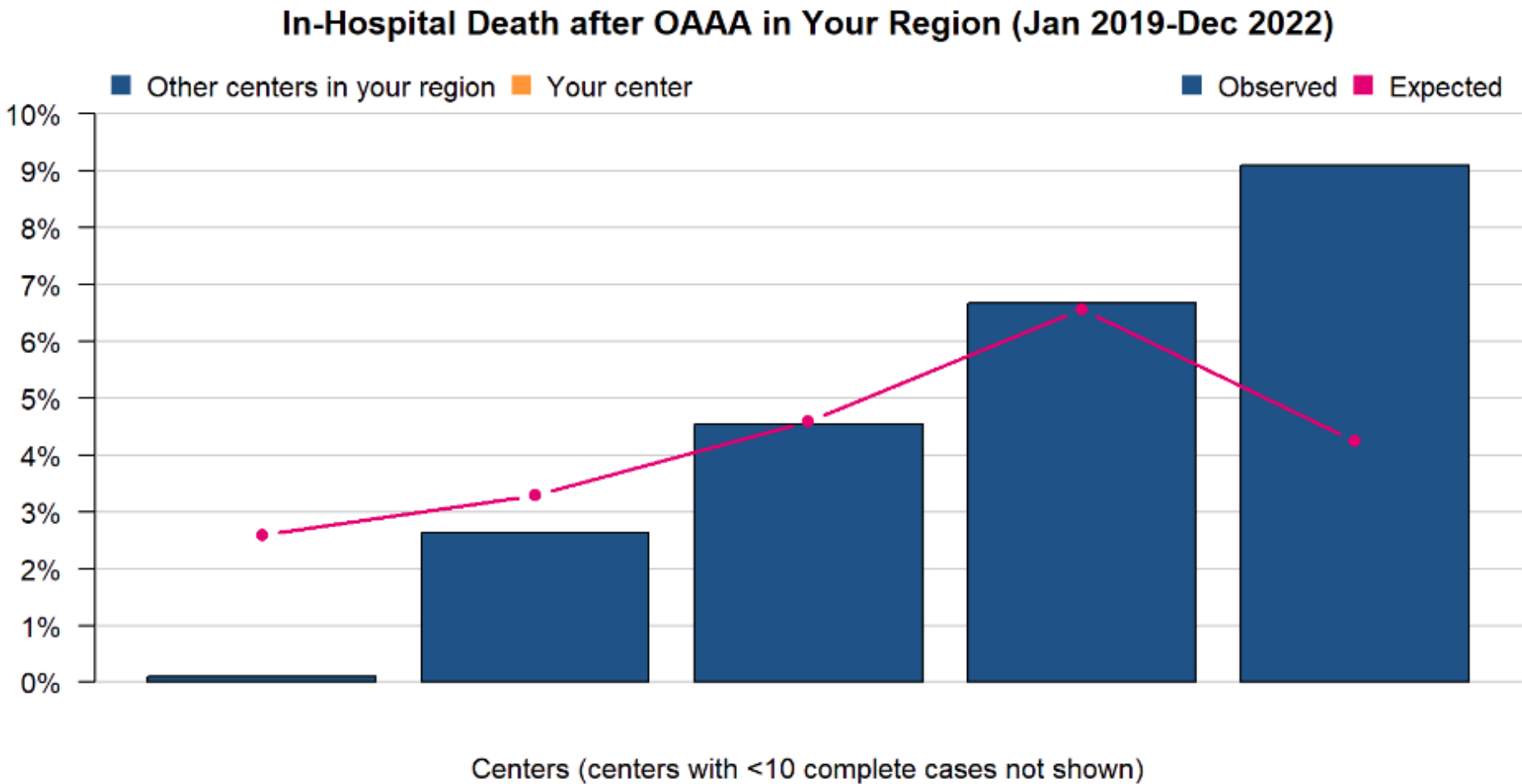
The table below gives the number of OAAA procedures meeting the inclusion criteria, and the observed and expected rates of in-hospital death for those cases.

	Your Center	Your Region	VQI Overall
Number of OAAA procedures meeting inclusion criteria		207	4664
Observed rate of In-Hospital Mortality among procedures meeting inclusion criteria		3.4%	4.2%
Number of procedures with complete data*		195	4369
Observed rate of In-Hospital Mortality among cases with complete data		3.6%	4%
Expected rate of In-Hospital Mortality among cases with complete data		3.9%	NA
P-value for comparison of observed and expected rates		1	NA

\*“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.

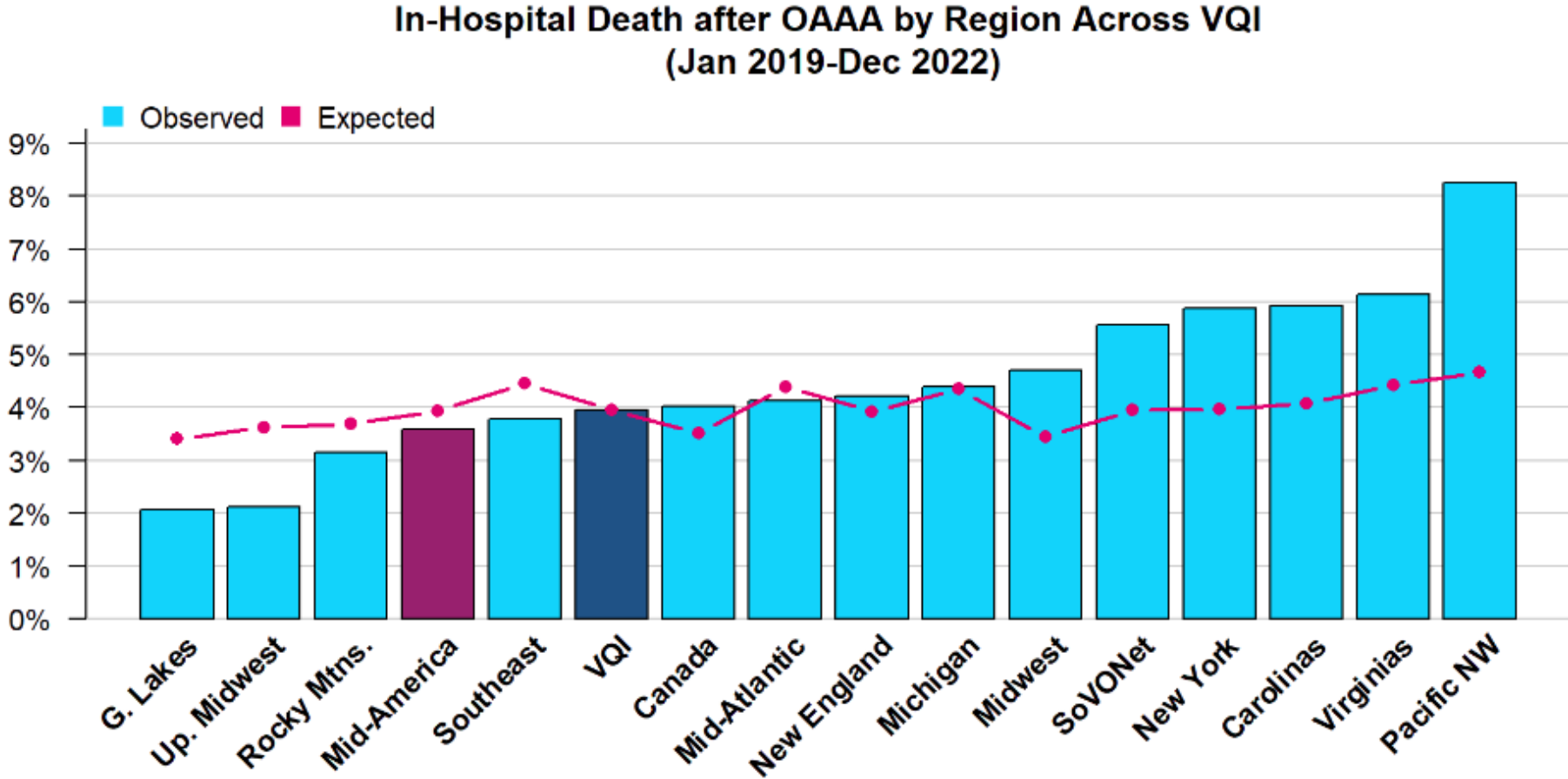


Rates shown are observed rates among cases meeting inclusion criteria.



5 of 12 centers displayed

Rates shown are among cases with complete data. “\*” Indicates center’s observed rate differs significantly from its expected rate



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

Rates shown are among cases with complete data. \*\*\* Indicates region's observed rate differs significantly from its expected rate



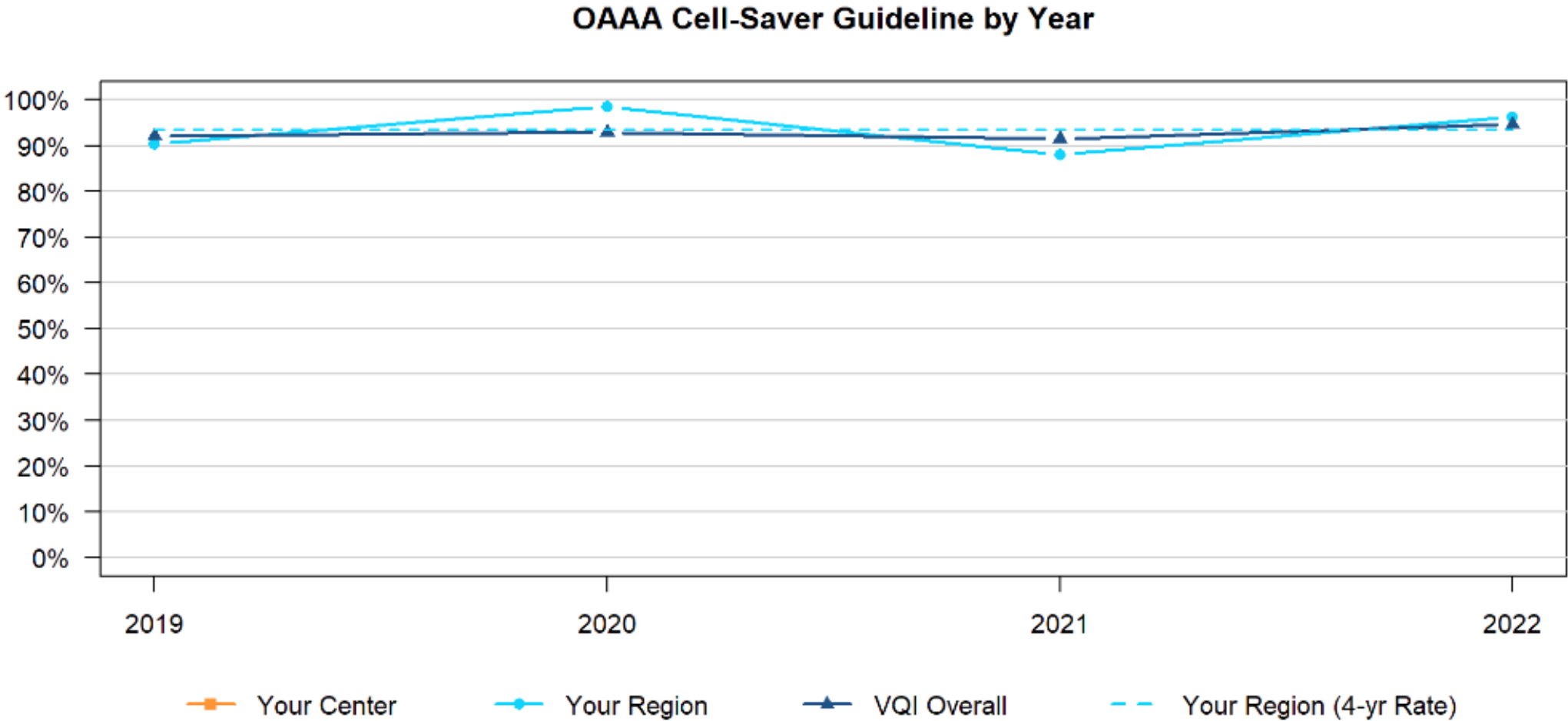
## OAAA: SVS Cell-Saver Guideline

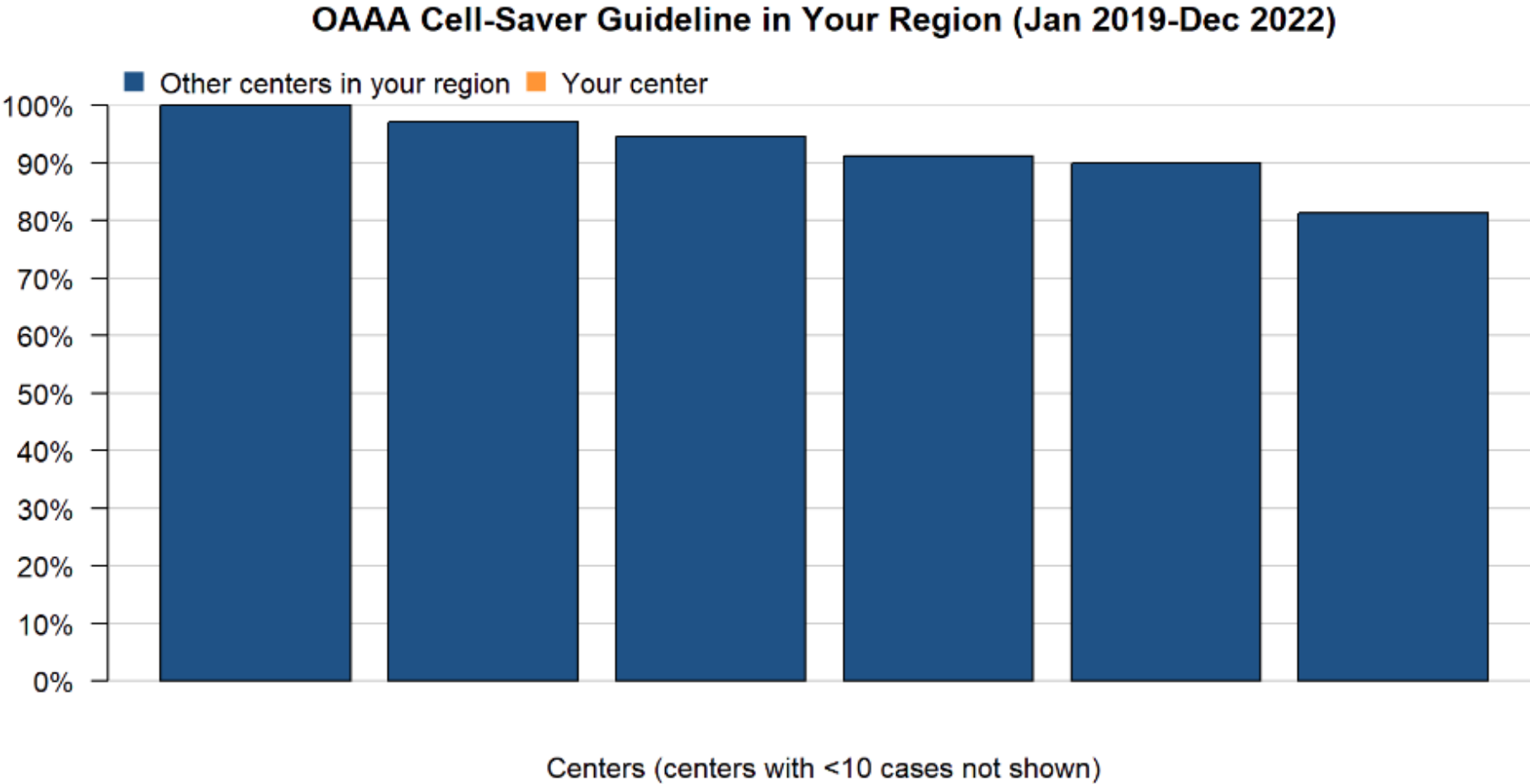
Procedures performed between January 1, 2019 and December 31, 2022

Includes Open AAA (OAAA) procedures. 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.

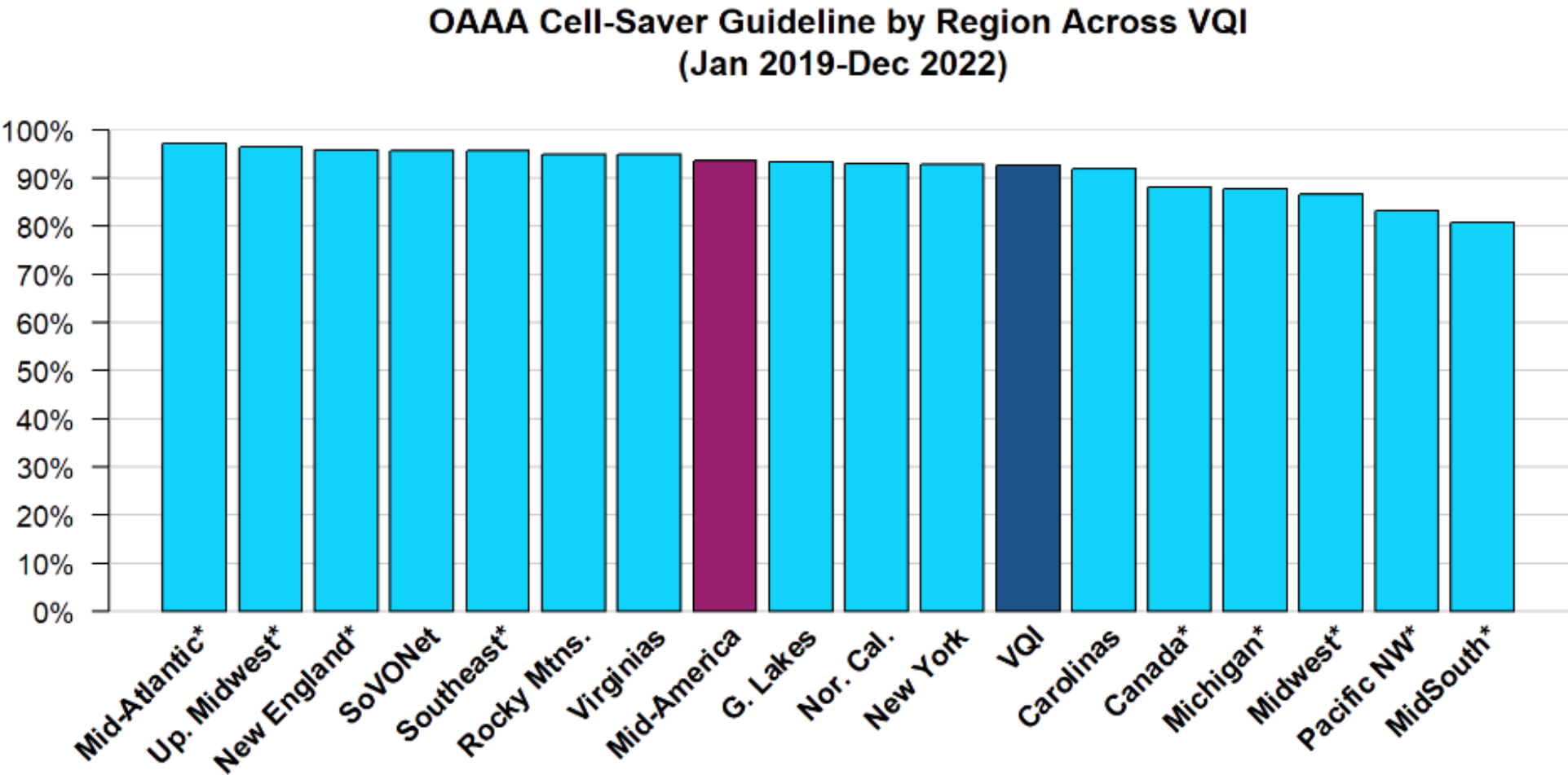
	Your Center	Your Region	VQI Overall
Number of OAAA procedures meeting inclusion criteria		233	4702
Percentage meeting SVS cell-saver guideline		93.6%	92.7%





6 of 12 centers displayed

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



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

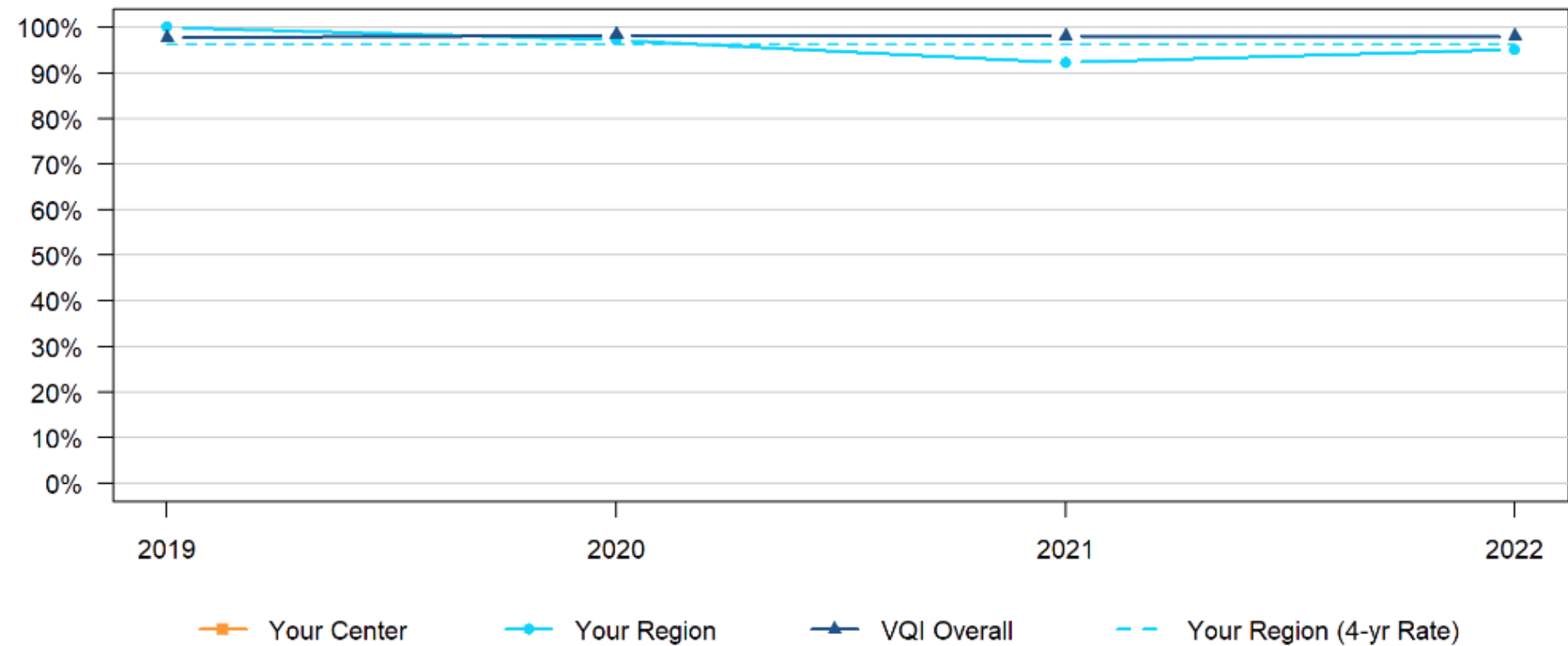
Procedures performed between January 1, 2019 and December 31, 2022

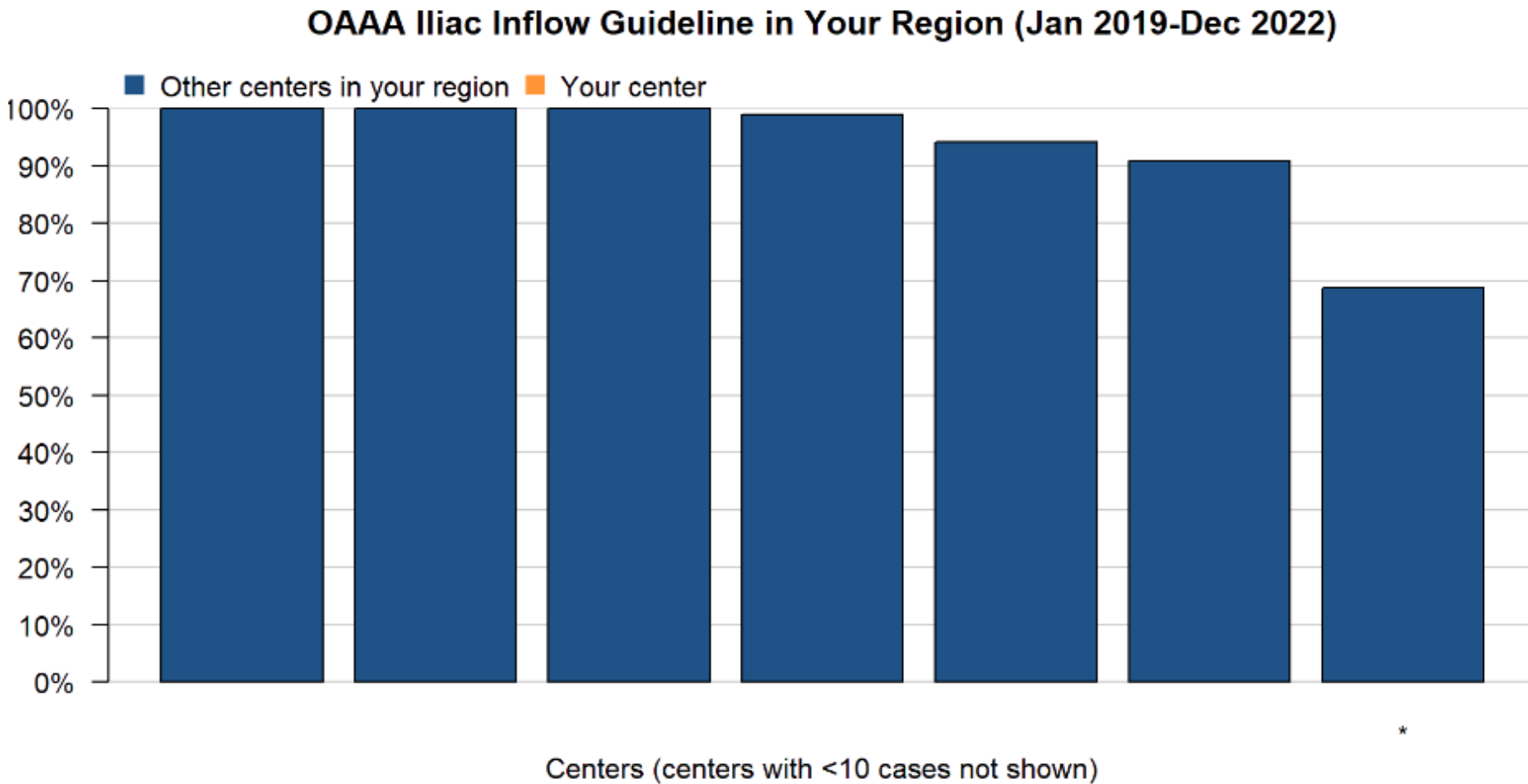
Includes Open AAA (OAAA) procedures. SVS iliac inflow guideline is met if preservation of flow was maintained to at least one internal iliac artery.

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.

	Your Center	Your Region	VQI Overall
Number of OAAA procedures meeting inclusion criteria		250	5304
Percentage meeting SVS iliac inflow guideline		96.4%	98.1%

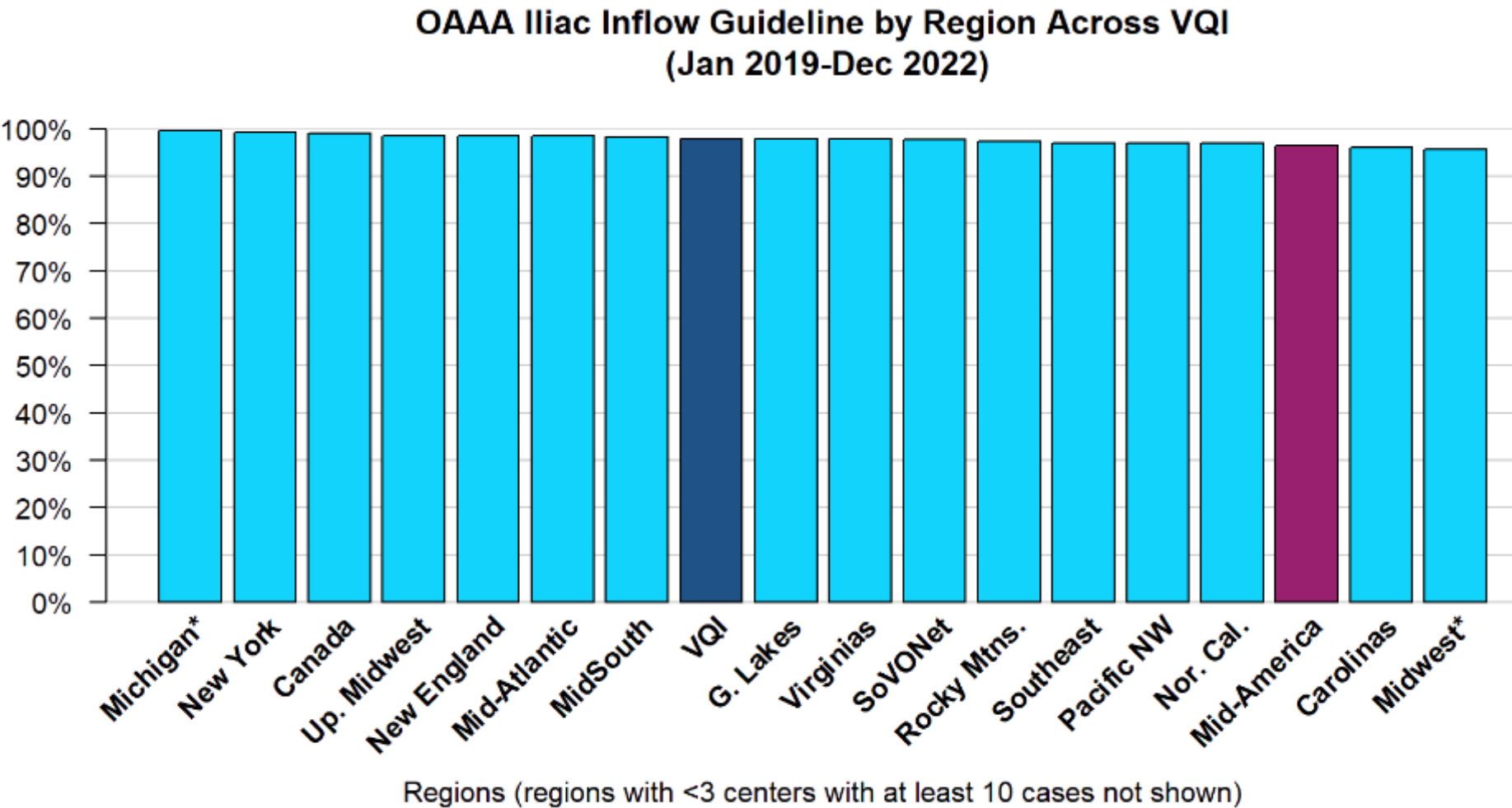
OAAA Iliac Inflow Guideline by Year





7 of 12 centers displayed

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



\*\*\* Indicates region's rate differs significantly from the VQI rate.



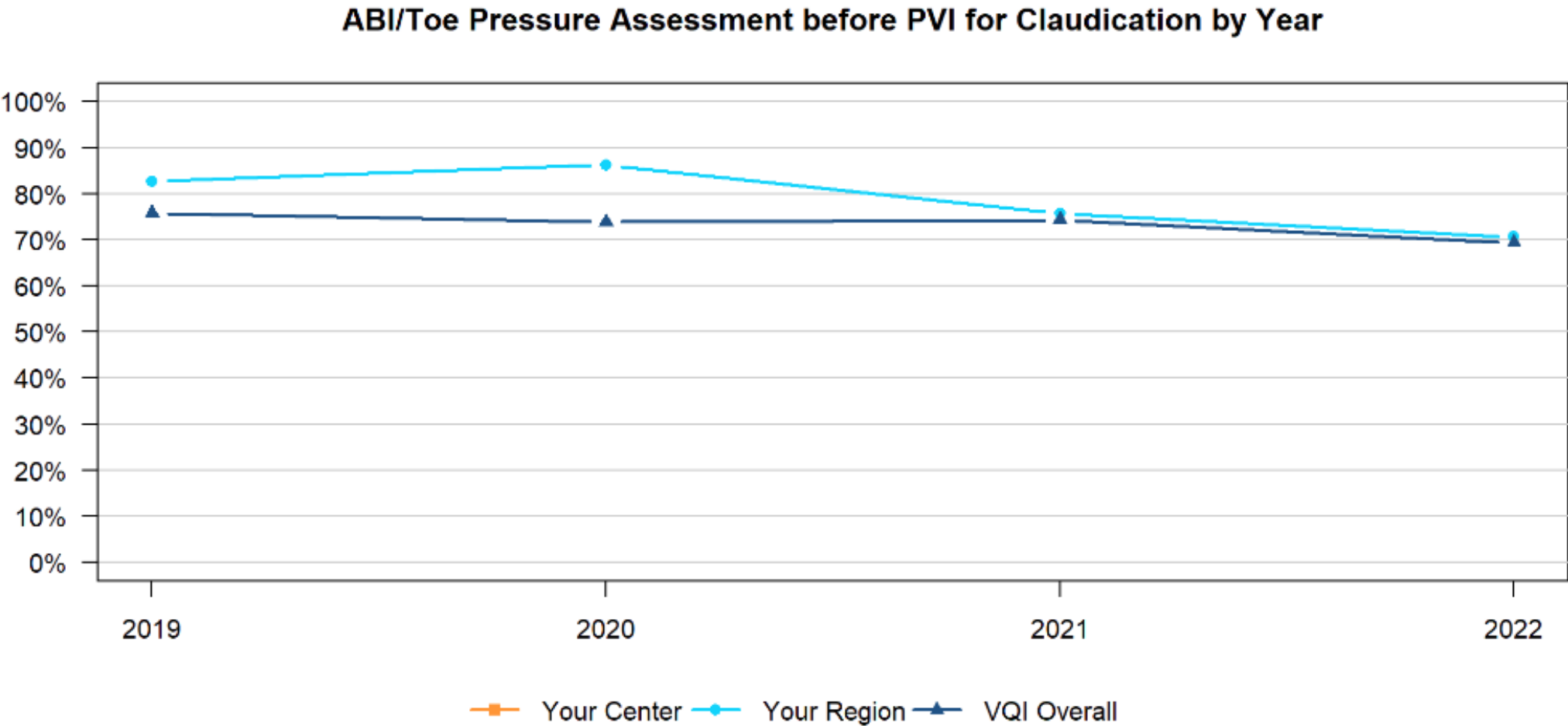
## PVI CLAUD: ABI/Toe Pressure

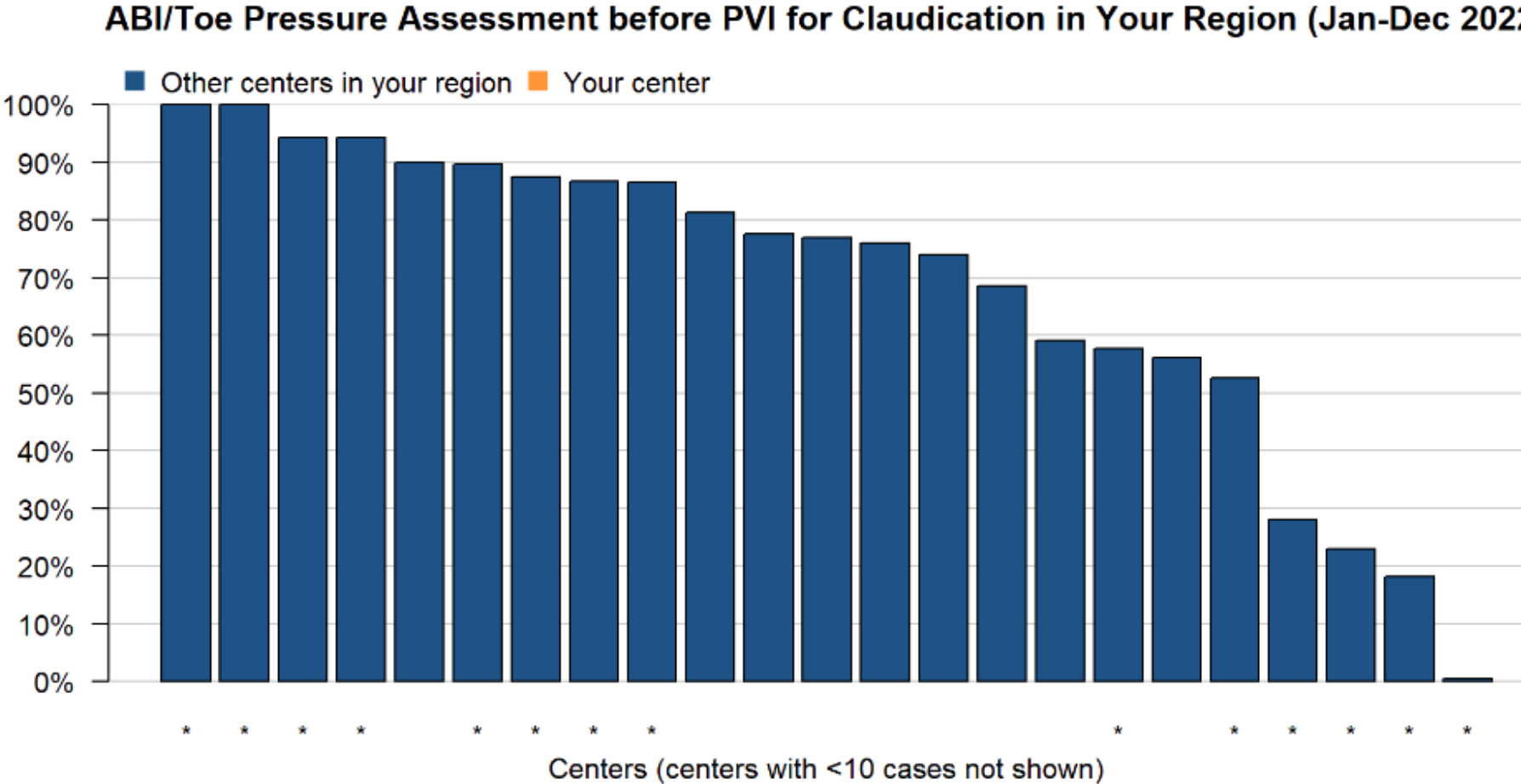
Procedures performed between January 1 and December 31, 2022

Includes Peripheral Vascular Intervention (PVI) procedures for mild, moderate, or severe claudication. “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.

	Your Center	Your Region	VQI Overall
Number of PVI procedures meeting inclusion criteria		1647	16075
Percentage with ABI/toe pressure assessment		70.6%	69.4%

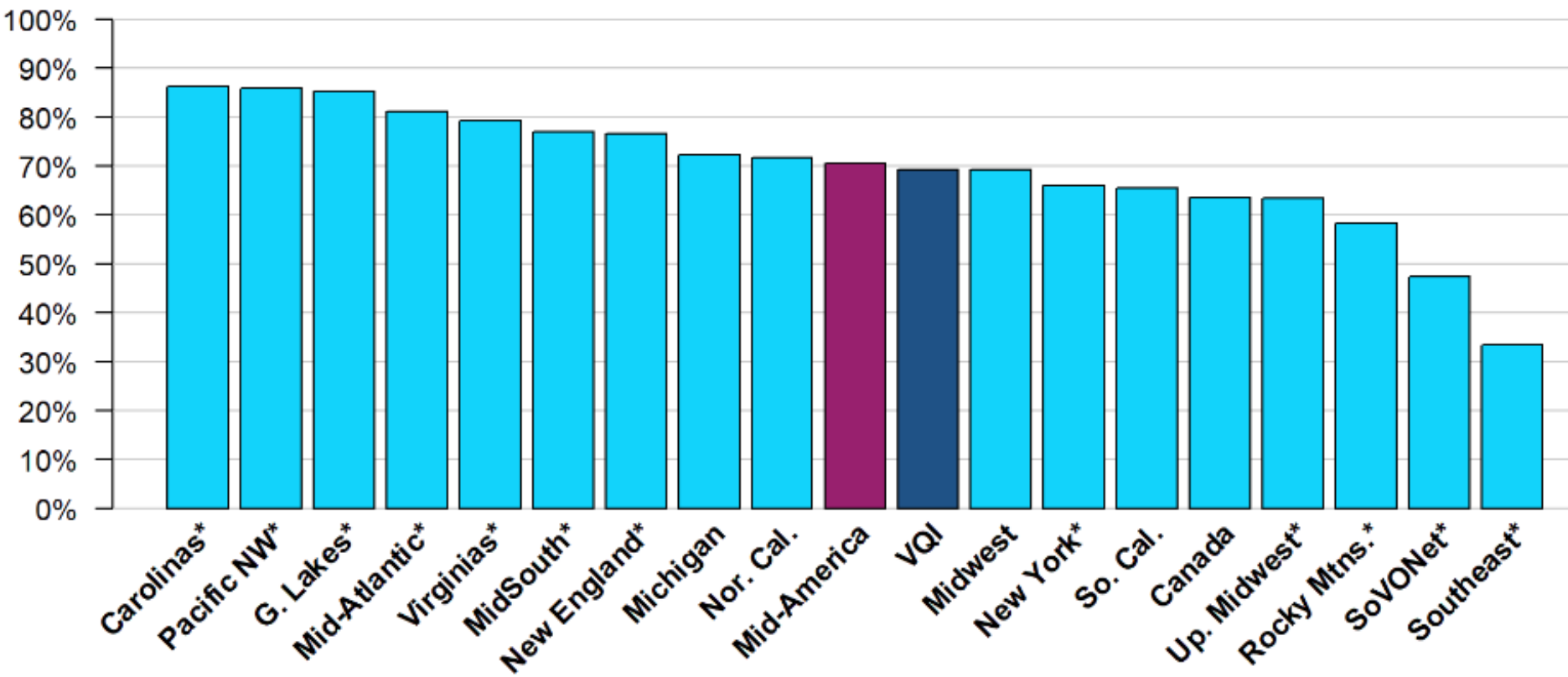




23 of 26 centers displayed

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

ABI/Toe Pressure Assessment before PVI for Claudication by Region Across VQI  
(Jan-Dec 2022)



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

\*\*\* Indicates region's rate differs significantly from the VQI rate.

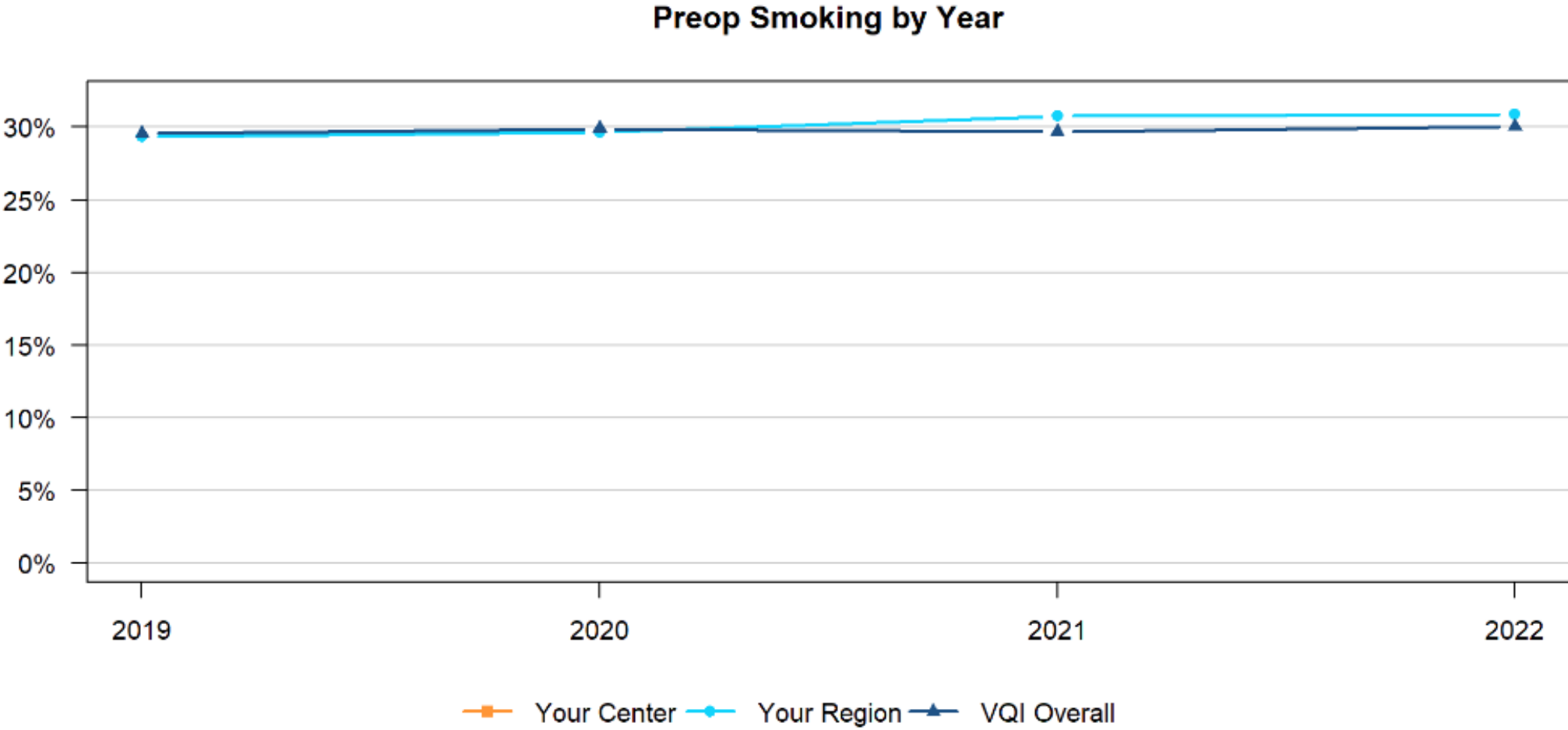
## Preop Smoking

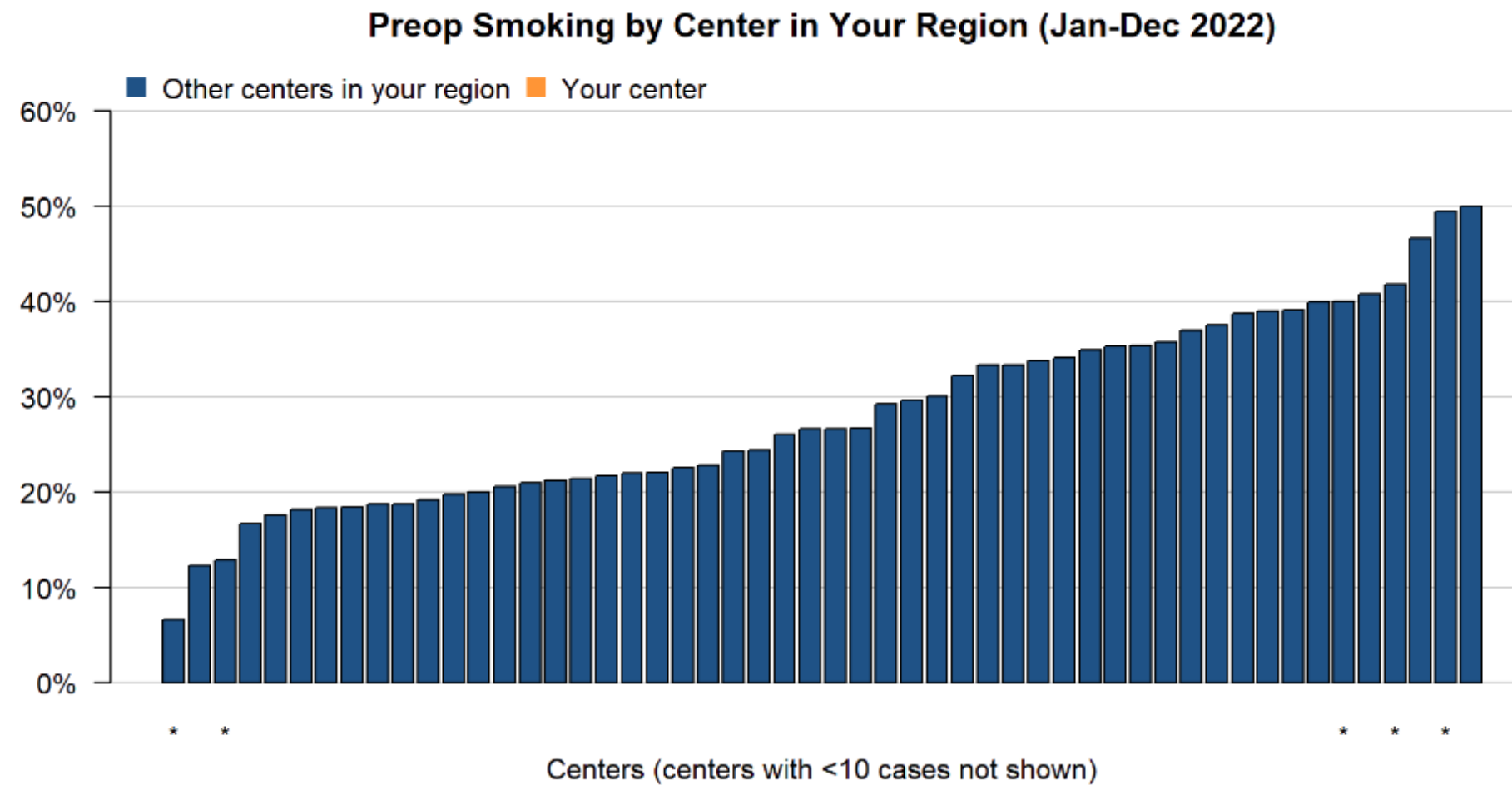
Procedures performed between January 1 and December 31, 2022

Includes elective CAS (TFEM CAS and TCAR), CEA, EVAR, INFRA, LEAMP, OAAA, PVI, SUPRA, and TEVAR procedures only.

The table below gives the number of procedures meeting the inclusion criteria, and the percentage of those procedures where the patient was still smoking within one month of the procedure.

	Your Center	Your Region	VQI Overall
CAS		1084 (21%)	15892 (22%)
CEA		1033 (25%)	15161 (25%)
EVAR		497 (34%)	6490 (32%)
INFRA		272 (41%)	5229 (39%)
LEAMP		NA (<3 centers)	1604 (26%)
OAAA		43 (47%)	992 (42%)
PVI		3240 (34%)	37730 (33%)
SUPRA		53 (51%)	1550 (55%)
TEVAR		134 (31%)	2575 (30%)
Overall (Jan-Dec 2022)		6393 (31%)	87223 (30%)

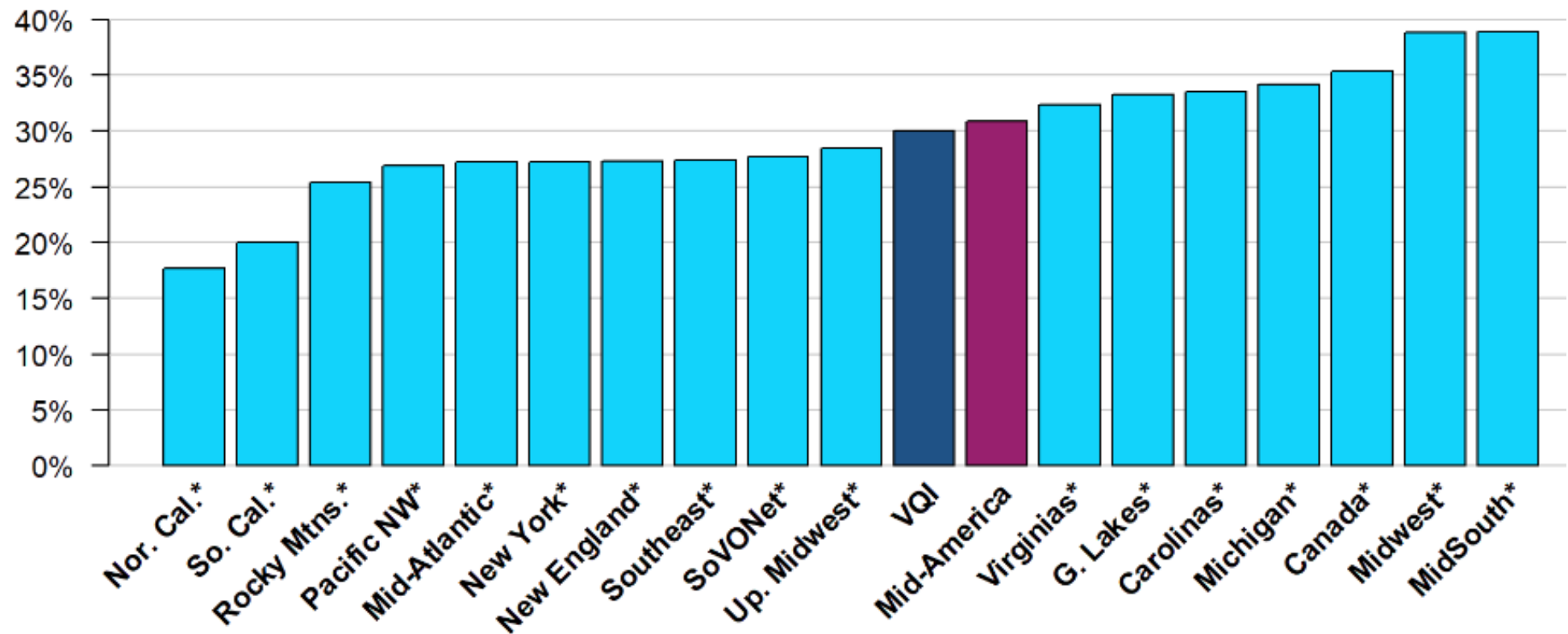




52 of 65 centers displayed

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

Preop Smoking by Region Across VQI (Jan-Dec 2022)



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

\*\*\* Indicates region's rate differs significantly from the VQI rate.



## Smoking Cessation

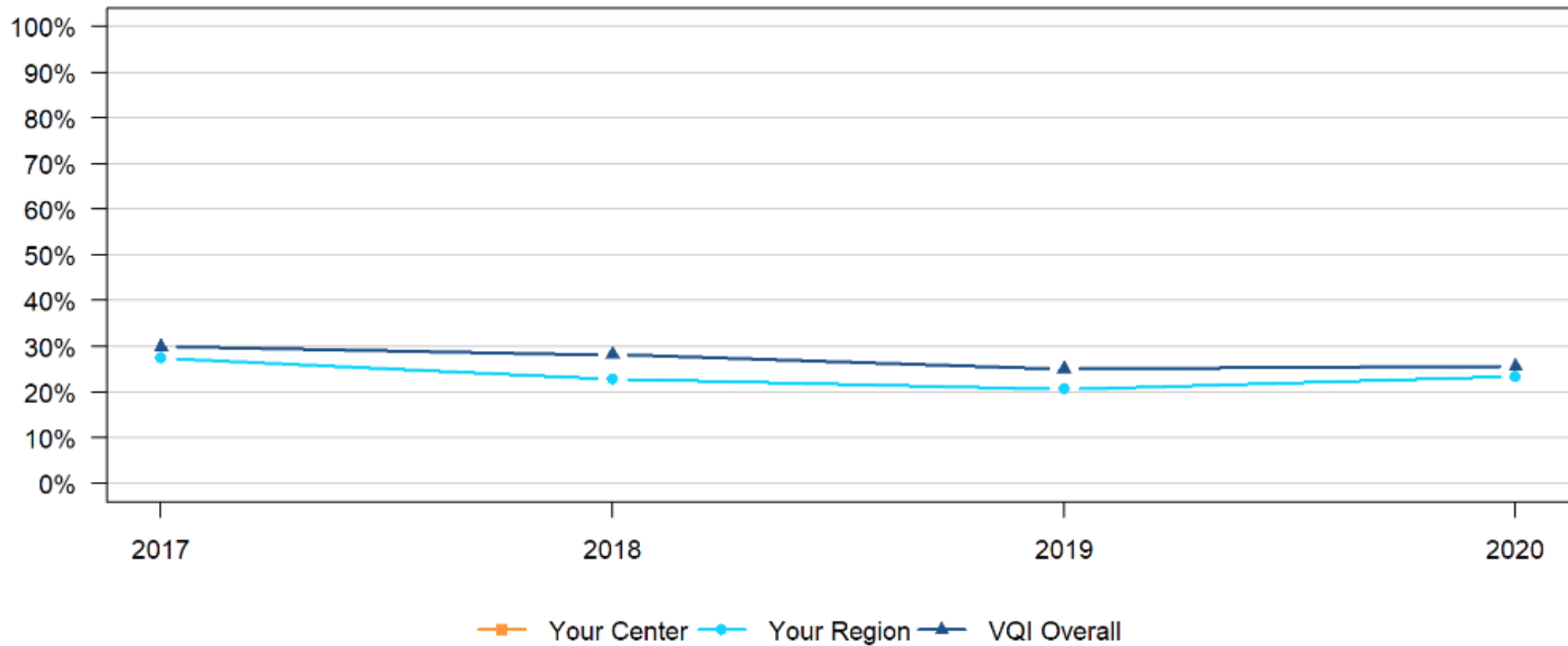
Procedures performed between January 1 and December 31, 2020

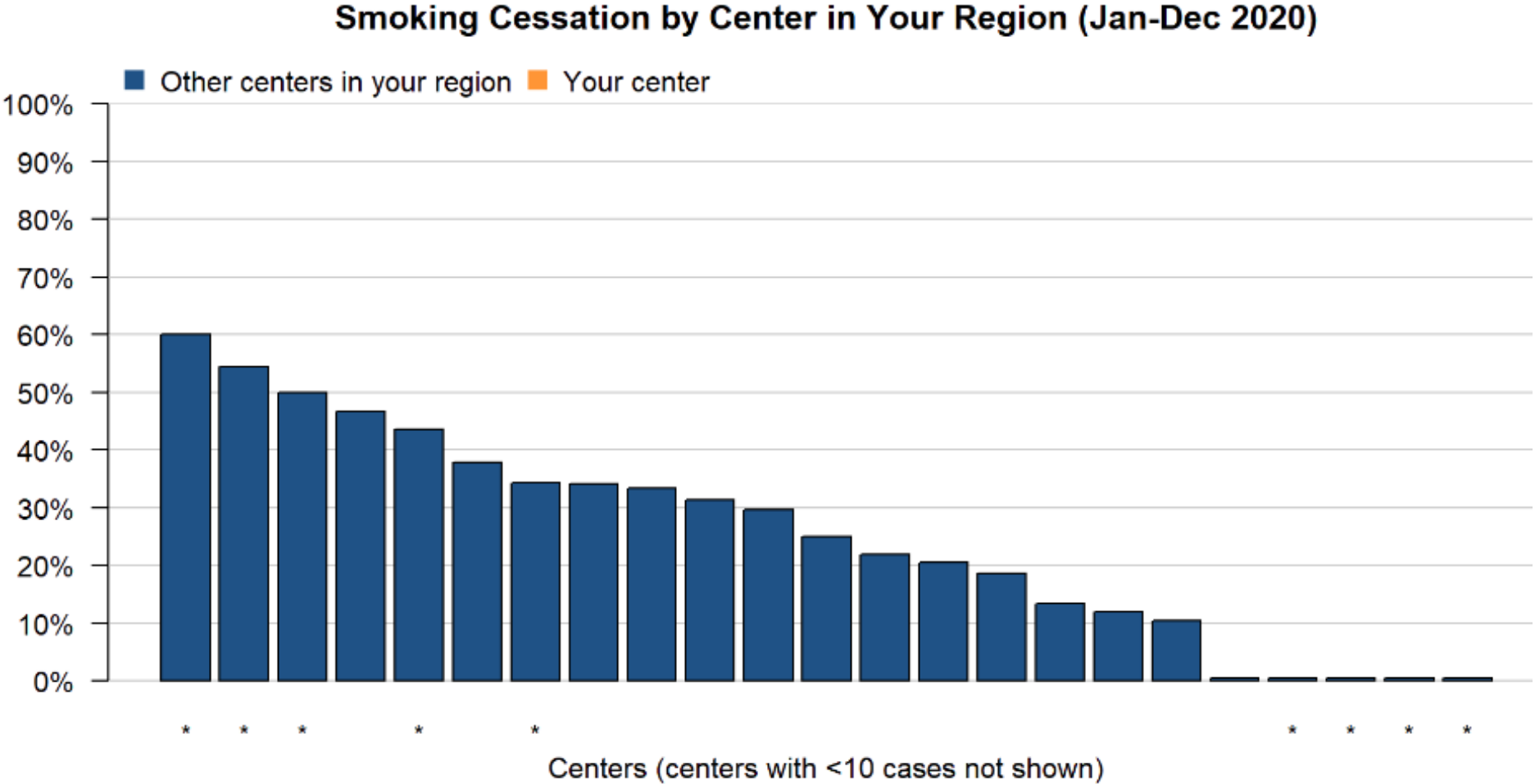
Includes CAS (TFEM CAS and TCAR), CEA, EVAR, HDA, INFRA, LEAMP, OAAA, PVI, SUPRA, and TEVAR procedures performed on patients still smoking within one month of the procedure. Excludes procedures that do not have at least one long-term follow-up record where the patient's follow-up smoking status was recorded.

The table below gives the number of procedures meeting the inclusion criteria, and the percentage of those procedures where the patient was not smoking within one month on follow-up for all long-term follow-up records where the patient's follow-up smoking status was recorded.

	Your Center	Your Region	VQI Overall
CAS		196 (24%)	2123 (26%)
CEA		219 (25%)	3104 (22%)
EVAR		94 (21%)	1640 (22%)
HDA		25 (NA)	647 (30%)
INFRA		99 (38%)	2171 (27%)
LEAMP		14 (36%)	519 (31%)
OAAA		18 (33%)	398 (25%)
PVI		405 (19%)	8478 (26%)
SUPRA		17 (35%)	845 (28%)
TEVAR		18 (22%)	567 (33%)
Overall (Jan-Dec 2020)		1105 (23%)	20492 (26%)

Smoking Cessation by Year

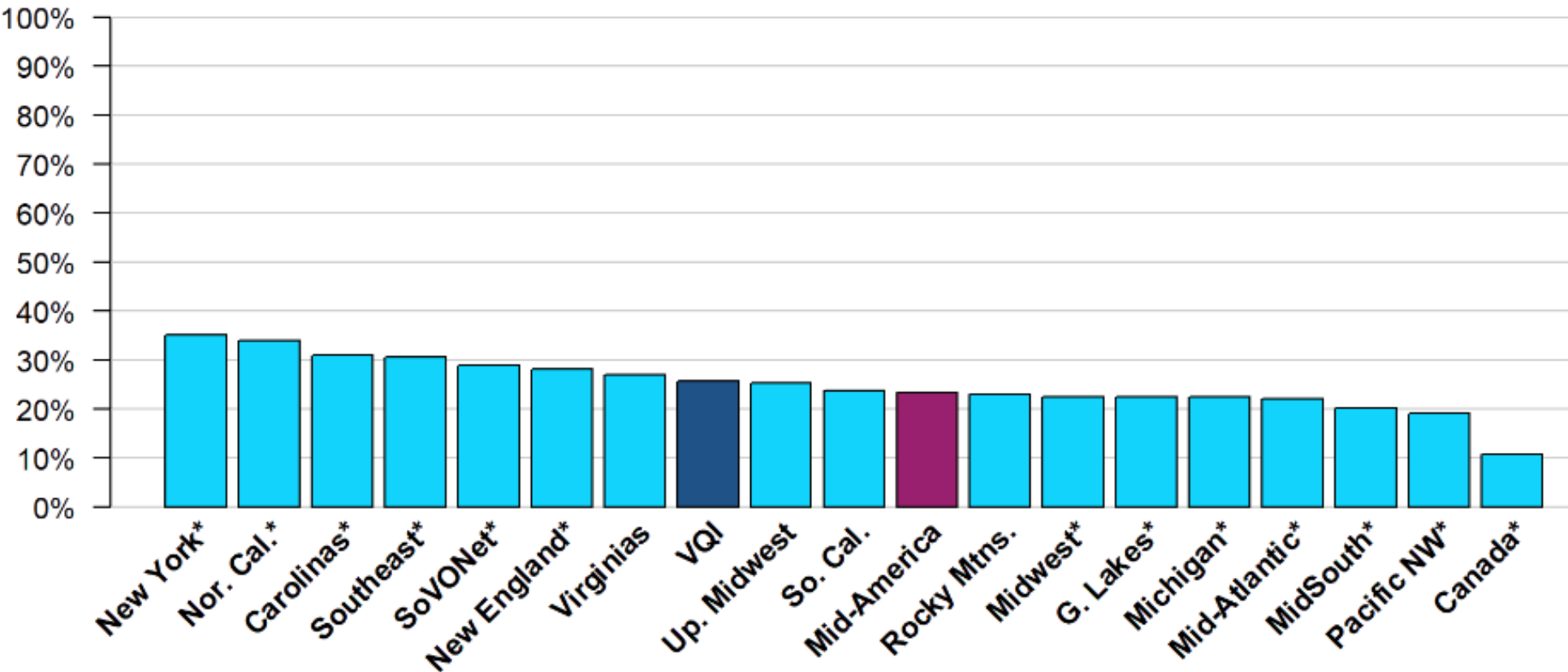




23 of 43 centers displayed

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

Smoking Cessation 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.

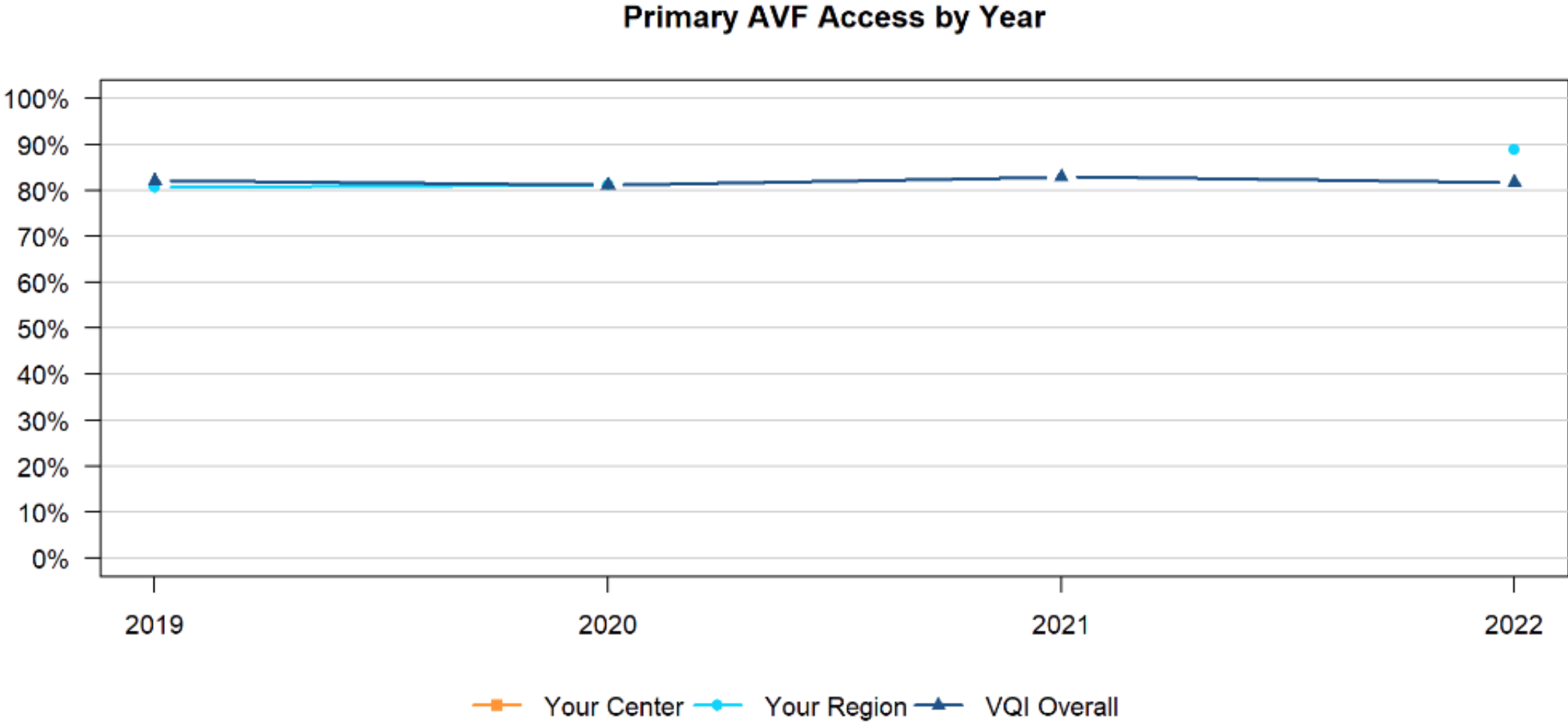
## HDA: Primary AVF vs. Graft

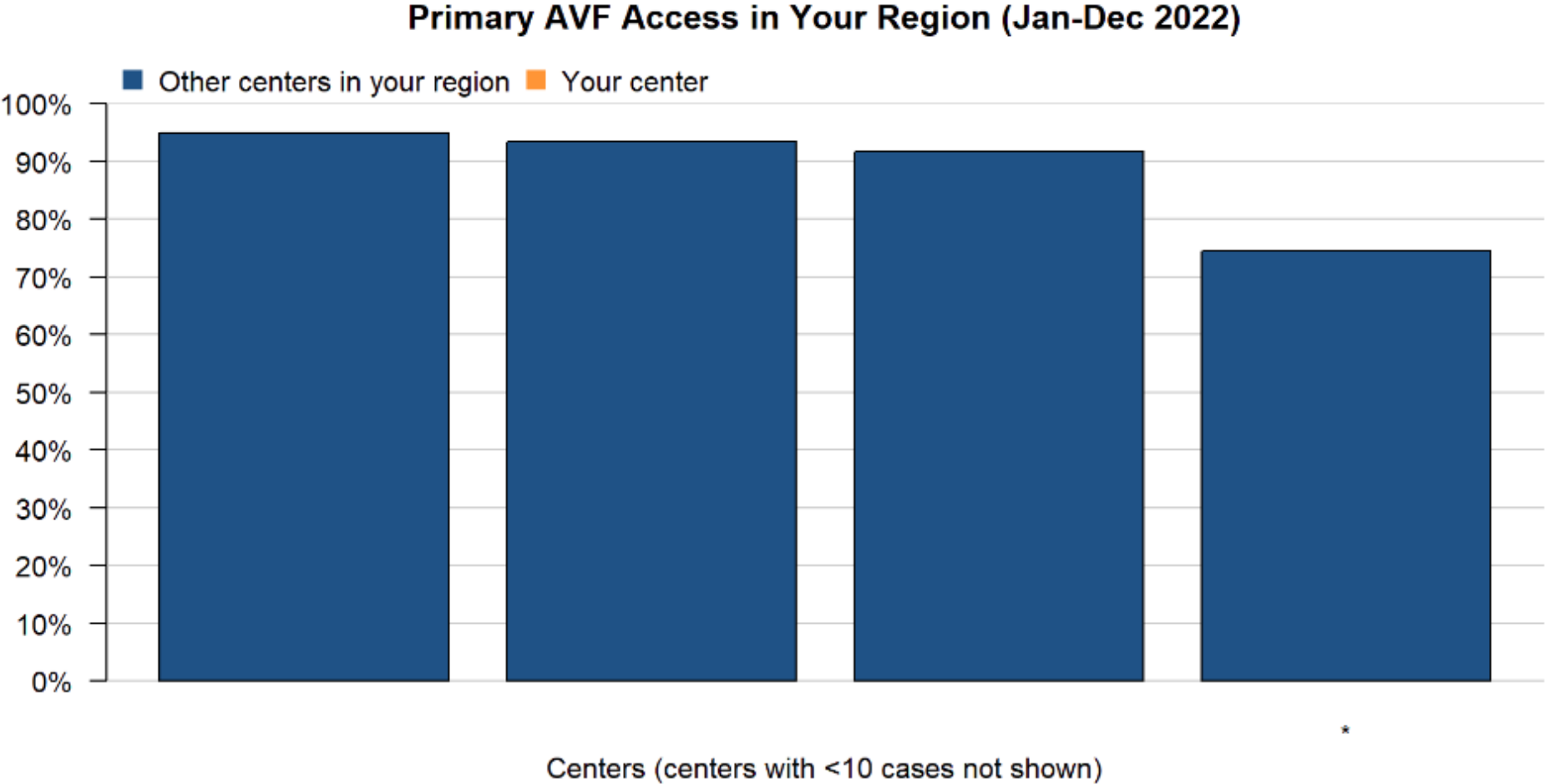
Procedures performed between January 1 and December 31, 2022

Includes Hemodialysis Access (HDA) procedures. 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.

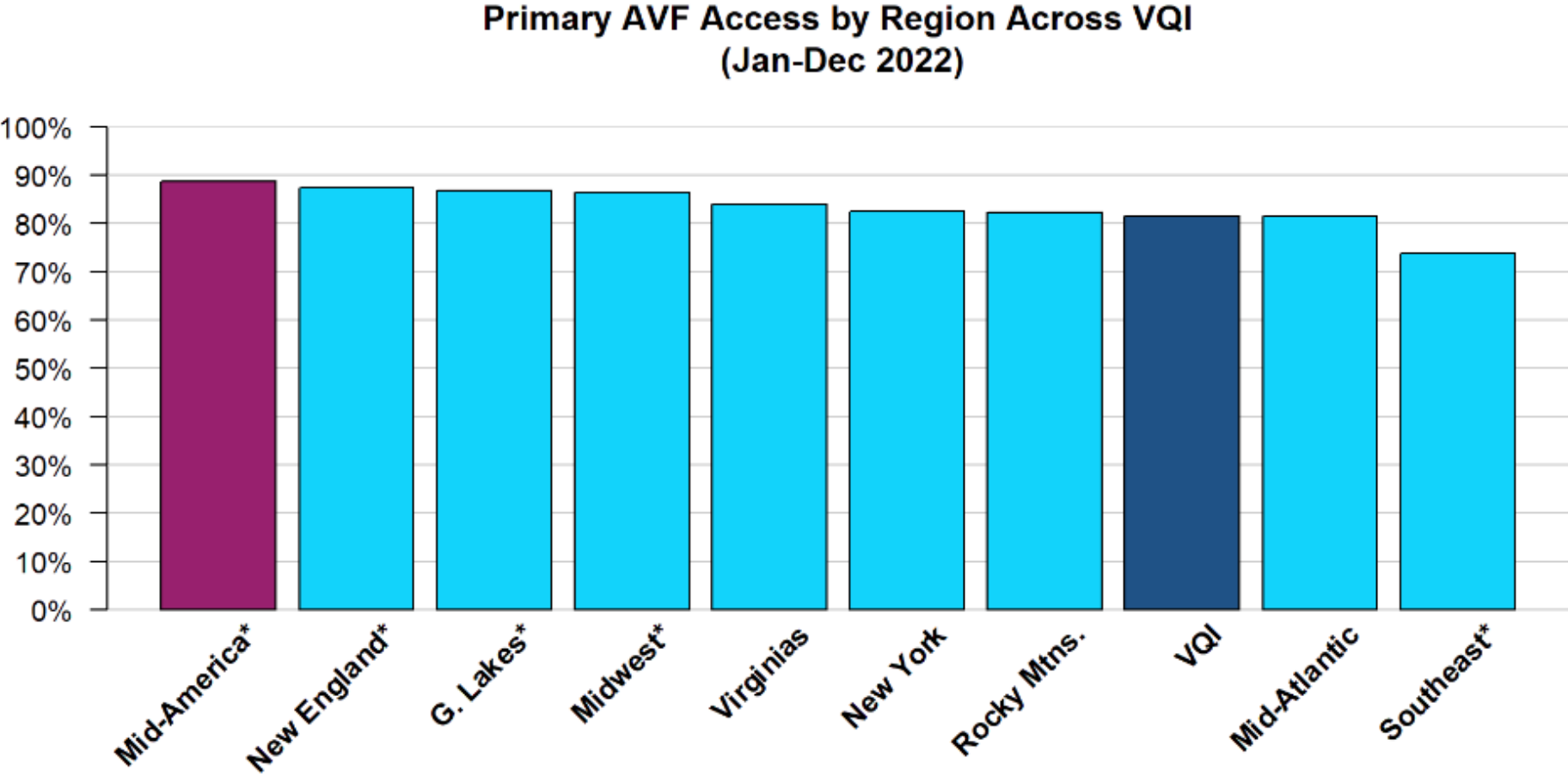
	Your Center	Your Region	VQI Overall
Number of HDA procedures meeting inclusion criteria		179	4585
Percentage with primary AVF		88.8%	81.7%





4 of 4 centers displayed

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



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

\*\*\* Indicates region's rate differs significantly from the VQI rate.



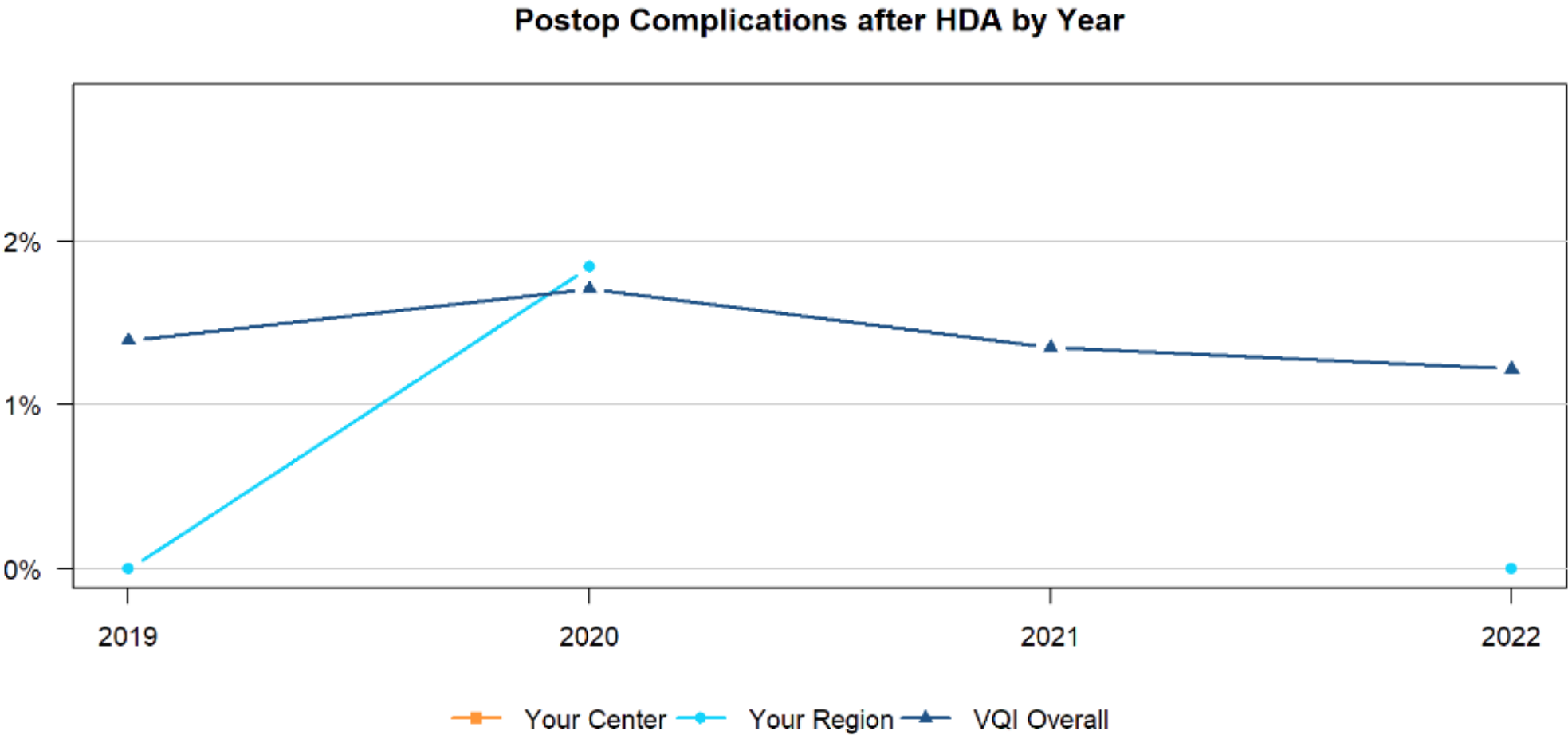
## HDA: Postop Complications

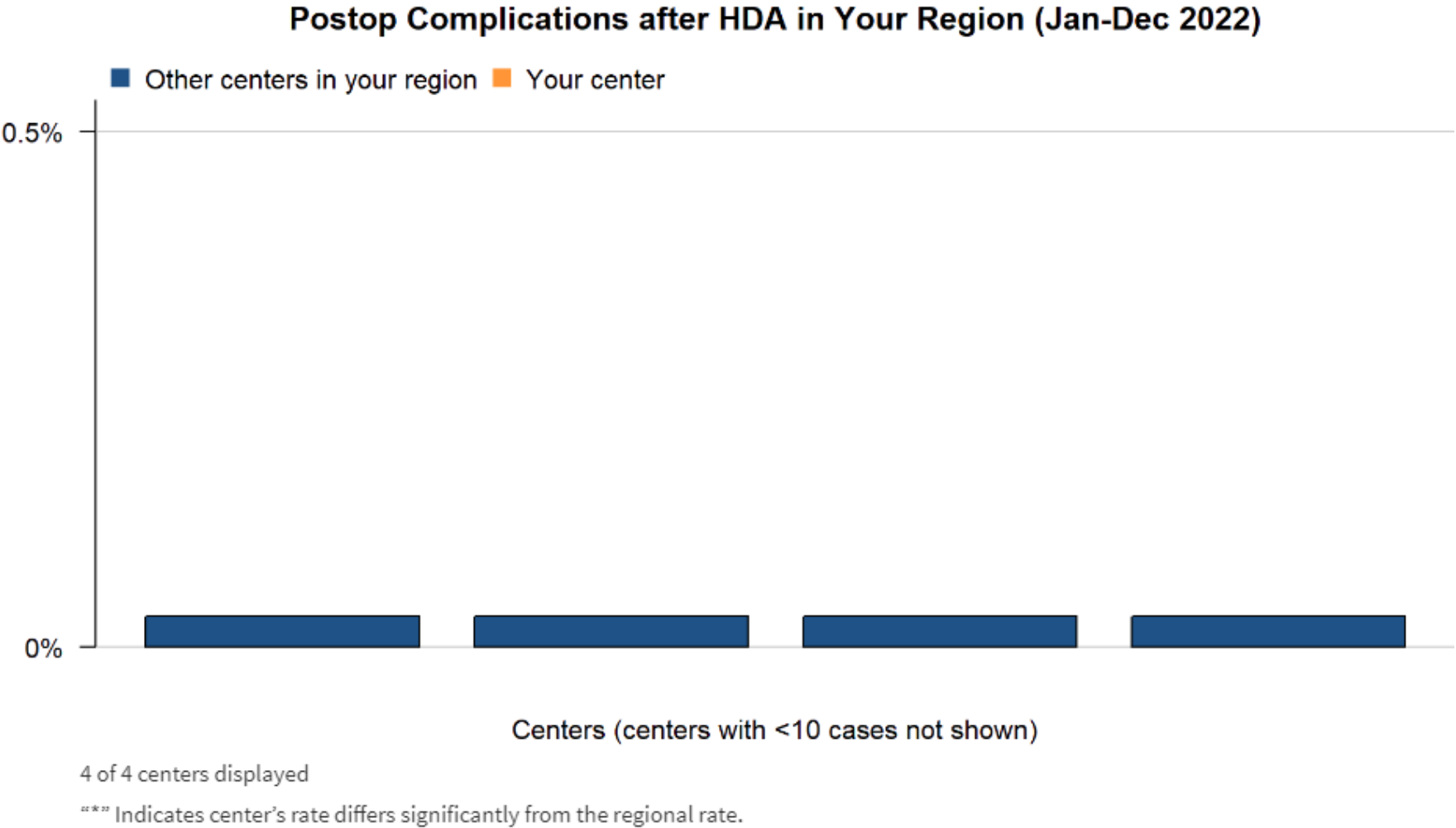
Procedures performed between January 1 and December 31, 2022

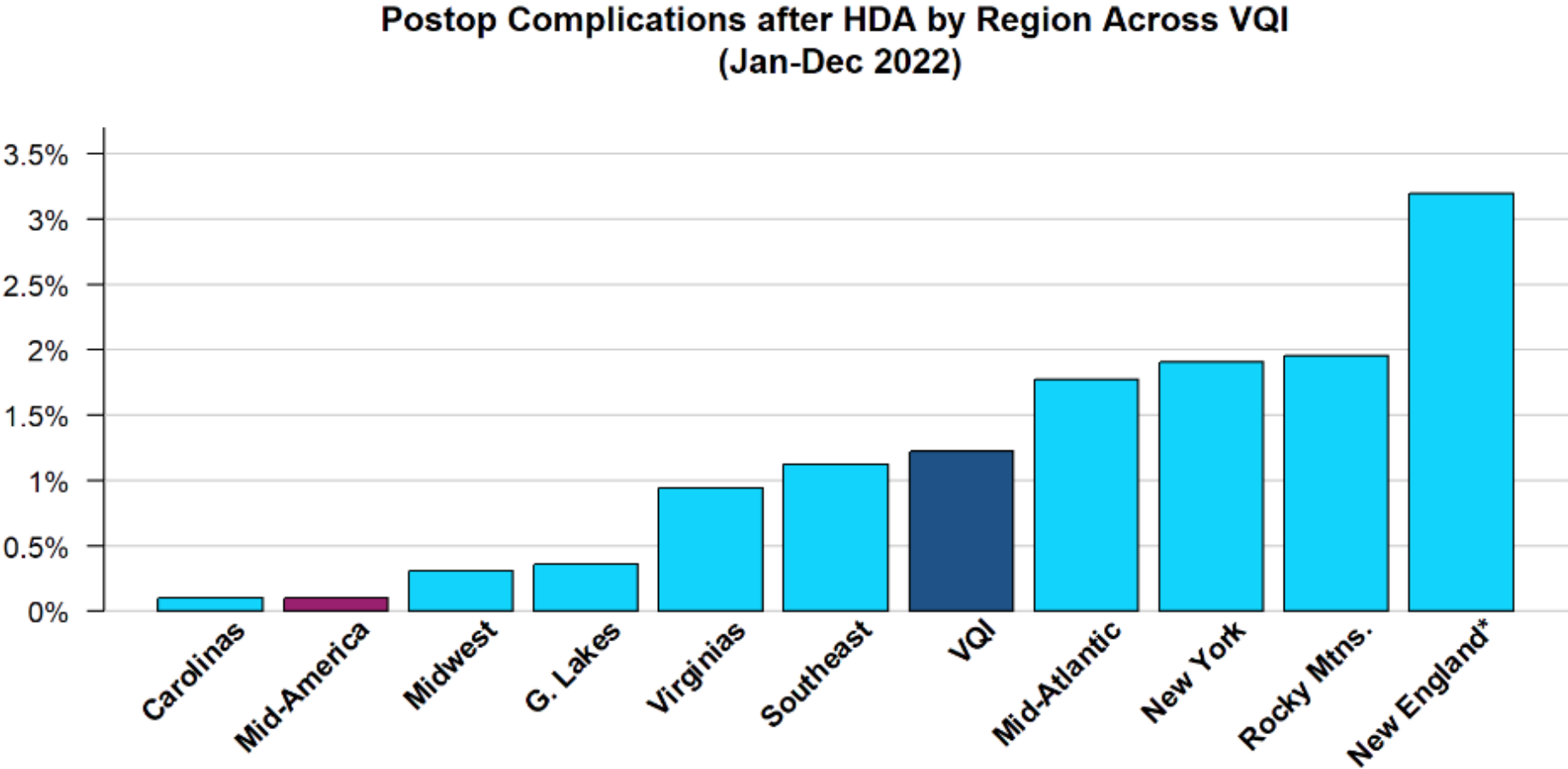
Includes Hemodialysis Access (HDA) procedures.

The table below gives the number of HDA procedures meeting the inclusion criteria, and the percentage of those procedures that resulted in an immediate postoperative complication. Postoperative complications are defined as bleeding, ischemic steal, ischemic monomelic neuropathy, access thrombosis, or other complication requiring reoperation.

	Your Center	Your Region	VQI Overall
Number of HDA procedures meeting inclusion criteria		224	5660
Percentage with immediate postoperative complications		0%	1.2%







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

\*\* Indicates region's rate differs significantly from the VQI rate.

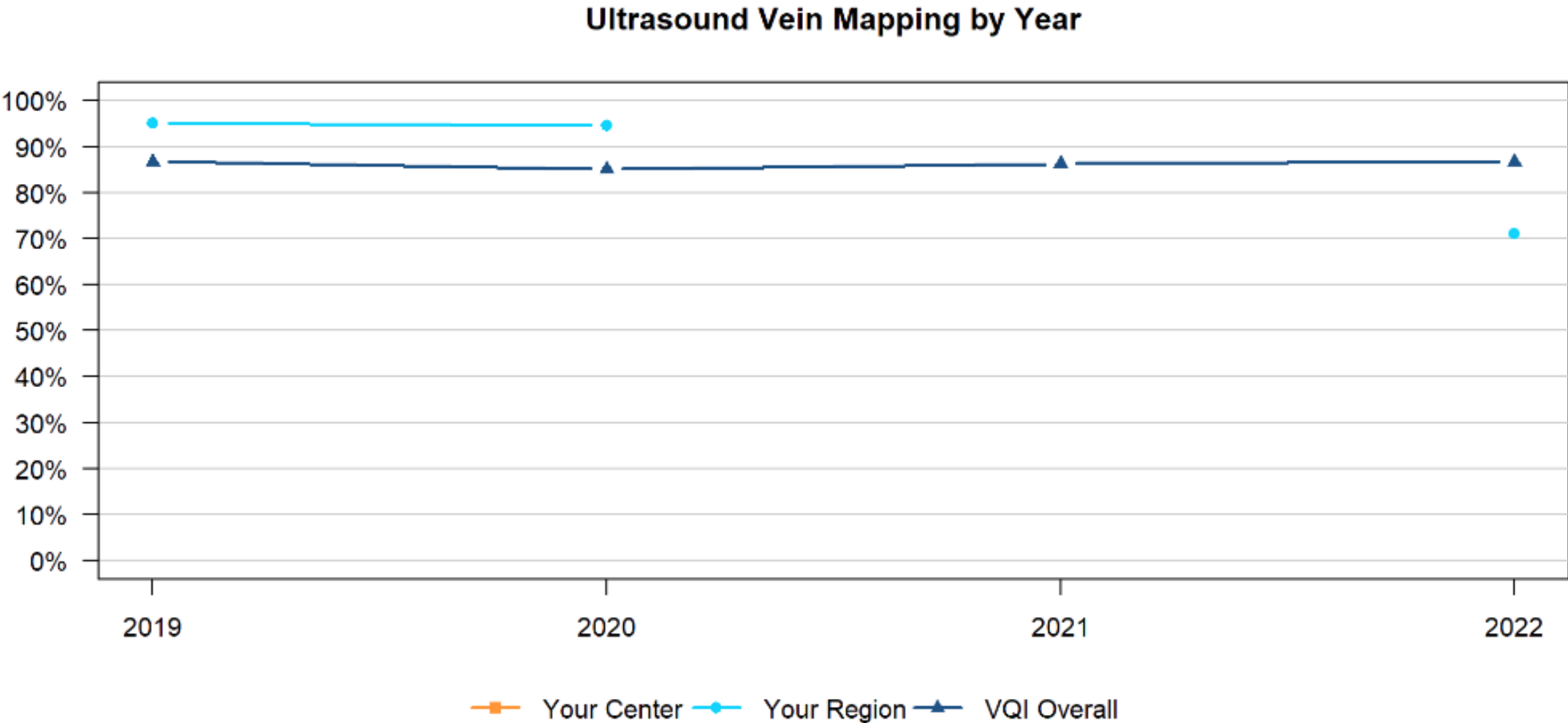
## HDA: Ultrasound Vein Mapping

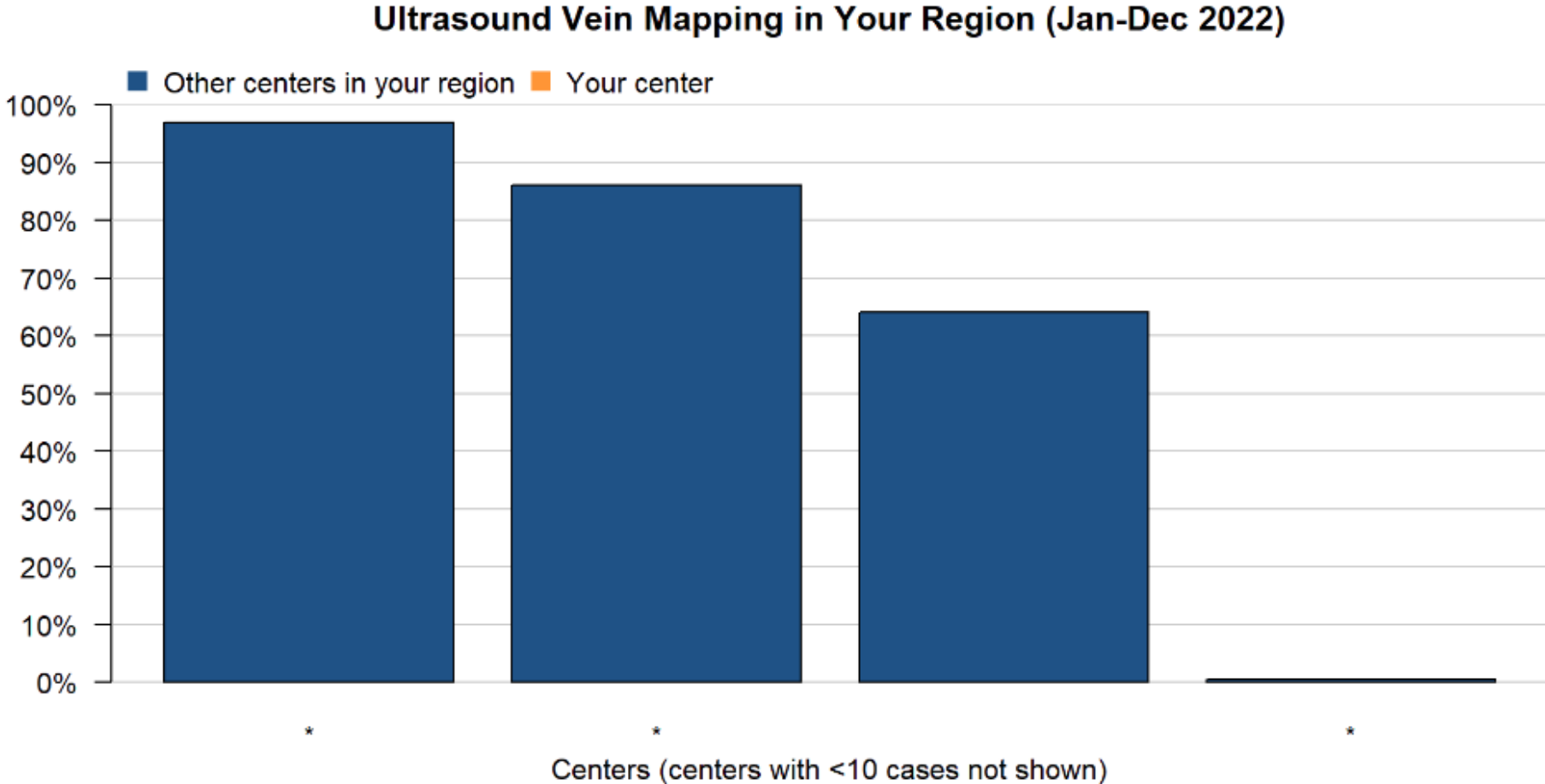
Procedures performed between January 1 and December 31, 2022

Includes Hemodialysis Access (HDA) procedures.

The table below gives the number of HDA procedures meeting the inclusion criteria, and the percentage of those procedures with preoperative ultrasound vein mapping.

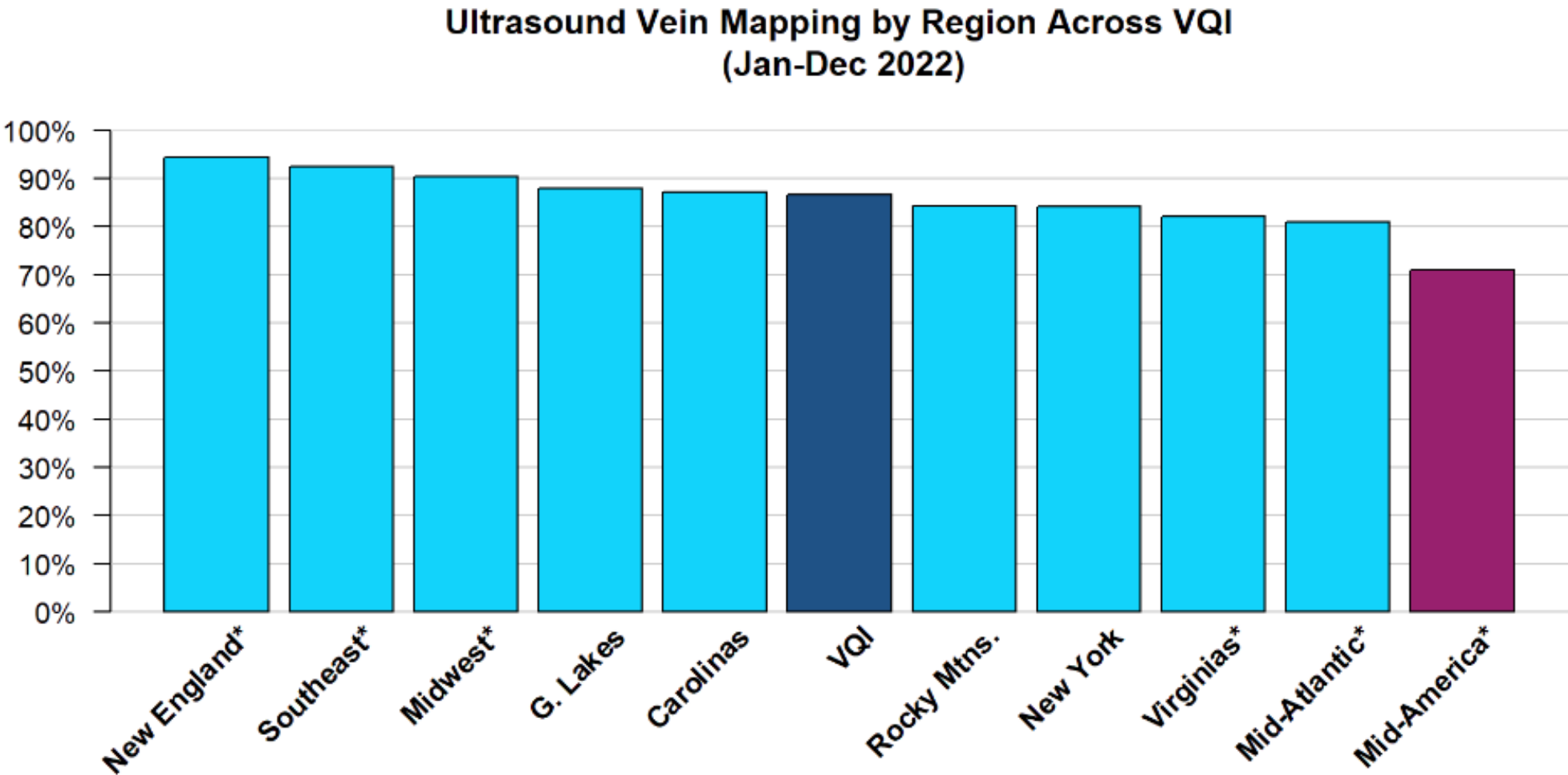
	Your Center	Your Region	VQI Overall
Number of HDA procedures meeting inclusion criteria		224	5661
Percentage with preoperative ultrasound vein mapping		71%	86.7%





4 of 4 centers displayed

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



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

\*\*\* Indicates region's rate differs significantly from the VQI rate.



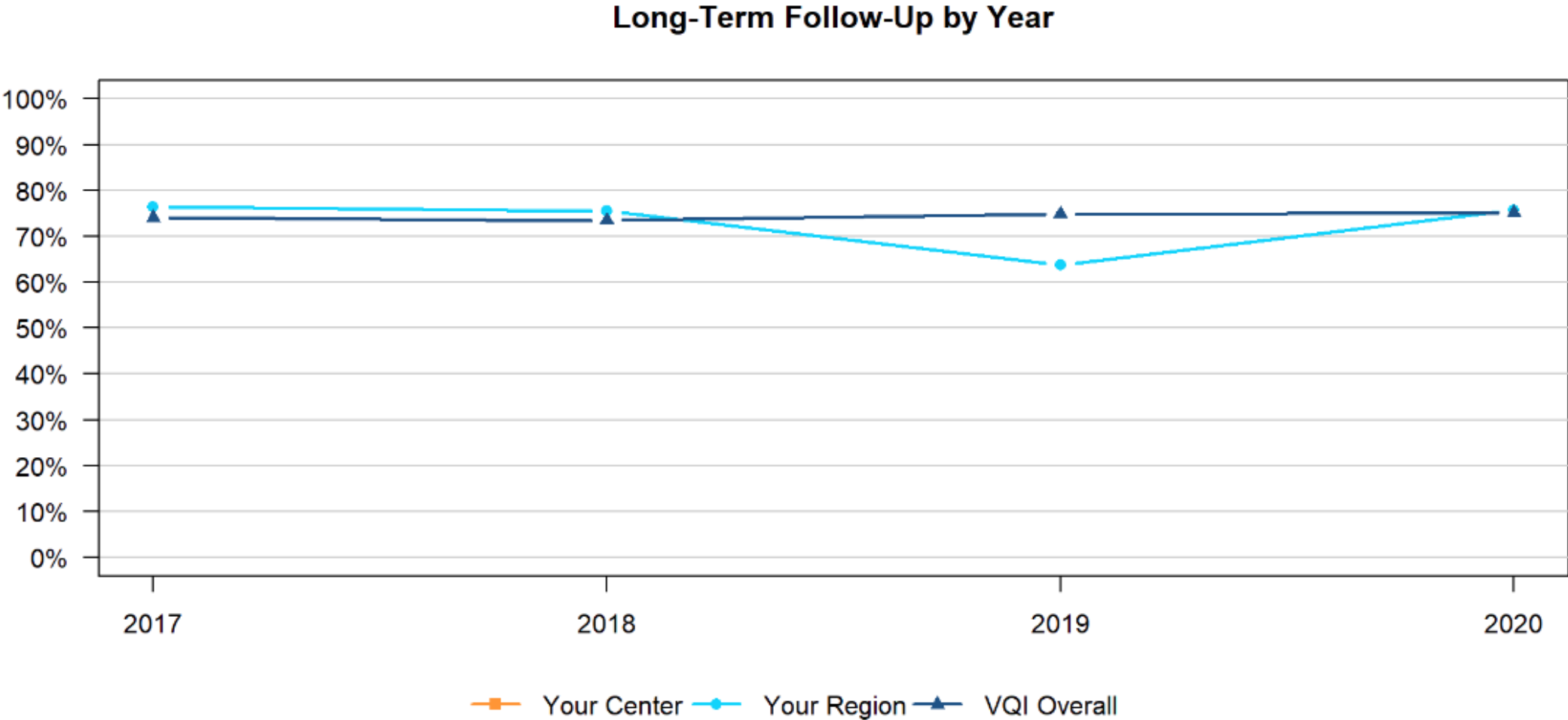
## Long-Term Follow-up

Procedures performed between January 1 and December 31, 2020

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

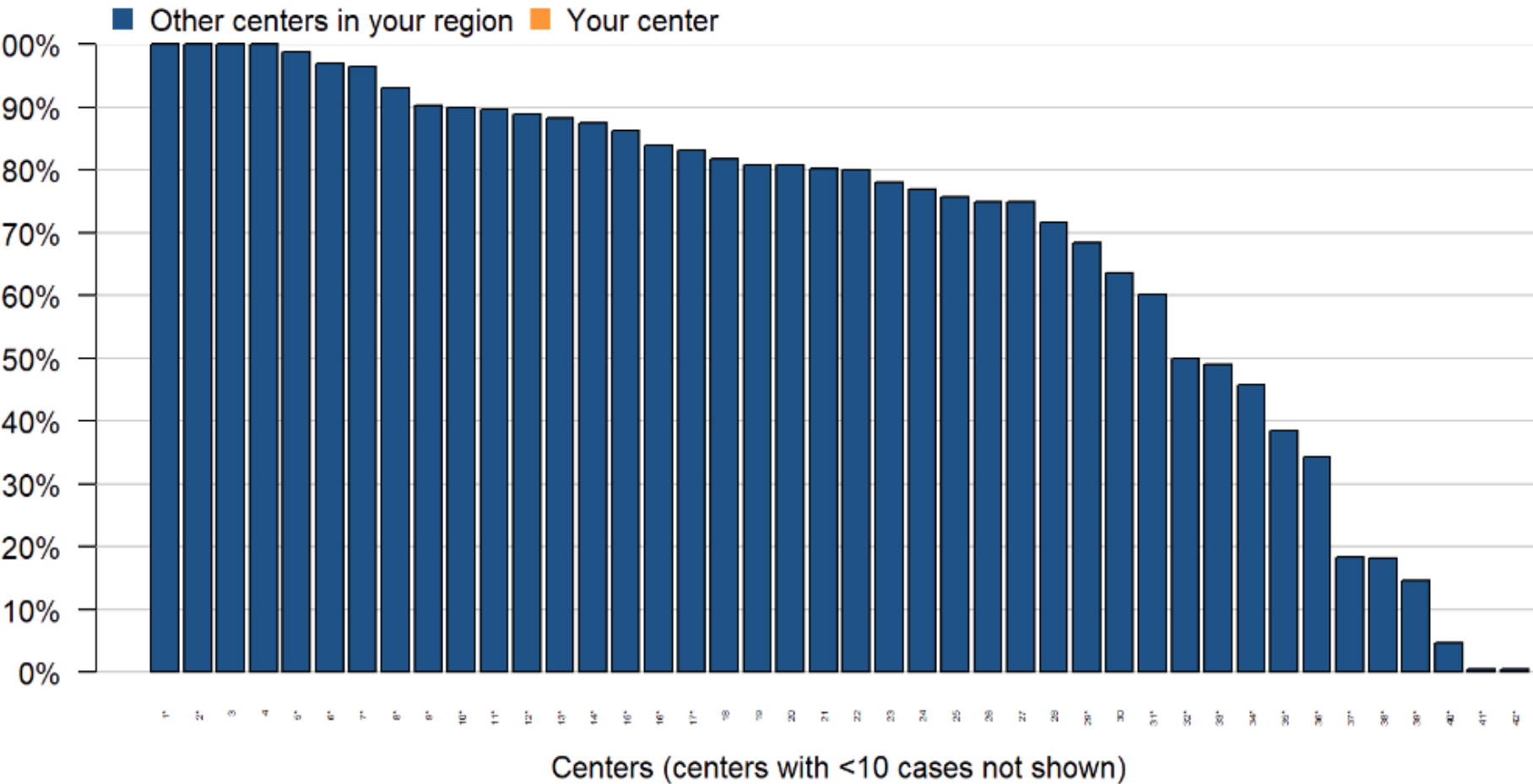
The table below gives the number of procedures meeting the inclusion criteria, and the percentage of those procedures with follow-up recorded between 9 and 21 months post-procedure.

	Your Center	Your Region	VQI Overall
CAS		1077 (73%)	12510 (72%)
CEA		1139 (77%)	17079 (77%)
EVAR		364 (87%)	6985 (76%)
HDA		326 (60%)	7359 (78%)
INFRA		300 (87%)	7243 (78%)
IVCF		83 (45%)	1526 (82%)
LEAMP		79 (77%)	3301 (75%)
OAAA		65 (69%)	1233 (79%)
PVI		1737 (77%)	39984 (74%)
SUPRA		42 (95%)	2021 (78%)
TEVAR		102 (77%)	2804 (74%)
Overall (Jan-Dec 2020)		5314 (76%)	102045 (75%)
Overall (Jan-Dec 2019)		7049 (64%)	105991 (75%)



# LTFU By Center

Long-Term Follow-Up by Center in Your Region (Jan-Dec 2020)

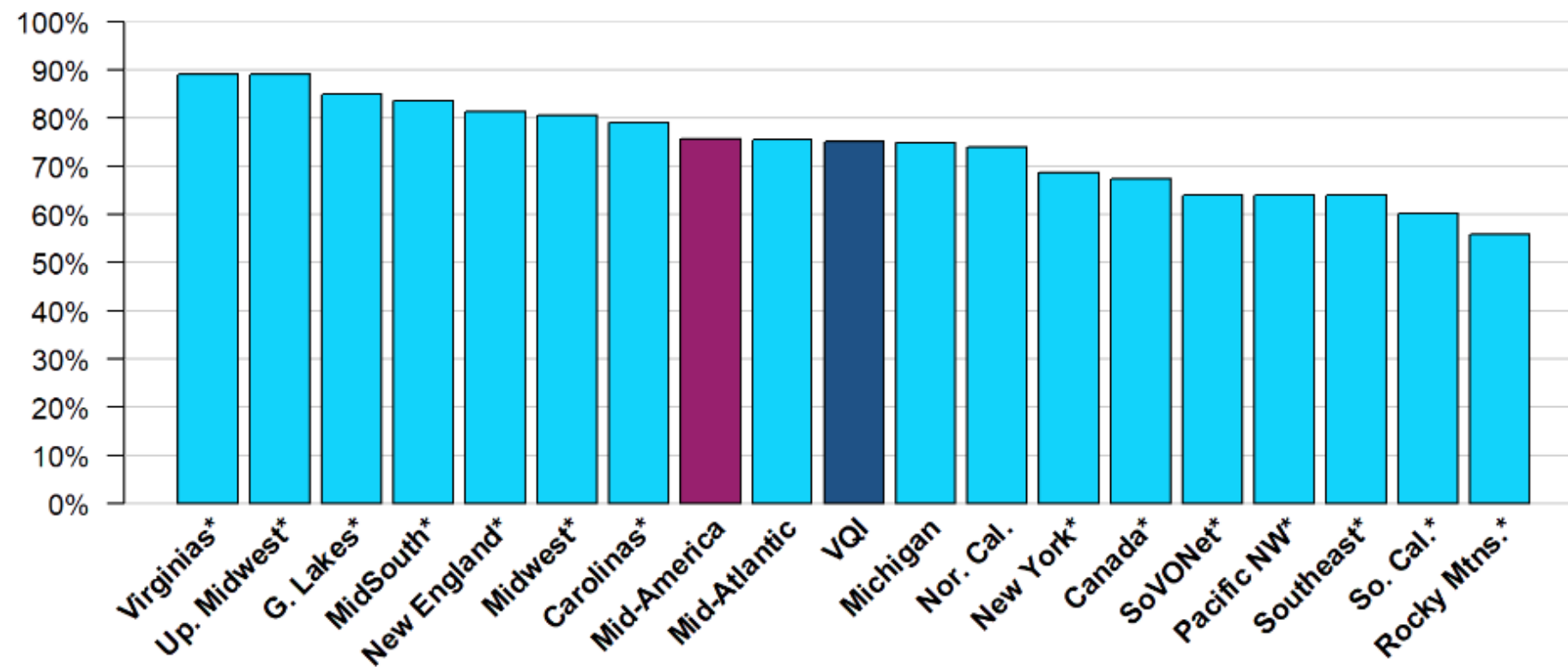


Index	Medical Center Name
1	Decatur Memorial Hospital
2	MacNeal Hospital
3	Gottlieb Memorial Hospital
4	Saint Luke's Episcopal Presbyterian Hospital
5	MercyOne Des Moines Medical Center
6	Barnes Jewish Hospital
7	Loyola University Medical Center
8	NorthShore Hospital
9	OSF St. Joseph Medical Center
10	OSF Saint Francis Medical Center
11	Kansas Heart Hospital
12	SSM Health St. Joseph Hospital - St. Charles
13	Nebraska Medicine
14	OSF Saint Anthony Medical Center
15	Saint Luke's Hospital of Kansas City
16	Carle Foundation Hospital
17	University of Kansas Hospital Authority
18	NA
19	The Methodist Medical Center of Illinois
20	UnityPoint Health Des Moines
21	University of Chicago Medical Center
22	AMITA Health Adventist Medical Center La Grange
23	AMITA Health Alexian Brothers Medical Center
24	SSM Health DePaul Hospital - St. Louis
25	SSM Health Saint Louis University Hospital
26	MercyOne Siouxland Medical Center
27	Mercy Hospital Springfield
28	Columbia Surgical Services, Inc.
29	Northwestern Memorial Hospital
30	Edward Hospital
31	Northwestern Medicine Central DuPage Hospital
32	Nebraska Methodist Hospital
33	Flint Hills Heart, Vascular, Vein Clinic, LLC
34	Memorial Medical Center
35	SSM Health St. Clare Hospital - Fenton
36	Premier Vascular, LLC
37	Bryan Medical Center
38	Elmhurst Memorial Hospital
39	University of Missouri Medical Center
40	Javon Bea Hospital - Riverside Campus
41	Cox Medical Center South
42	Mosaic Life Care

42 of 50 centers displayed

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

Long-Term Follow-Up 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.

## What factor do you feel most contributes to challenges with LTFU?

- Lack of dedicated staff for VQI data collection/abstraction
- Patients don't follow-up or follow-up elsewhere
- Follow-up occurs outside the LTFU window (9-21 months)
- Lack of resources to coordinate clinic follow-up
- Challenges with clinical documentation of follow-up documenting follow-up (example: aortic diameter, etc.)
- Other

# **LTFU Toolkit**

**Betsy Wymer, DNP, RN, CV-BC**

**December 2022**

# Vascular Quality Initiative

- VQI Contract
  - VQI governing policy is specific for LTFU at one year
  - <https://www.vqi.org/wp-content/uploads/SVS-PSO-Governing-Policies-rev051418.pdf>
- CMS Reimbursement Surveillance Projects (example TCAR)
  - LTFU required
  - Possible audits and/or forfeited reimbursement
  - <https://clinicaltrials.gov/ct2/show/NCT02850588?term=tcar&draw=2&rank=1>



- LTFU is exactly 2 years behind the given Procedure Timeframe
- LTFU is considered 9-21 months post procedure
- <https://www.vqi.org/resources/reporting/>

VQI Reporting Schedule 2022 - 2023			
Report	Data Cut Date*	Anticipated Delivery Date**	Procedure Timeframe***
<b>VQI Regional Quality Reports</b>			
Spring 2023	1-Feb-23	1-Mar-23	CY 2022
Fall 2023	1-Aug-23	1-Sep-23	July 1, 2022 - June 30, 2023
Fall 2023, RMVQI	1-Jun-23	1-Jul-23	May 1, 2022 - April 30, 2023
<b>VQI Best Practices Dashboards</b>			
Fall 2022	1-Sep-22	1-Oct-22	July 1, 2021 - June 30, 2022
Winter 2022	1-Dec-22	1-Jan-23	October 1, 2021 - September 30, 2022
Spring 2023	1-Mar-23	1-Apr-23	CY 2022
Spring 2023 (4-year Cumulative)	1-Mar-23	1-Apr-23	CY 2019 - CY 2022
Summer 2023	1-Jun-23	1-Jul-23	April 1, 2022 - March 31, 2023
Fall 2023	1-Sep-23	1-Oct-23	July 1, 2022 - June 30, 2023
Winter 2023	1-Dec-23	1-Jan-24	October 1, 2022 - September 30, 2023
<b>VQI Quality Initiative Updates</b>			
Fall 2022	1-Oct-22	1-Nov-22	DC Meds: Through Quarter 3 2022 EVAR Sac Diameter: 2020
Spring 2023	1-Apr-23	1-May-23	DC Meds: Through Quarter 1 2023 EVAR Sac Diameter: 2021
Summer 2023	1-Jul-23	1-Aug-23	DC Meds: Through Quarter 2 2023 EVAR Sac Diameter: 2021
Fall 2023	1-Oct-23	1-Nov-23	DC Meds: Through Quarter 3 2023 EVAR Sac Diameter: 2021
<b>VQI 2022 Participation Awards</b>	1-Feb-23	1-Mar-23	CY 2022
<p>* The data-entry/completion deadline for each report is exactly one day prior to the Data Cut Date. Any changes or updates to the data on or after the Data Cut Date will not be reflected in the given report.</p> <p>** The Anticipated Delivery Date is generally within 1 month of the Data Cut Date. Major report updates may require extended time for development, testing, and quality assurance.</p> <p>*** For the reporting of LTFU outcomes, the procedure timeframe used is exactly 2 years behind the given Procedure Timeframe.</p>			

- Currently, VQI **requires** 1-year LTFU
  - 9-21 months post procedure
- Pathways allows additional follow up visits
  - Member requested
  - 30-day follow up
    - Focus on Readmission
  - 2 year follow up
    - Additional LTFU
- Additional F/U **encouraged**, not mandatory

*Please visit the Pathways Support Tab/Training Schedule for upcoming events and to register for requested training*

**PATHWAYS 101: Introduction to PATHWAYS Functional Training** – Twice per month  
(2<sup>nd</sup> & 4<sup>th</sup> Wednesdays)

**PATHWAYS 102: Introduction to PATHWAYS Follow-up and Reporting Tools** - Quarterly

Support

Documents

Release Notes

Training Schedule

Training Schedule

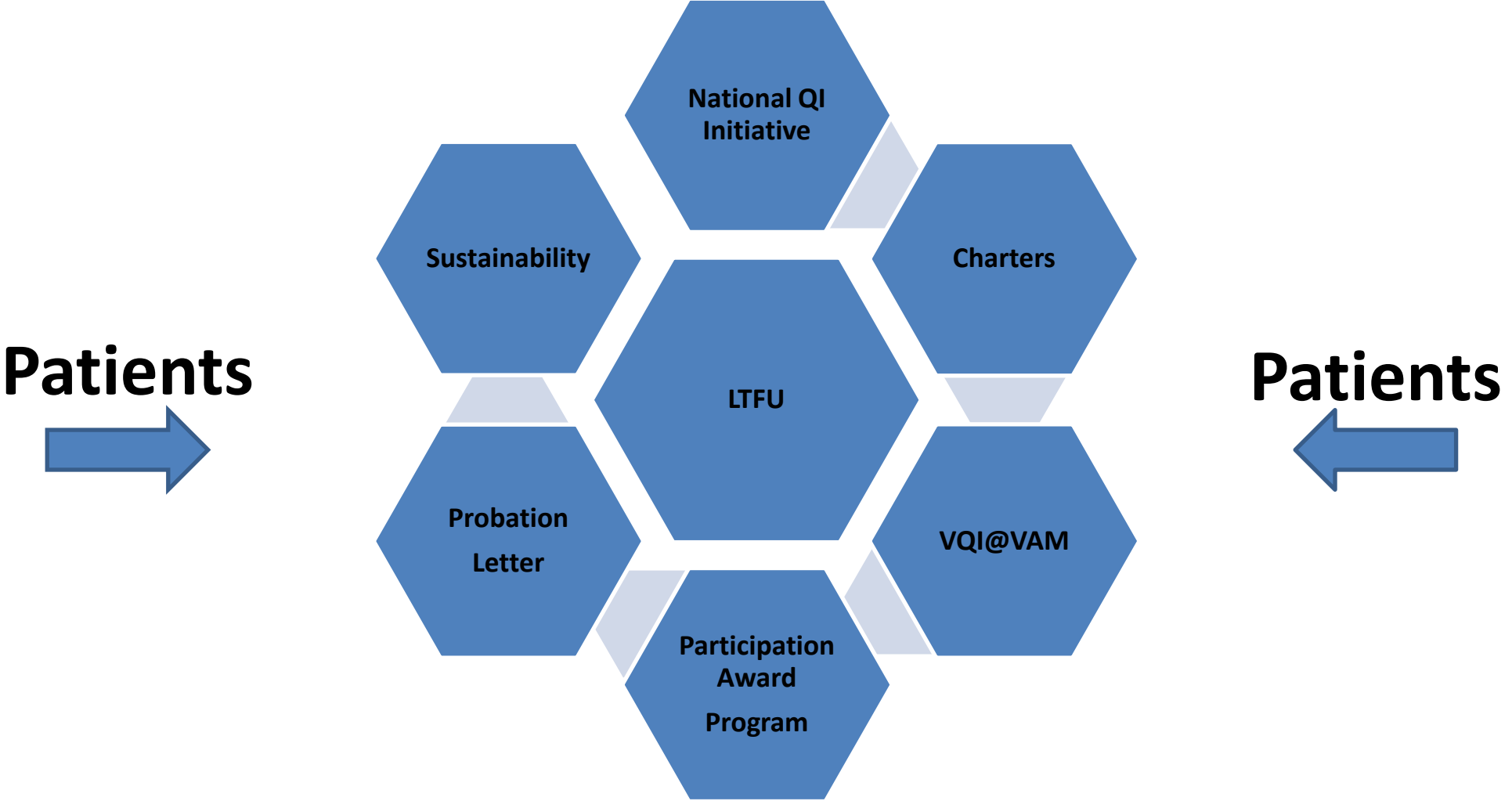
Please click the register link below to sign-up for an upcoming training session.

Q

Go

Actions

Training	Date & Time (ET)	Register
TEST - PATHWAYS Training Webinar	01/18/2022 @ 03:00 PM	<a href="#">Register</a>
Training Trial	01/12/2022 @ 07:18 PM	<a href="#">Register</a>



## EVAR Long Term Follow-Up (LTFU) Imaging

- Review center data
- Attend regional meetings
  - 2x per year
- Meet with leaders
- Compare center with national benchmark
- Where do you stand?
- Where do you *want* to stand?

## **Dr. Gary Lemmon**

Indiana University Health System

“For the first time in over 30+ years of clinical practice, vascular surgeons using VQI now have meaningful quality measures of their choosing rather than opaque metrics from hospital administrative databases.”

**What quality measures are most meaningful to you and your team? (choose all that apply)**

- Major complications and adverse events
- Reporting of quantitative data (ABI, aortic diameter, etc.)
- Length of stay
- Medication adherence
- Long-term follow-up
- Other, including any not currently present in the regional report

- Charters are accepted year-round (Jan 1 – Dec 31)
- 1 charter per center per year = 2 participation points max
- Quarterly Focus Charter Calls  
Register for the calls -  
<https://www.vqi.org/quality-improvement/>
- View sample charters  
<https://www.vqi.org/quality-improvement/> (quality tools)

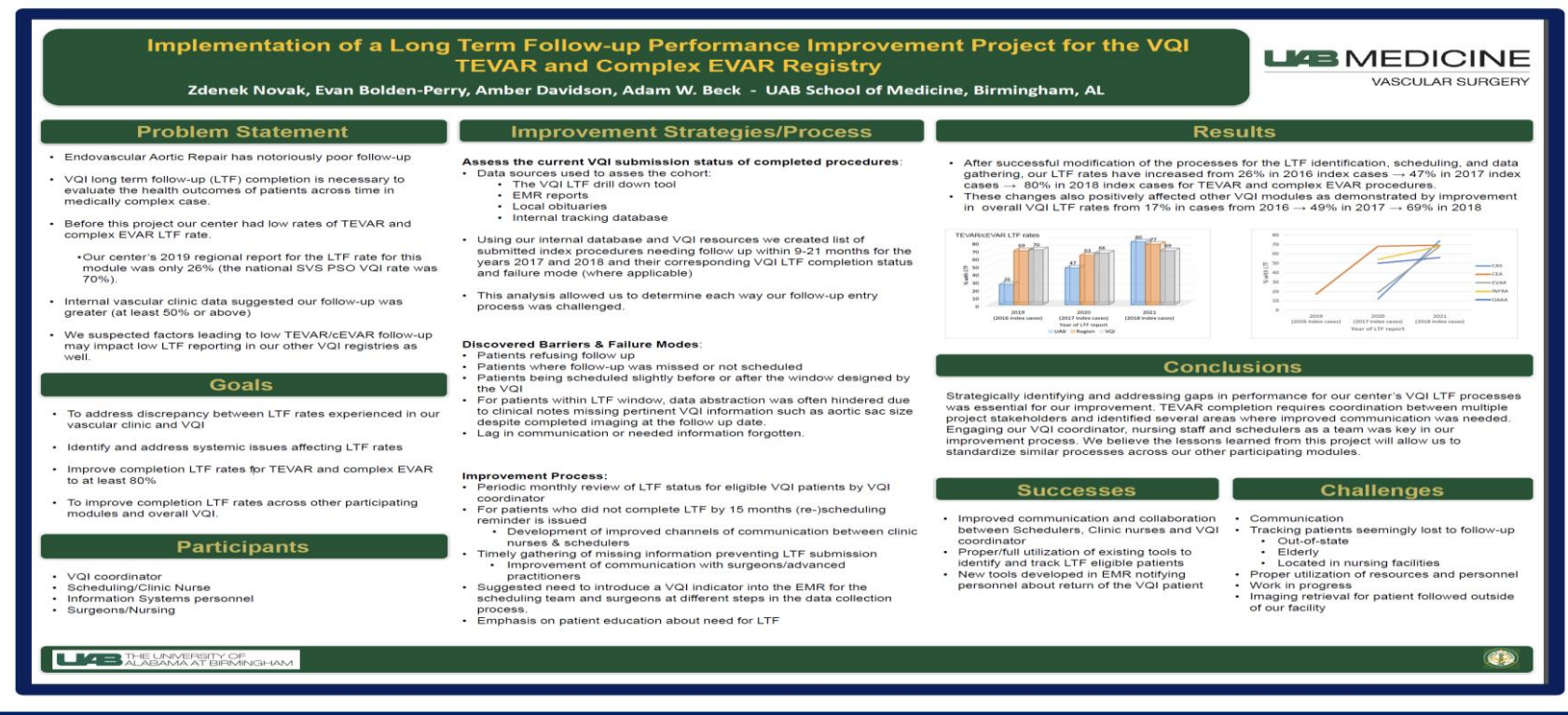
Project Overview		
Problem Statement:		
Goal:		
Scope:		
Deliverable(s):		
Resources Required (including data sources):		
Key Metrics		Milestones
Outcome Metrics:	Milestone / Description:	Date (mm/yy):
Process Metrics:		
Team Members		
Exec Sponsor:	Clinical Sponsor:	
Sponsor:	Process Owner:	
Project Leader:	Team Members:	



## Implementation of a Long-Term Follow-up Performance Improvement Project for the VQI TEVAR and Complex EVAR Registry

Authors: Zdenek Novak, Evan Bolden-Perry, Amber Davidson, Adam W. Beck

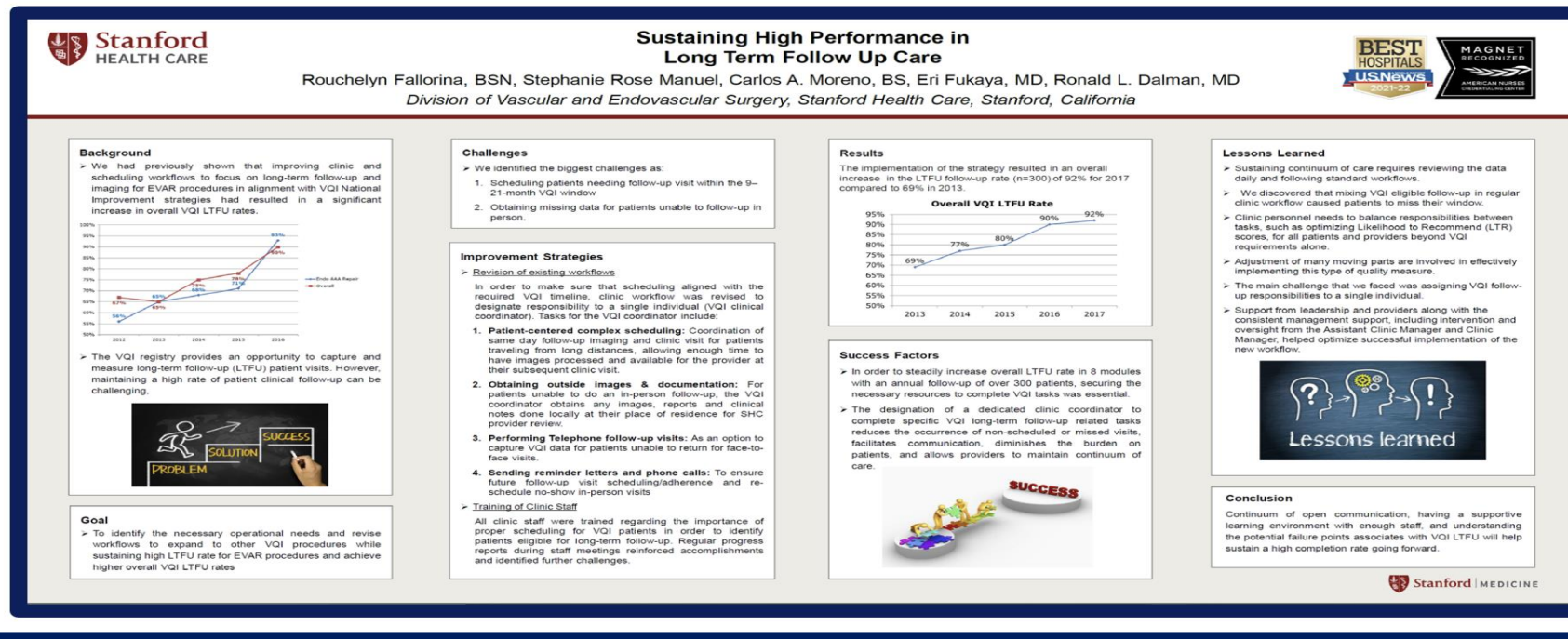
UAB School of Medicine, Birmingham, AL



## Sustaining High Performance in Long Term Follow Up Care

Authors: Rouchelyn Fallorina, BSN, Stephanie Rose Manuel, Carlos A. Moreno, BS, Eri Fukaya, MD, Ronald L. Dalman, MD

Stanford Health Care, Stanford, California (Division of Vascular and Endovascular Surgery)



- VQI@VAM Annual Reports
  - QI Supplemental Quality Guide
  - QI Abstracts Guide
  - Quality Rapid Fire Presentations
  - SVS VQI Detailed Annual Report
- <https://www.vqi.org/qualityimprovement/> (quality tools)



## **Dr. Patrick Ryan**

Nashville Vascular and Vein Institute

“The VQI provides the best method for monitoring quality in my vascular surgery practice thus effecting the greatest possible quality and outcomes for my patients.”

# Participation Awards Program

**\*subject to change annually**

The following is a list of the four domains for the 2023 Participation Awards criteria:

- **Domain 1 – LTFU – 40% weighted** 
- **Domain 2 – Regional Meeting Attendance – 30% weighted**
- **Domain 3 – QI Project – 25% weighted**
- **Domain 4 – Registry Subscriptions – 5% weighted**

## Domain – LTFU – 40% weighted

LTFU reporting demonstrates a commitment to monitoring the ongoing effectiveness of treatment, assessing potential problems and providing optimal medical management. LTFU allows a more meaningful assessment of quality (as opposed to only perioperative outcomes) and is a cornerstone of VQI.

A center's LTFU rate will be determined according to the scale below. Since this category is weighted at 40%, the number of points a center earns for LTFU will be multiplied by 4 before calculating the overall score.

- LTFU rate  $\geq 90\%$       6 points
- LTFU rate  $\geq 80\%$       4 points
- LTFU rate  $\geq 70\%$       2 points
- LTFU rate  $< 70\%$       0 points



- Probation letters come out annually in July
- Check your LTFU status throughout the year
- Must be at >50%

LTFU reporting in the VQI is defined as the submission of a follow-up form at least nine months after the procedure in surviving patients. The SVS PSO Governing Council has determined that data from centers with LTFU reporting <50% cannot accurately depict outcomes and is inconsistent with the quality improvement mission of the VQI. Centers are actually given two full years to complete LTFU within a 9-21-month time period, after a procedure. Of all eligible centers, 25% of VQI members failed to report LTFU for at least 50% of procedures performed in 2019. These centers are now being placed on probation until they can improve their LTFU reporting to include at least 50% of their procedures for a consecutive 12-month interval.

There are several consequences of LTFU probation. If a center does not improve its LTFU rate and remains below 50% for an additional 12 months or longer, there are two additional consequences of probation:

- Such centers will not be permitted to participate in new industry-sponsored projects to assess device performance if LTFU is included in these projects, since complete reporting is critical for these projects. Centers will only be prohibited from participating in industry-sponsored projects for the specific registries that continue to have a LTFU rate of < 50%.
- Such centers will not be permitted to receive de-identified datasets for research, for any registry in which their LTFU remains at <50%.

- Sign into Pathways
- Select Tools
- Select 'LTFU completion rate by procedure'
- Input dates 1/1/2020 – 12/31/2020
- This shows the compilation % for the Center
- Email a screenshot of this entire screen to [bwymmer@svspso.org](mailto:bwymmer@svspso.org)
- If you have difficulties, please contact [pathwayssupport@fivoshealth.com](mailto:pathwayssupport@fivoshealth.com)

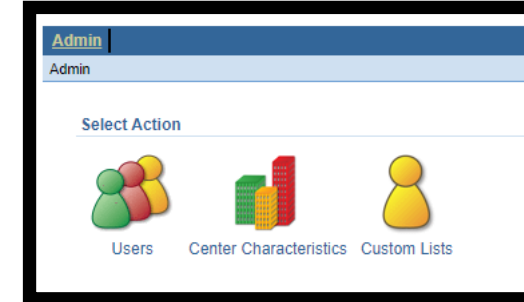


## **Dr. Jeb Hallett**

Medical University of South Carolina (MUSC)

“In the Carolinas Vascular Regional Quality Group, the VQI has been a wonderful, professional, and personal ‘glue’, for our regional quality efforts.”

- Update and Maintain Center Characteristics
- Continue Stakeholder Updates
- Check LTFU Status
- Review Return on Investment Possibilities
- Share your Quality story



Procedure/treatment Date From   Procedure/treatment Date To

Procedure Type	Completion Rate
Carotid Artery Stent	100% (28/28)
Overall	100% (28/28)

\*Denominator only includes submitted records.

<https://drive.google.com/file/d/1oXkxdw1KsYGuYN6OUFfw43tlx4o0--6y/view?usp=sharing>

# Long Term Follow Up

OSF Saint Francis Medical Center  
Stephanie Shanklin BSN RN

# In the beginning

- I began abstracting in 2021
- First priority was abstracting new cases
- Personal bias -Long Term Follow Up's were of lesser importance
- Attended VQI-VAM Summer 2022
- For the 1<sup>st</sup> time I heard the importance of LTFU
  - Other centers/physicians had assumed all of their patients were following up, but when someone really made it a priority they discovered they had some work to do
  - Physician at VAM stated "it just took one person to focus on it"
  - This created my spark-I knew I could do better

# Processes

## Prior state

- Pull up LTFU cases by Month and Year
- Look once if no LTFU can be found, mark lost to FU(No matter if it was 10 or 21 months post procedure)

## Current state

- Pull up cases by month and year
- Keep a running list of how many are still incomplete and continue to recheck those until the window closes at 21 months post procedure
- Recheck list weekly
- Created a sub report displaying open and close windows
- For EVAR and TEVAR cases that have not had a LTFU in past 18 months I contact the office to see if they can reattempt scheduling the patient prior to the 21 close window

# 58% completion in 2019 to 90% 2020-current close window

Procedure/treatment Date From   Procedure/treatment Date To

Procedure Type	Completion Rate
Carotid Artery Stent	67% (14/21)
Carotid Endarterectomy	67% (81/121)
Endo AAA Repair	86% (30/35)
Infra-inguinal Bypass	53% (20/38)
Open AAA Repair	67% (2/3)
Peripheral Vascular Intervention	54% (262/486)
Supra-inguinal Bypass	46% (6/13)
Thoracic and Complex EVAR	44% (4/9)
Overall	58% (419/726)

\*Denominator only includes submitted records.

Procedure/treatment Date From   Procedure/treatment Date To

Procedure Type	Completion Rate
Carotid Artery Stent	92% (23/25)
Carotid Endarterectomy	94% (102/109)
Endo AAA Repair	94% (34/36)
Infra-inguinal Bypass	92% (11/12)
Open AAA Repair	100% (1/1)
Peripheral Vascular Intervention	84% (71/85)
Supra-inguinal Bypass	100% (5/5)
Thoracic and Complex EVAR	71% (5/7)
Overall	90% (252/280)

\*Denominator only includes submitted records.

Procedure/treatment Date From   Procedure/treatment Date To

Procedure Type	Completion Rate
Carotid Artery Stent	100% (25/25)
Carotid Endarterectomy	91% (30/33)
Endo AAA Repair	83% (24/29)
Infra-inguinal Bypass	94% (17/18)
Peripheral Vascular Intervention	90% (194/216)
Supra-inguinal Bypass	100% (2/2)
Thoracic and Complex EVAR	83% (5/6)
Overall	90% (297/329)

\*Denominator only includes submitted records.

## Barriers that remain

- Particular to PVI- inability to submit for credit if claudication status is not documented
- I had read only rights to our EMR and depend completely on office to reach out to patients
- Currently, I only contact office with TEVAR and EVAR missing follow ups due to post covid staffing constraints



- IVC filter retrieval
- Infra and Suprainguinal bypass major complications

## IVCF: Filter Retrieval Reporting

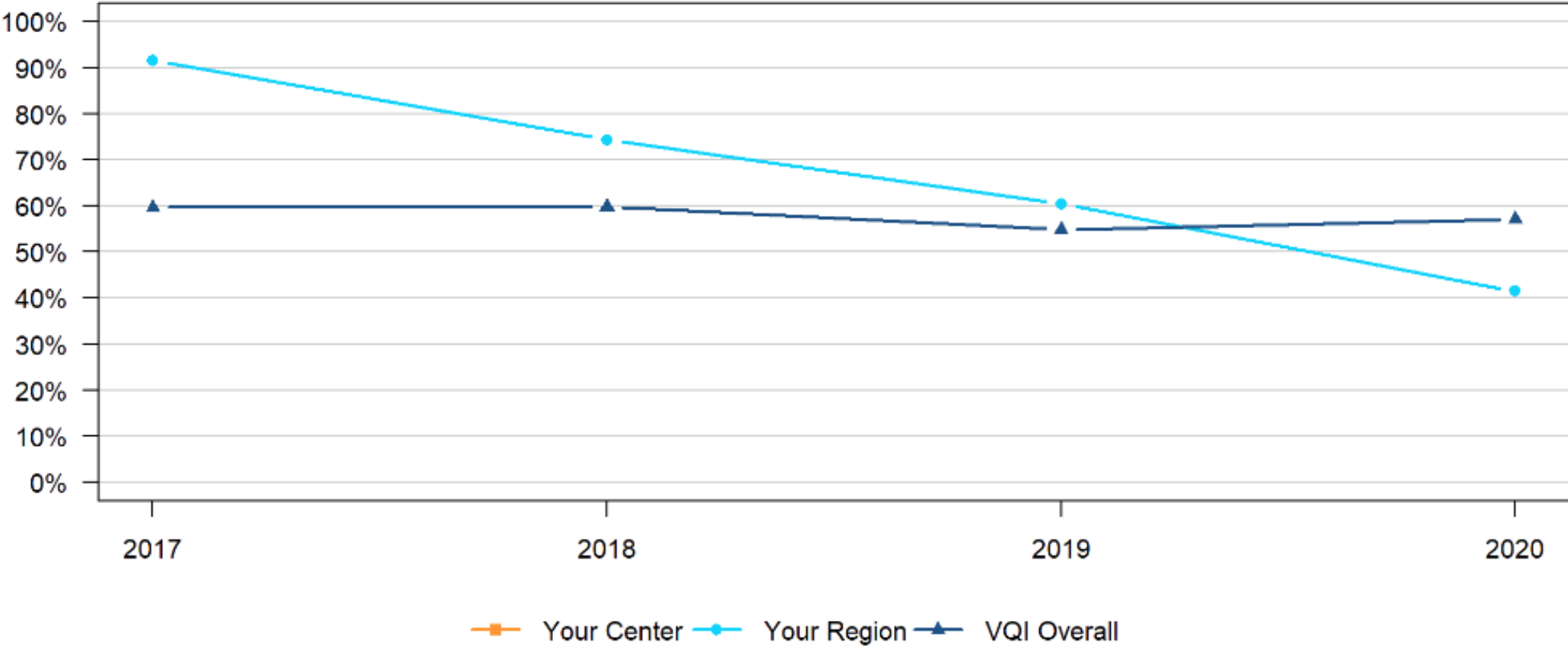
Procedures performed between January 1 and December 31, 2020

Includes Inferior Vena Cava Filter (IVCF) procedures. Excludes filters with permanent planned duration, patients who have expired, 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.

	Your Center	Your Region	VQI Overall
Number of IVCF procedures meeting inclusion criteria		70	943
Number without follow-up records		35	108
Number with follow-up records		35	835
Percentage with Filter Retrieval, or Attempt at Retrieval		41.4%	57.1%
Percentage not retrieved because No Follow-up Records Created		50%	11.5%
Percentage not retrieved because Not Clinically Indicated		2.9%	20.6%
Percentage not retrieved because Patient Declined		0%	2.1%
Percentage not retrieved because Lost to Follow-Up		0%	5.4%
Percentage not retrieved because Deemed Too Late for Removal		0%	0.4%
Percentage not retrieved because Planned Later Removal		5.7%	3.7%
Percentage not retrieved because No Reason Given		0%	0.5%

IVC Filter Retrieval Reporting by Year



## INFRA CLTI: Major Complications

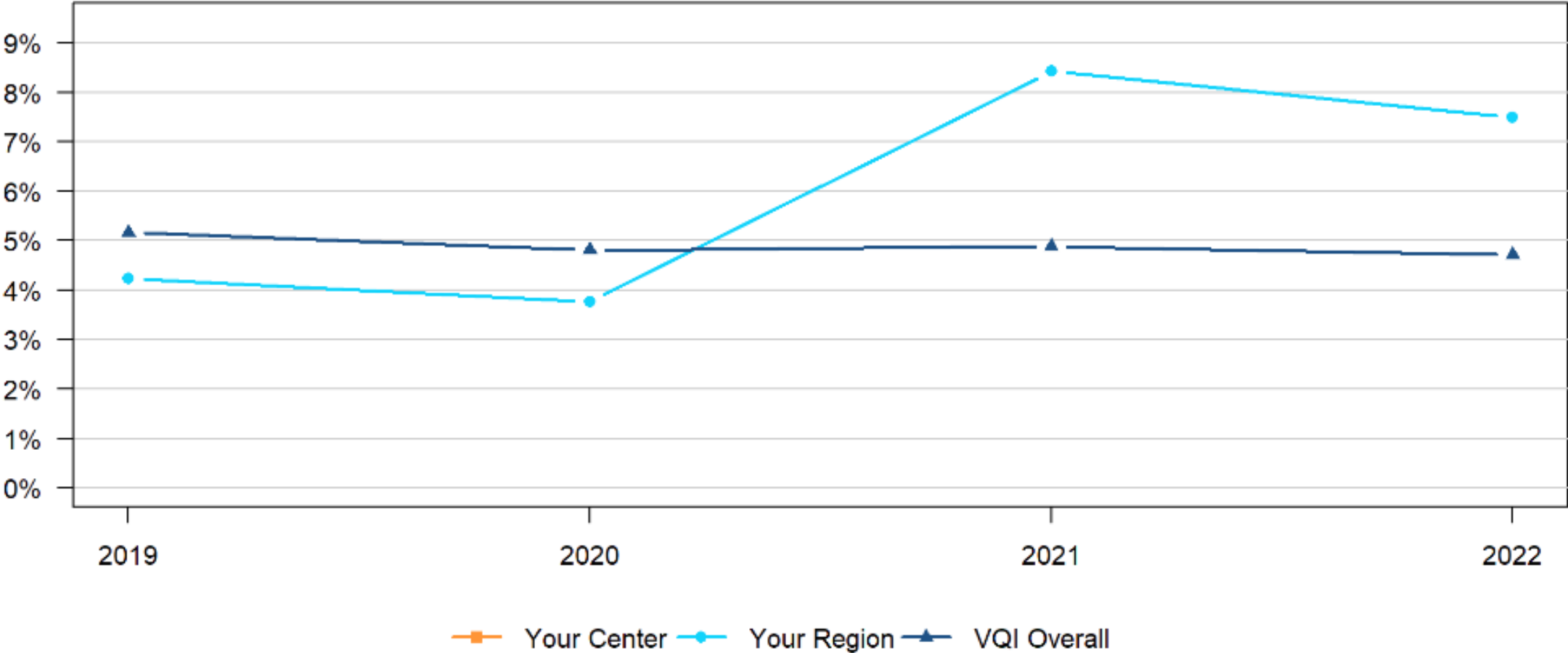
Procedures performed between January 1 and December 31, 2022

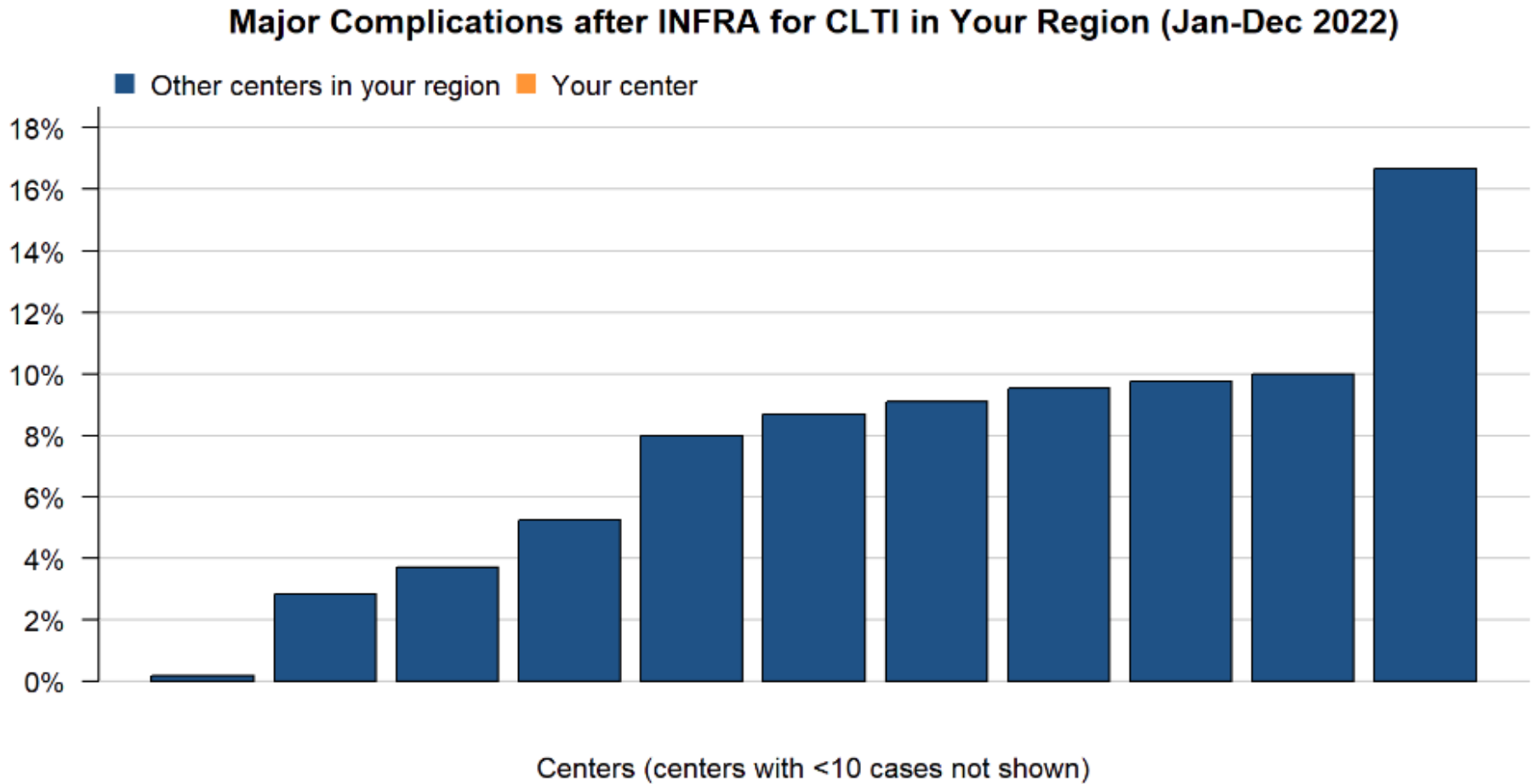
Includes Infrainguinal Bypass (INFRA) procedures for rest pain, tissue loss, or acute ischemia. Major complications are defined as in-hospital death, ipsilateral BK or AK amputation, or graft occlusion.

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.

	Your Center	Your Region	VQI Overall
Number of INFRA procedures meeting inclusion criteria		267	5203
Percentage with major complications		7.5%	4.7%

Major Complications after INFRA for CLTI by Year

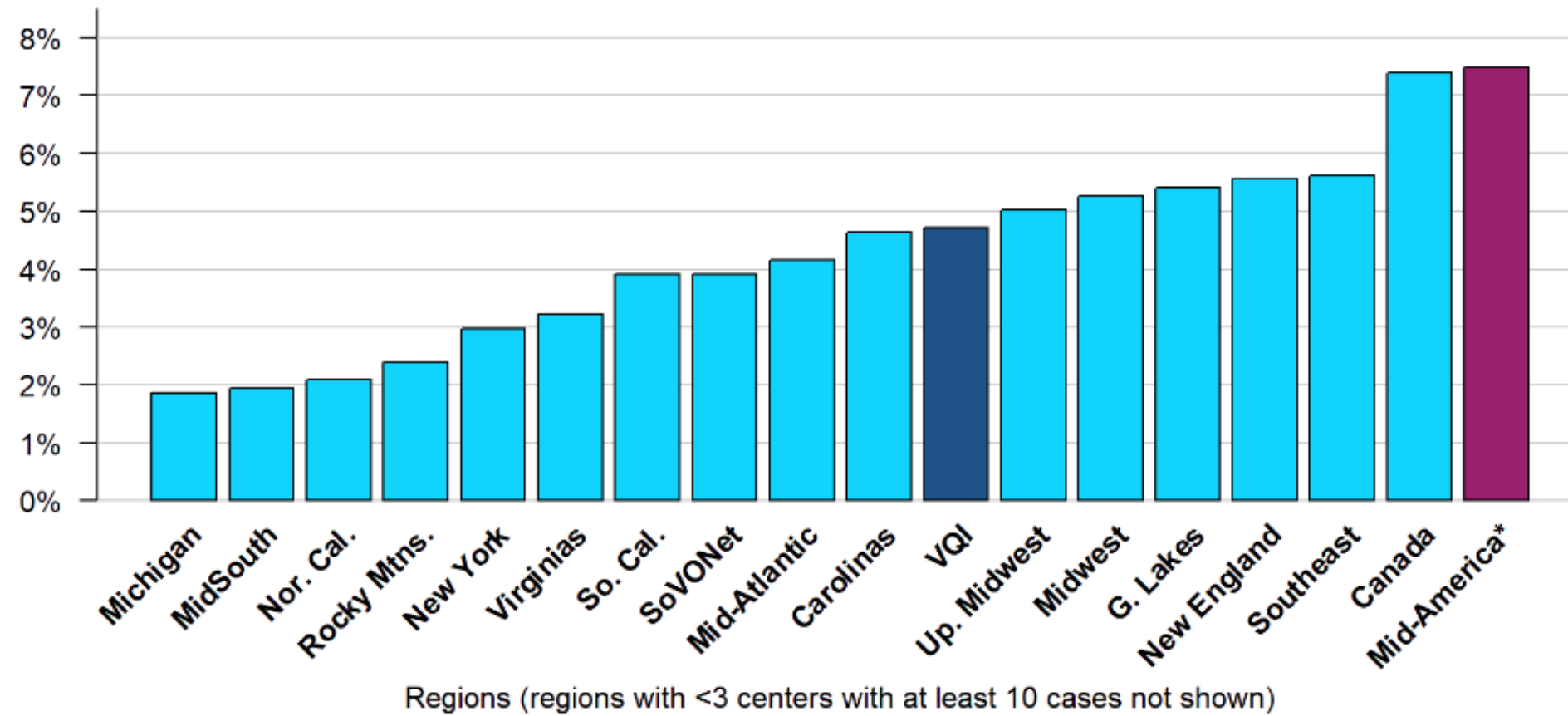




11 of 15 centers displayed

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

Major Complications after INFRA for CLTI by Region Across VQI (Jan-Dec 2022)



\*\* Indicates region's rate differs significantly from the VQI rate.

## SUPRA CLTI: Major Complications

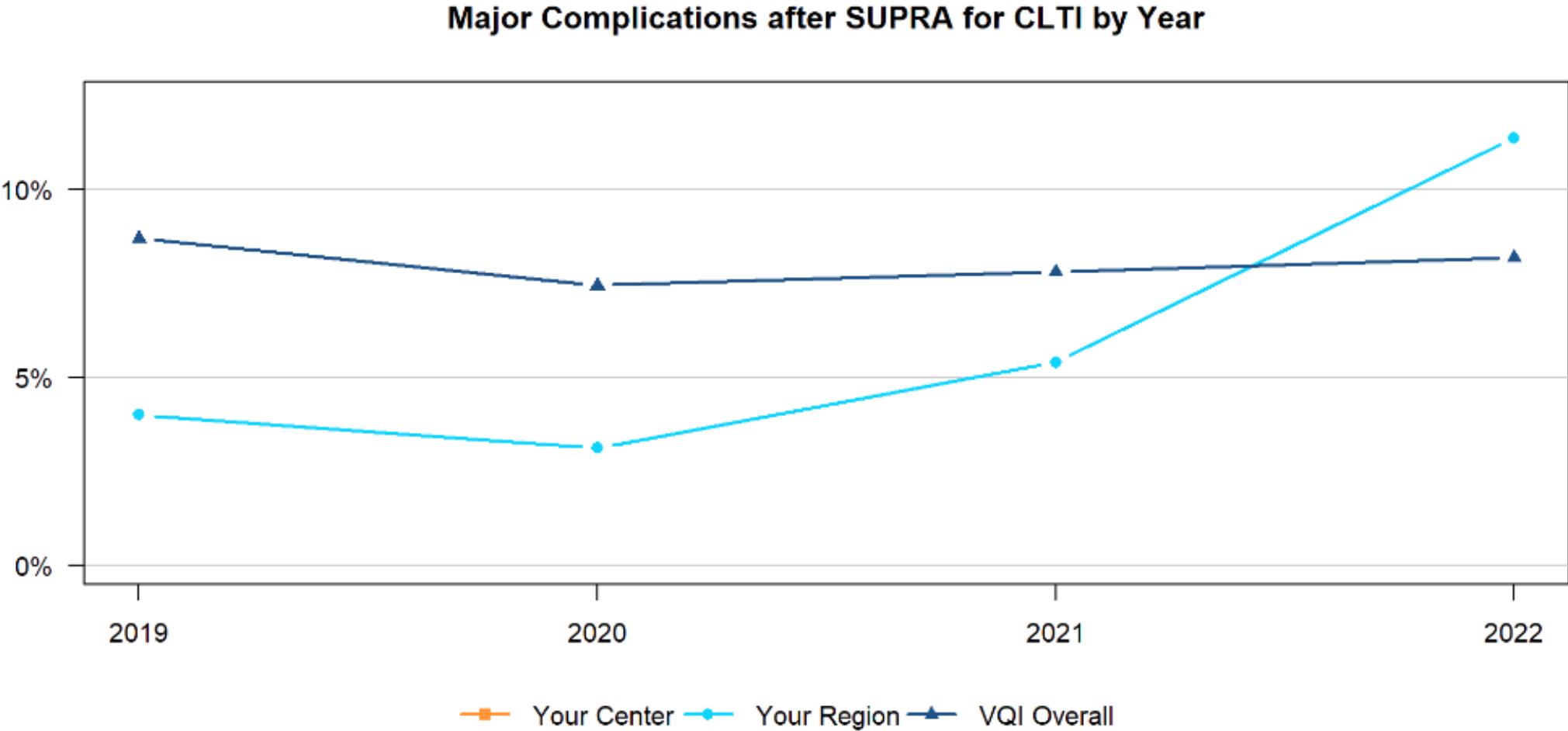
Procedures performed between January 1 and December 31, 2022

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.

	Your Center	Your Region	VQI Overall
Number of SUPRA procedures meeting inclusion criteria		44	1282
Percentage with major complications		11.4%	8.2%







## Enhanced Recovery Pathway for Lower Extremity Arterial Bypass (LEAB)



Ashley Vavra, MD, MS  
Assistant Professor  
Department of Surgery, Division of Vascular Surgery

# What is an Enhanced Recovery Pathway?

- Evidence based
- Standardization and process improvement – make it easy to do the right thing
  - Minimize variation
  - Protocols
  - Use of the EMR
- Minimize the stress of surgery
- Setting patient expectations

# What is an Enhanced Recovery Pathway?

	Traditional Pathway	Enhanced Recovery
BEFORE SURGERY	<ul style="list-style-type: none"><li>• Variable patient education</li><li>• Variable Pre-op eval</li><li>• Prolonged fasting</li></ul>	<ul style="list-style-type: none"><li>• Standardized education and pre-op evaluation</li><li>• Minimized fasting</li><li>• Preoperative carbohydrate load</li><li>• Opioid sparing pre-medication</li></ul>
DURING SURGERY	<ul style="list-style-type: none"><li>• Large volume IV fluids</li><li>• High dose opioids</li><li>• Variable SSI prevention</li></ul>	<ul style="list-style-type: none"><li>• Minimize IV fluids</li><li>• Opioid sparing strategy</li><li>• Standardized SSI prevention</li></ul>
AFTER SURGERY	<ul style="list-style-type: none"><li>• Variable timeline for progress</li><li>• Gradual diet introduction</li><li>• High dose opioids</li><li>• Large volume IV fluids</li><li>• Variable OOB expectations</li></ul>	<ul style="list-style-type: none"><li>• Standardized timeline for progress</li><li>• Immediate diet reintroduction</li><li>• Opioid sparing strategy</li><li>• Minimize IV fluids</li><li>• Structured OOB &amp; ambulation</li></ul>

# What is an Enhanced Recovery Pathway?



Decreased length of stay

Decreased complications

Improved patient satisfaction

Enhanced Recovery Pathway

Colorectal

Bariatric

Breast

Orthopedic surgery

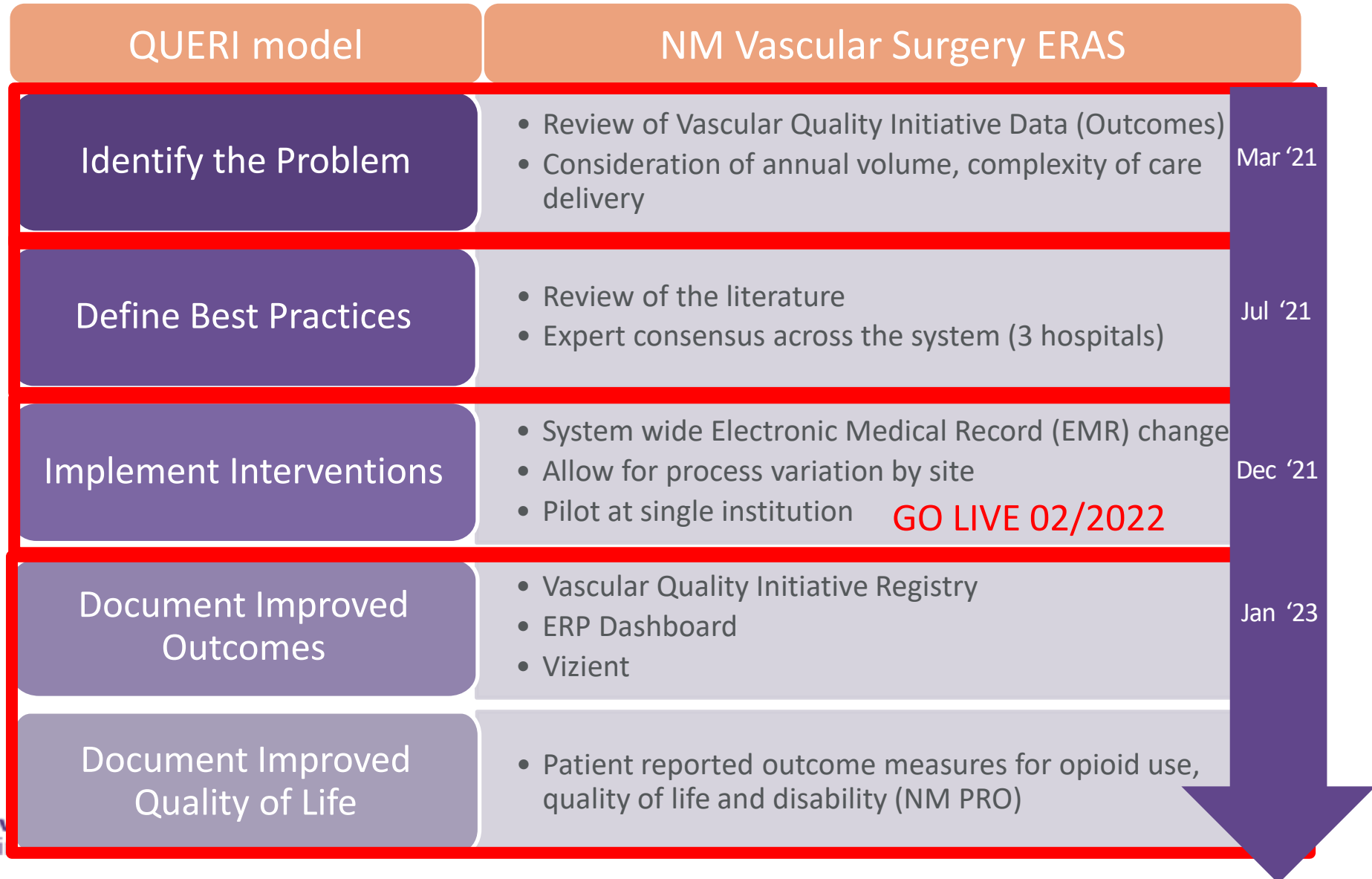
Urology

Cardiac

Gyne Onc



# Approach to ERP Implementation



# Why Lower Extremity Arterial Bypass?



- Review of VQI data demonstrates significant opportunity for improved outcomes
- NMH annual volume ~ 115
- Patients are primarily cared for by VS team at NMH

Category	Outcome/Complication	Your Center	Your Region	VQI Overall
Case Data				
	Number of Cases Reviewed	10	161	5375
	Median Postop LOS (days)	7	5	5 [3 4 5 6 7]
	Median Total LOS (days)	10.5	7	7 [3.5 5 7 9 11]
Postop Events				
	Wound Infection	10%	5%	2.7% [0 0 0 3.1 8.7]
	Graft Infection	0%	0%	0.2% [0 0 0 0 0]
	Any Transfusion (Pre/Intra/Post)	40%	36.6%	34.1% [7.7 20 35.1 50 60]
	MI	0%	1.9%	2.9% [0 0 0 4 8.3]
	CHF	0%	1.9%	1.5% [0 0 0 0 4.3]
	Stroke	0%	1.2%	0.6% [0 0 0 0 2]
	Change in Renal Function	10%	6.2%	5.2% [0 0 3.1 8 12.5]
	New Dysrhythmia	0%	3.7%	3.4% [0 0 0 5 9.9]
	Return to OR	30%	14.9%	15.8% [0 3.4 13.2 24 33.3]
	Ipsilateral Amputation	20%	17.4%	15.2% [0 6.5 14.3 20.6 33.3]
	Graft Patent at Discharge	90%	98.1%	98.3% [94.4 98 100 100 100]
Discharge Medications				
	Antiplatelet+Statin	100%	93.3%	87.1% [69.2 78.7 91.2 100 100]
Discharge Destination				
	Home	70%	64.6%	71% [50 61 71.4 80 90.4]
	Rehab Unit	30%	15.5%	15% [0 2.1 12.5 24.5 37.4]
	Nursing Home	0%	15.5%	10.8% [0 0 6.5 17.4 26.5]
	Other Hospital	0%	2.5%	1.4% [0 0 0 0 4]
	Homeless	0%	0%	0.1% [0 0 0 0 0]
	Dead	0%	1.9%	1.8% [0 0 0 2.1 5.5]

# Summary of Major Changes

## BEFORE SURGERY

- Standardized education and pre-op evaluation
- Minimized fasting
- Preoperative carbohydrate load
- Opioid sparing pre-medication

## DURING SURGERY

- Minimize IV fluids
- Opioid sparing strategy
- Standardized SSI prevention

## AFTER SURGERY

- Immediate diet reintroduction
- Protein supplementation
- Opioid sparing strategy
- Minimize IV fluids
- OOB POD 0, ambulate and PT/OT eval POD1
- Remove foley POD1



## Dashboard Elements

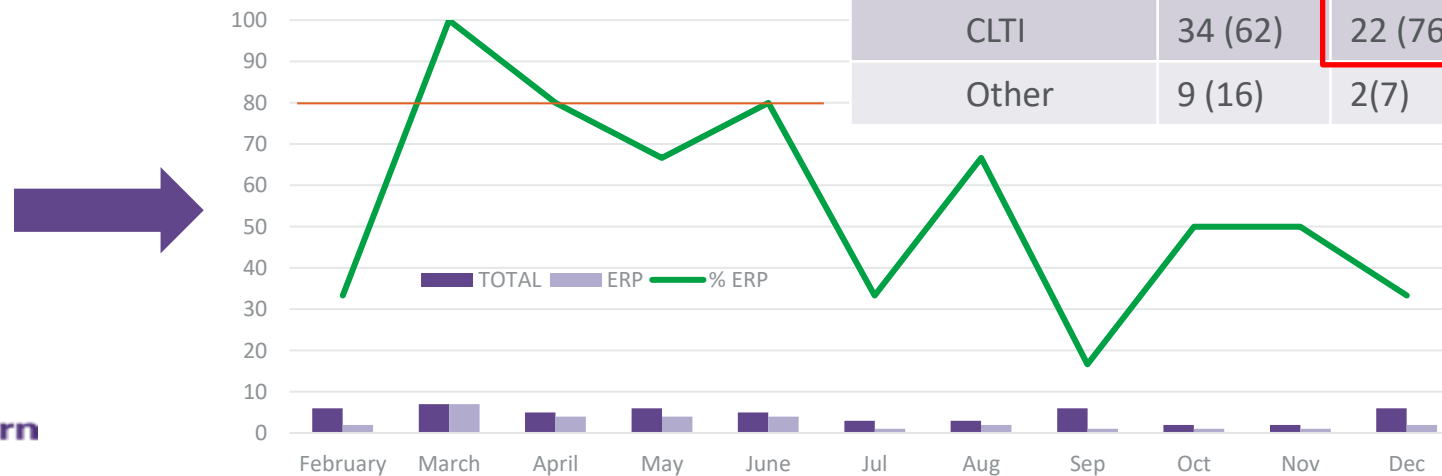
VQI and Vizient	EDW Dashboard/Getwell Loop
Length of stay	Patient Education
Transfusion rates	Minimize Pre-Op Fasting
Return to the operating room	POD1 Euvolemia
Bypass patency	Early Post-Op Diet
Unplanned amputation	Post-op multimodal Analgesia Rate
Medication adherence (ASA/statin)	Length of Stay
Discharge destination	Average Surgery Duration
Complications	Unplanned Readmission (%)
Infection	Average OR end to Discharge
Cardiac	<i>Frailty Assessment Complete</i>
Pulmonary	PROMs
Neurologic	Opioid Use Survey
Renal	PAD-specific QOL

# Why Lower Extremity Arterial Bypass?

\* p<0.05

	N (%)		
	ALL	ERP	No ERP
Volume	55	26 (47)	29 (53)
Avg Age	68	67	68
Male Sex	41 (75)	20 (77)	21 (73)
White Race	32 (58)	16 (62)	16 (55)
Avg BMI	28	28	28
Avg Preop Hgb A1C	7	7	7
BK pop/tibial target	41 (75)	19 (73)	22(75)
Procedure (min)	365	386	346

	N (%)		
	ALL	ERP	No ERP
Urgency *			
Elective	34 (62)	22 (76)	12(46)
Urgent	13 (24)	3 (10)	10 (39)
Emergent	8 (14)	4 (14)	4 (15)
Inpatient	31 (56)	12 (41)	19 (73)
Outpatient *	24 (44)	17 (59)	7 (27)
Indication *			
ALI	9 (16)	2(7)	7(27)
Claud	3 (6)	3 (10)	0
CLTI	34 (62)	22 (76)	12 (46)
Other	9 (16)	2(7)	7 (27)



# Outcomes



## Process Measures

	ERP	No ERP
Patient Education	23 (79)	5 (20)
Carb Drink	18 (62)	2 (8)
Preop Chlorhex	26 (90)	13 (50)
Drop Fluids POD1	29 (100)	22 (85)
PT/OT POD1	25 (86)	20 (77)
Early Diet	29 (100)	23 (88)

\*  $p < 0.05$

## Outcome Measures

	ERP	No ERP
Return to OR	4 (14)	7 (27)
Readmission	7 (24)	9 (35)
Total LOS	8.4	10.8
Postop LOS *	5.85	8.4

# Outcomes

## INFRA CLTI

Procedure Timeframe: January 1, 2022-December 31, 2022

Includes Infrainguinal Bypass (INFRA) procedures for rest pain, tissue loss, or acute ischemia.

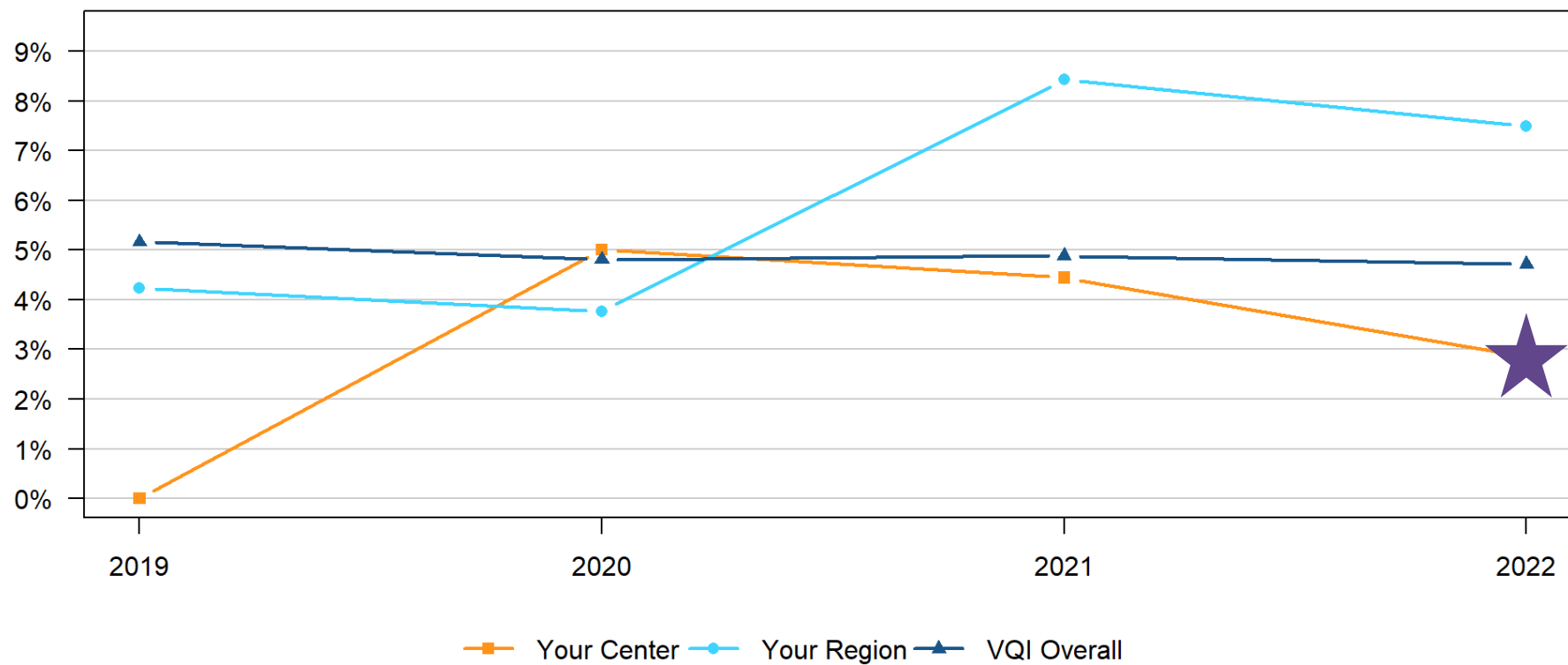


Legend: Blue = "Top" 25th percentile Coral = "Bottom" 25th percentile

Category	Outcome/Complication	Your Center	Your Region	VQI Overall
<b>Case Data</b>				
	Number of Cases Reviewed	35	268	5339
	Median Postop LOS (days)	6	7	5 [3 4 5 6.5 8]
	Median Total LOS (days)	8	10	7 [3.5 5 7 10 13]
<b>Postop Events</b>				
	Wound Infection	11.4%	7.5%	2.6% [0 0 0 2.8 6.7]
	Graft Infection	0%	0%	0.2% [0 0 0 0 0]
	Any Transfusion (Pre/Intra/Post)	40%	35.2%	33.4% [6.2 19 31.1 45.4 60]
	MI	0%	2.6%	2.6% [0 0 0 3.1 7.6]
	CHF	0%	1.5%	1.2% [0 0 0 0 3.5]
	Stroke	0%	0%	0.8% [0 0 0 0 2.8]
	Change in Renal Function	8.6%	7.5%	4.9% [0 0 0 6.2 11.5]
	New Dysrhythmia	2.9%	4.1%	3.1% [0 0 0 4.1 7.9]
	Return to OR	5.7%	30%	16.1% [0 4.9 11.8 22.7 33.3]
	Ipsilateral Amputation	20%	21.3%	16.8% [0 6.7 15.4 23.8 31.8]
	Graft Patent at Discharge	97.1%	90%	98.2% [94.7 97.9 100 100 100]
<b>Discharge Medications</b>				
	Antiplatelet+Statin	94.1%	93.7%	88.2% [68.1 81.8 90.9 100 100]
<b>Discharge Destination</b>				
	Home	54.3%	66.8%	68.5% [46.2 59 69.7 80.7 100]
	Rehab Unit	40%	19%	17.3% [0 1.3 12.1 27.1 40]
	Nursing Home	5.7%	12.3%	11% [0 0 5 17.4 30.3]
	Other Hospital	0%	0%	1.4% [0 0 0 0 3]
	Homeless	0%	0%	0.2% [0 0 0 0 0]
	Dead	0%	1.9%	1.6% [0 0 0 1.8 5]

## Outcomes

Major Complications after INFRA for CLTI by Year

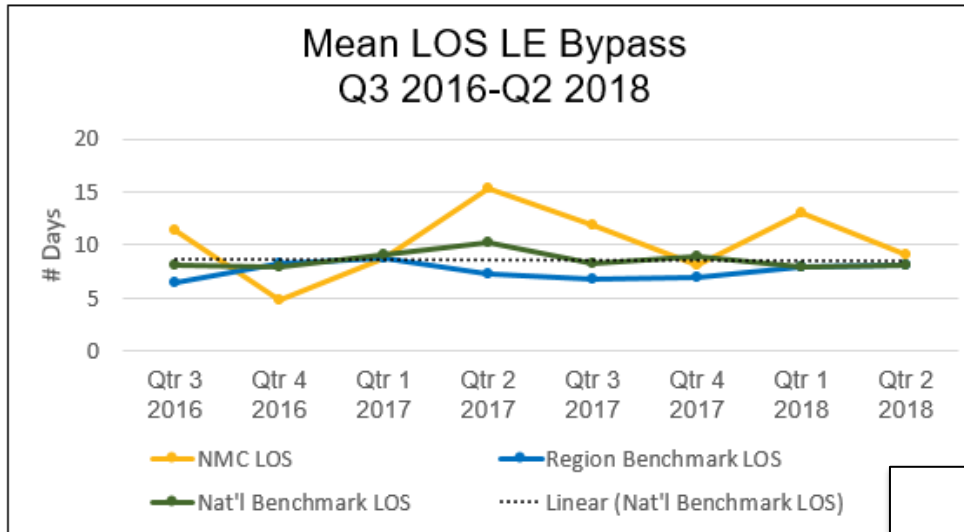


## Conclusions

- Enhanced Recovery is feasible in a PAD population for lower extremity arterial bypass
- Facilitators include institutional experience with and support of ERP
- Barriers include acute, inpatient cases

# LE Bypass LOS Overview

- Nebraska Medicine started participating in the Vascular Quality Initiative (VQI) Registry in 2016
- VQI data consistently showed Nebraska Medicine was about 2 days above the regional and national benchmarks



## PROJECT PROPOSED SOLUTIONS

Paralleled with Enhanced Recovery after Surgery  
Program at Nebraska Medicine (NERAS)

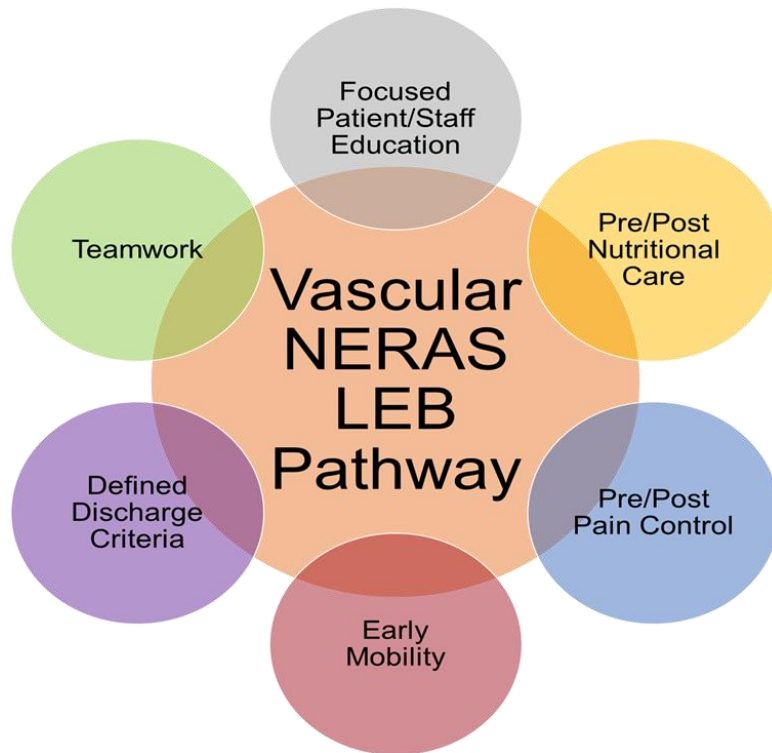
**Enhanced Recovery after Surgery**  
*Set of Guidelines and Practices for surgical patients before, during, and after surgery to achieve early recovery*

Critical Issues	NERAS
No Vascular Clinical Care Pathway	✓
No Standardized Criteria Defined for Discharge	✓
Lack of Staff Education Pre/Post Surgery	✓
Lack of Patient Education Pre/Post Surgery	✓
Inconsistent Team Communication	✓

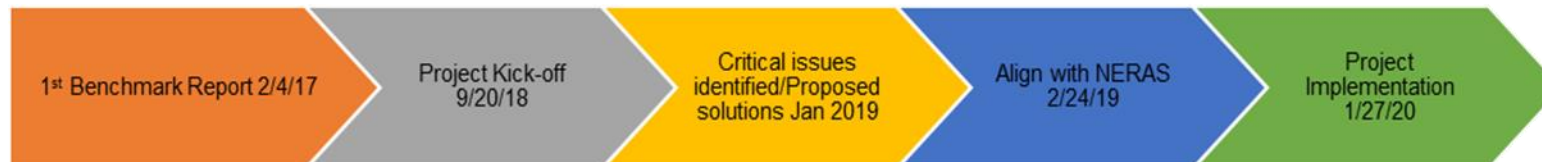


# Standardized Vascular Pathway

## Incorporated with NERAS Pathway

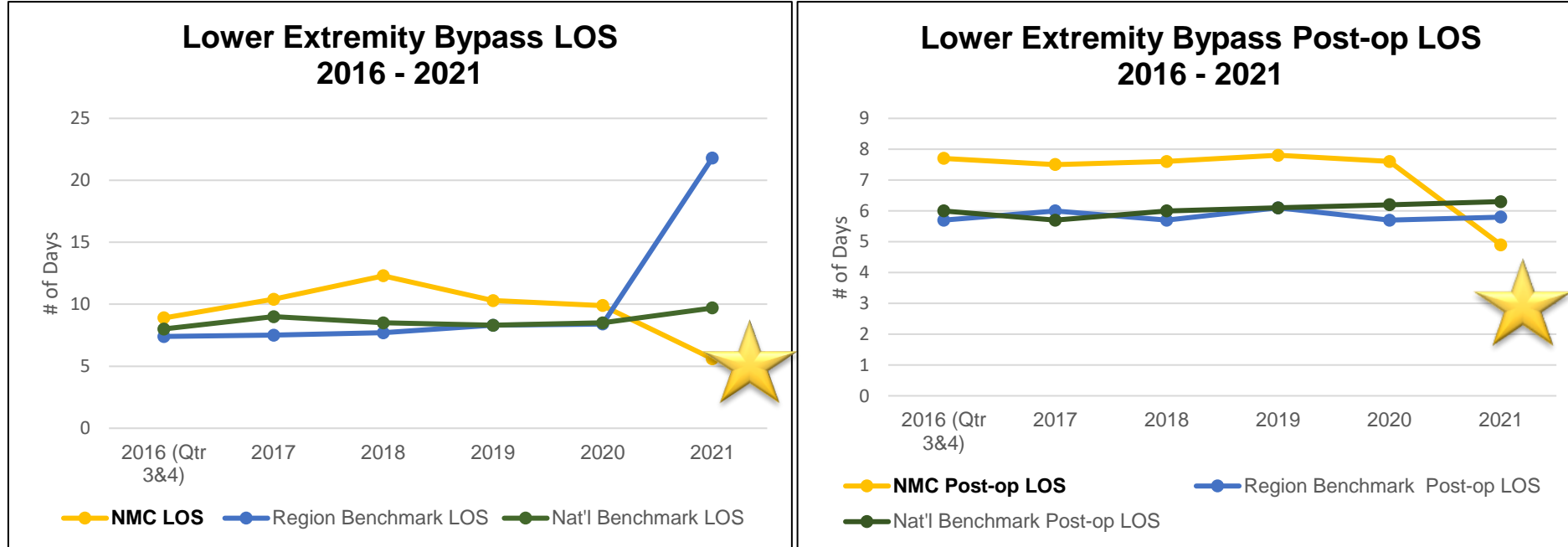


Project Data Element	Intervention
Nutrition	Carb loading drink Nutrition consult Additional Labwork
Pain Control	Lyrica and Tylenol to pre/post-op regimen
Infection	Post-op Antibiotic
Ambulation	Goal = Out of bed 8 hrs post procedure Ambulate QID Up in chair for all meals
Education	Staff Education Patient Education/pre-op packet
Discharge Planning	Radar Rounds Discharge Checklist Recovery Milestone Checklist





# Results

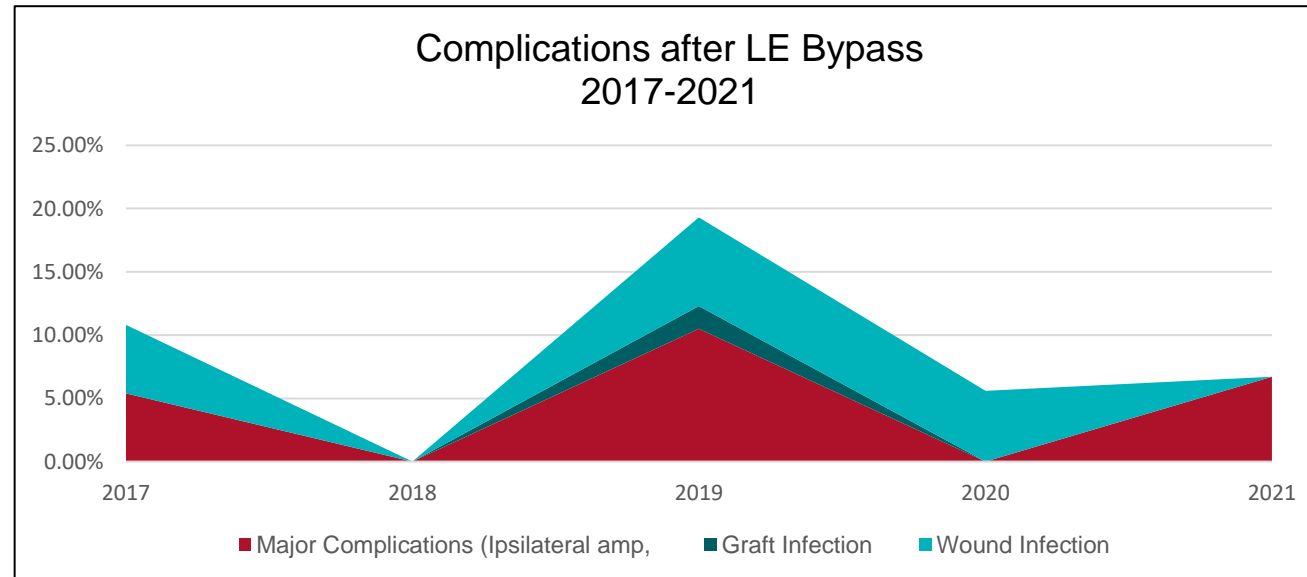


- Baseline established in 2017
- Incremental progress noted in 2019 prior to formal implementation
- Sustained improvement noted in 2020 despite increasing patient acuity and low volumes related to the pandemic
- Exceeded benchmark LOS for the first time in 2021

# Complication Data LE Bypass

- Major complications = in-hospital death, ipsilateral BK or AK amputation, or graft occlusion at discharge in patients with an indication of rest pain, tissue loss, or acute ischemia.

	2017	2018	2019	2020	2021
Major Complications	5.4%	0.0%	10.5%	0.0%	6.7%
Graft Infection	0.0%	0.0%	1.8%	0.0%	0.0%
Wound Infection	5.4%	0.0%	7.0%	5.6%	0.0%



## Tracy Campin – Lead Data Manager

**Are you interested in returning to a full day format?** (approx. 10AM-4PM with lunch. AM focused on data abstraction and management, PM focus on QI projects, outcomes, building collaborations)

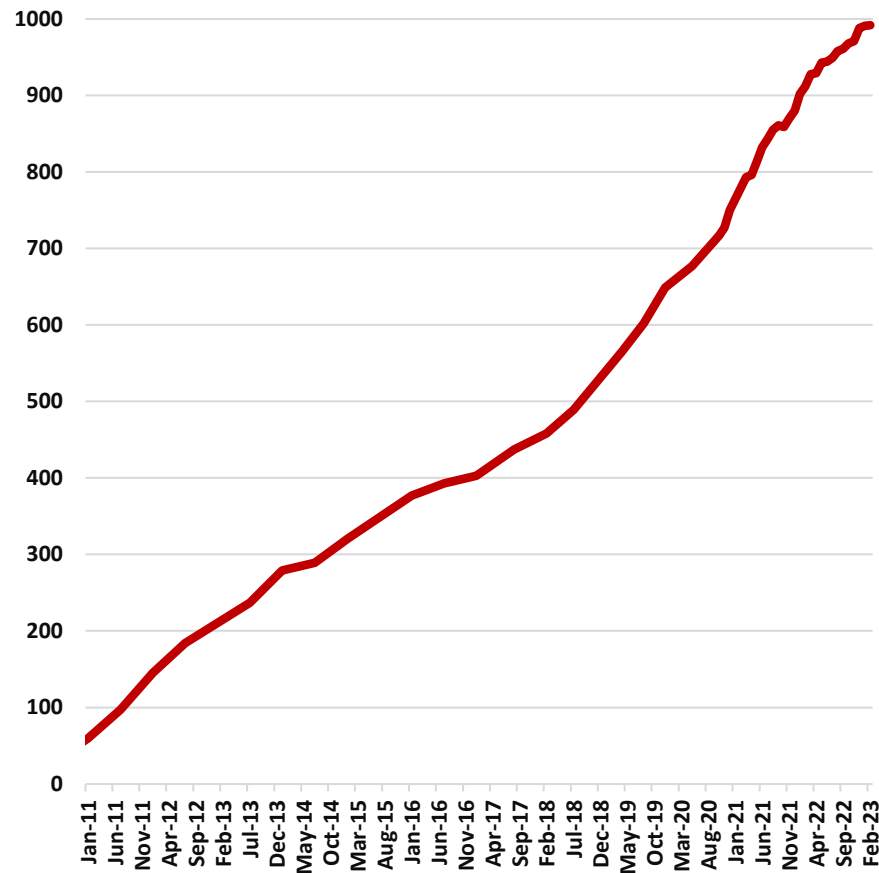
- Yes, at both fall and spring meetings
- Yes, at one of the two meetings
- No
- Maybe or not sure

# National VQI Update

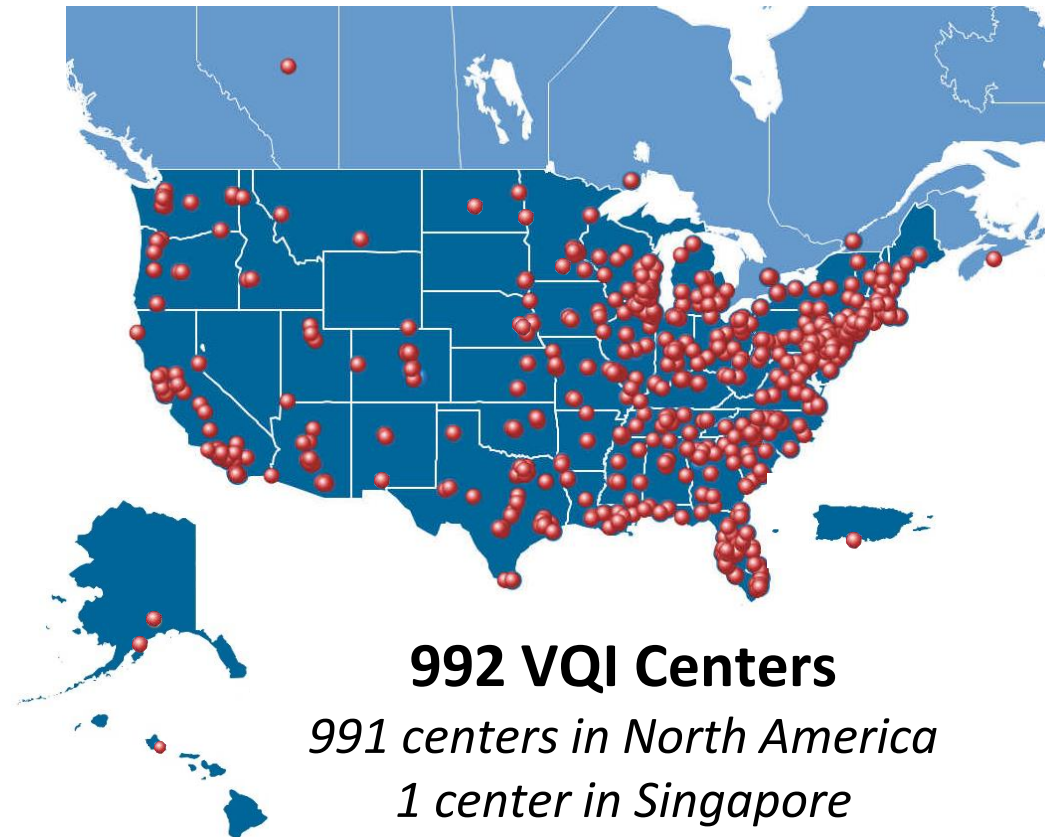
**Melissa Latus, BSN RN**

**SVS PSO Clinical Project Manager**

## Number of Participating Centers



## Location of VQI Participating Centers

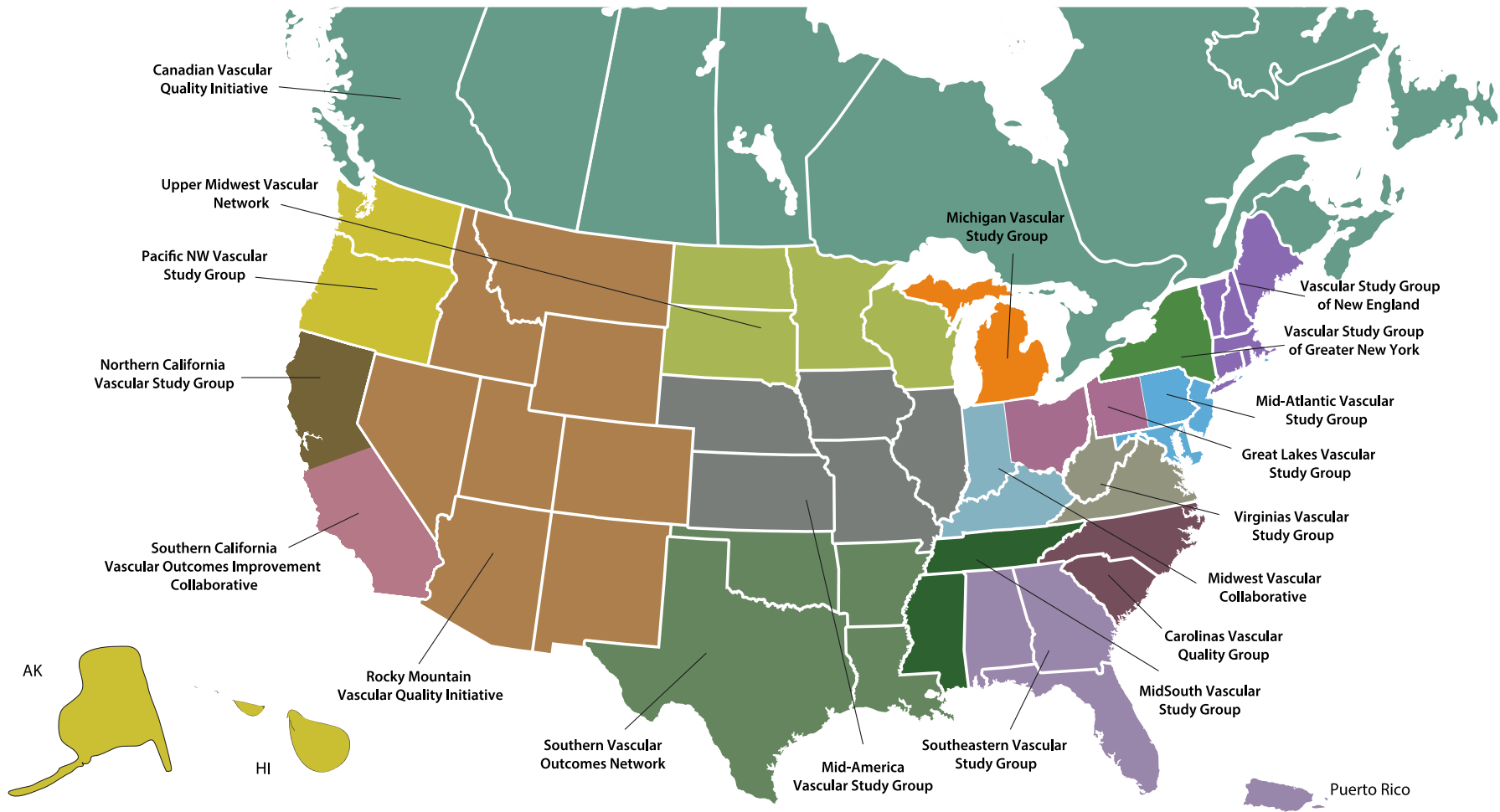


- SVS PSO recognizes need to reduce number of registry variables while maintaining balance between QI & research/publishing
- Work underway to decrease data entry burden
- Registry committees have begun reviewing variables
  - Possible variable retirement
  - Marking variables as mandatory versus **NOT** mandatory for record completion
- Variables required for reporting measures, industry projects & guideline/AUC recommendations will be taken into consideration
- Progress being made with data integration between EMRs & VQI. Updates provided at the VQI Annual Meeting



# 18 Regional Quality Groups

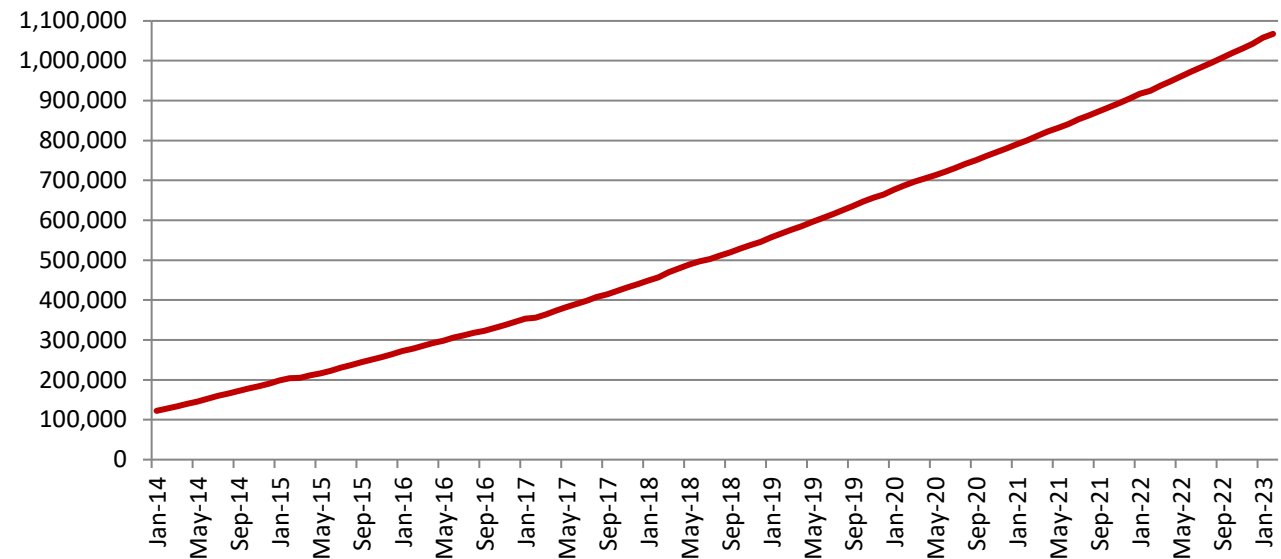
## 18 Regional Quality Groups





Total Procedures Captured (as of 3/1/2023)		1,066,834
Peripheral Vascular Intervention		367,998
Carotid Endarterectomy		190,201
Infra-Inguinal Bypass		80,201
Endovascular AAA Repair		79,316
Hemodialysis Access		75,770
Carotid Artery Stent		94,032
Varicose Vein		60,449
Supra-Inguinal Bypass		25,655
Thoracic and Complex EVAR		28,286
Lower Extremity Amputations		27,921
IVC Filter		18,184
Open AAA Repair		17,546
Vascular Medicine Consult		1,119
Venous Stent		156

## VQI Total Procedure Volume



Total Procedure Volume reflects net procedures added to the registry for the month

# Save the Date!

2023 VQI Annual Meeting  
June 13-14, 2023

Gaylord National Resort & Convention Center  
National Harbor, MD (outside **Washington, DC**)

2  
0  
2  
3

[https://www.compusystems.com/servlet/ar?evt\\_uid=805](https://www.compusystems.com/servlet/ar?evt_uid=805)



2023  
Vascular  
Annual  
Meeting™

National Harbor, MD • June 14-17



Society for  
Vascular Surgery



Society for  
Vascular Surgery

SVS Member Username/Password Help - Contact SVS Membership Department at 800-258-7188 or 312-334-2300. Non-Member and VQI Registrants are required to create an account.

Registration categories are auto assigned based on current membership status. Pay lapsed dues online at [www.vascular.org](http://www.vascular.org) to obtain member registration rates.

Start New SVS Registration



SOCIETY®  
VASCULAR  
NURSING

EMPOWERING NURSES THROUGH  
EDUCATION & COLLABORATION

Registration categories are auto assigned based on current membership status. Pay lapsed dues online to obtain membership rates. Please allow up to 72 hours for payment to be applied.

Start New SVN Registration



In collaboration with NCDR®

VQI Annual Meeting  
Registration allows for admission to VQI ONLY.

Start New VQI Registration

RPVI

RPVI Course  
Registration allows for admission to RPVI ONLY.

Start New RPVI Registration

# A Brand New VQI.org!

**SVS** | **VQI**  
In collaboration with NCDR®

ABOUT VQI REGISTRIES QUALITY IMPROVEMENT REGIONAL GROUPS PARTNERS & COLLABORATIONS DATA ANALYSIS & RESEARCH RESOURCES CONTACT / JOIN

Q

Improving the quality, safety, effectiveness and cost of vascular healthcare by collecting and exchanging information.

BEGIN YOUR SEARCH HERE.

Enter keyword or term to search...

Q

ABOUT THE VQI →

VQI REGISTRIES →

REGIONAL GROUPS →

QUALITY IMPROVEMENT →

https://staging.vqi.bytesco.site/about/

- The addition of 14 registry specific pages
- More robust search capabilities, so customers can easily get the information they need
- Clean presentation of content
- Consistent menu options for each of the 18 Regional Group Pages.
- Streamlined Members Only area

## Jeff Yoder – Statistician

- Start Date December 2022
- M.S. degree in Statistical Science from Indiana University
- Teaching assistant at Indiana University.



## Top Responsibilities:

Working with the PSO Analytics team on a variety of projects and initiatives.



- Infra/Supra Inguinal Bypass Revisions Live late March 30, 2023
- New National Quality Initiative Smoking Cessation to be announced at VQI@VAM
- Data Integrity Audit Program
- Risk Calculator
- Follow-up reports:
  - IVC Filter and Varicose Vein
- Coming soon:
  - Harmonization of CAD variables
  - Harmonization of Anticoagulation
  - Open AAA Registry Revision



- Data Integrity Audits have begun Spring 2023.
- The Carotid Artery Stent Registry - first to go live.
- Additional registries will be added on a regular basis.
- Data results will not be punitive; will be utilized to update training and help texts.
- Audits are being performed by a third-party vendor – Telligen.
- Audited records will be blindly abstracted by Telligen; then compared to the completed case in Pathways for matches.
- More information to come soon.
- All inquires should be sent to Melissa Latus. [mlatus@svspso.org](mailto:mlatus@svspso.org)

- In partnership with the American College of Surgeons
- Inpatient launch late March, Outpatient launch June
- Standards derived by SVS members; program is used to measure compliance w/standards
- Six National Quality Strategies to align organizational functions to drive improvement based on the aims & priorities of the Agency for Healthcare Research and Quality (AHRQ):
  - Measurement & feedback w/ required registry participation
  - Certification, accreditation, & regulation w/required facility regulation
  - Consumer incentives & benefit designs with thorough discussion of treatment options and consent
  - Health information technology, working with outside software for continuation of care
  - Innovation & diffusion with research
  - Work force development w/ the capability of resident training



- TASC/GLASS
  - Dr. Elizabeth Genovese, M.D.
- Varicose Vein
  - Dr. Jennifer Ellis, M.D.

Visit VQI.org for a full listing of all Educational video offerings

<https://www.vqi.org/registry-education-members-only/>

## REGISTRY EDUCATION WEBINARS

- VQI Educational Session – Vascular Medicine Consult (VMC)
- VQI Educational Session – Infra/Supra
- VQI Educational Session – PVI
- VQI Educational Session – EVAR
- VQI Educational Session – TEVAR/COMPLEX EVAR
- VQI Educational Session – CAS and CEA
- VQI Educational Session – Open AAA
- SVS VQI Infra/Supra Registry Revisions Webinar
- SVS VQI Educational Webinar – TASC/GLASS
- SVS VQI Education Webinar – TASC/GLASS Slides

Do you think your site would find value in participating in the SVS Verification program?

- Yes
- No

Do you think you will pursue participation in one or both of these programs?

- Yes
- No

**SPECIAL  
OFFER**

## Venous Stent Registry and Vascular Medicine Consult Registry Free Trial

For a limited time, SVS VQI is offering a **complimentary one-year trial subscription** to the VSR and VMC for an easily accessible first-hand experience of its value and ROI.

<https://mailchi.mp/5119b784e8d0/no-time-like-the-present>

To learn more about the Venous Stent Registry offer click here: [Venous Stent](#)

To learn more about the Vascular Medicine Consult Registry offer click here: [Vascular Medicine](#)

Or email [vqi@fivoshealth.com](mailto:vqi@fivoshealth.com) to contact an account executive.

- **A Vascular Quality Initiative frailty assessment predicts post discharge mortality in patients undergoing arterial reconstruction** Kraiss LW, Al-Dulaimi R, Allen CM, Mell MW, Arya S, Presson AP, Brooke BS.  
<https://pubmed.ncbi.nlm.nih.gov/35709866/>
- **Ankle-brachial index use in peripheral vascular interventions for claudication** Hawkins KE, Valentine RJ, Duke JM, Wang Q, Reed AB. <https://pubmed.ncbi.nlm.nih.gov/35276260/>
- **Assessing the quality of reporting of studies using Vascular Quality Initiative (VQI) data** Mirzaie AA, Delgado AM, DuPuis DT, Olowofela B, Berceli SA, Scali ST, Huber TS, Upchurch GR Jr, Shah SK.  
<https://pubmed.ncbi.nlm.nih.gov/35760240/>
- **Incidence of Procedure-Related Complications in Patients Treated With Atherectomy in the Femoropopliteal and Tibial Vessels in the Vascular Quality Initiative** Sanon O, Carnevale M, Indes J, Gao Q, Lipsitz E, Koleilat I.  
<https://pubmed.ncbi.nlm.nih.gov/35466788/>
- **Survival, reintervention and surveillance reports: long-term, center-level evaluation and feedback of vascular interventions** Fowler XP, Gladders B, Moore K, Mao J, Sedrakyan A, Goodney P.  
<https://pubmed.ncbi.nlm.nih.gov/36248241/>

- **Perioperative outcomes of carotid endarterectomy and transfemoral and transcervical carotid artery stenting in radiation-induced carotid lesions** Batarseh P, Parides M, Carnevale M, Indes J, Lipsitz E, Koleilat I.  
<https://pubmed.ncbi.nlm.nih.gov/34560219/>
- **Long-term implications of elective evar that is non-compliant with clinical practice guideline diameter thresholds** de Guerre LEVM, Dansey KD, Patel PB, Marcaccio CL, Stone DH, Scali ST, Schermerhorn ML.  
<https://pubmed.ncbi.nlm.nih.gov/34508797/>
- **Effect of postoperative antithrombotic therapy on lower extremity outcomes after Infrapopliteal bypass for chronic limb-threatening ischemia** Marcaccio CL, Patel PB, Wang S, Rastogi V, Moreira CC, Siracuse JJ, Schermerhorn ML, Stangenberg L. <https://pubmed.ncbi.nlm.nih.gov/35074410/>
- **The association between device instructions for use adherence and outcomes after elective endovascular aortic abdominal aneurysm repair** De Guerre LEVM, O'Donnell TFX, Varkevisser RRB, Swerdlow NJ, Li C, Dansey K, van Herwaarden JA, Schermerhorn ML, Patel VI. <https://pubmed.ncbi.nlm.nih.gov/35276256/>
- **Association of preoperative vein mapping with hemodialysis access characteristics and outcomes in the Vascular Quality Initiative** Fedorova E, Zhang GQ, Shireman PK, Woo K, Hicks CW.  
<https://pubmed.ncbi.nlm.nih.gov/34718099/>

# Regional Meeting CME/CE Credit



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.**

# CE/CME Meeting Attendance Credit

## **REMEMBER TO PSO:**

- **P**UT your FULL NAME in Zoom for remote attendees. Record of meeting attendance is required for CME/CE credit (no exceptions will be made)
- **S**END an email to [ljohnson@svspso.org](mailto:ljohnson@svspso.org) with names of group members that are sharing 1 device
- **O**FFICIALLY apply for CME/CE credit by clicking the URL or QR code provided here:





[https://dmu.co1.qualtrics.com/jfe/form/SV\\_cMG3Ei  
TtstdTpfU](https://dmu.co1.qualtrics.com/jfe/form/SV_cMG3EiTtstdTpfU)

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 2023

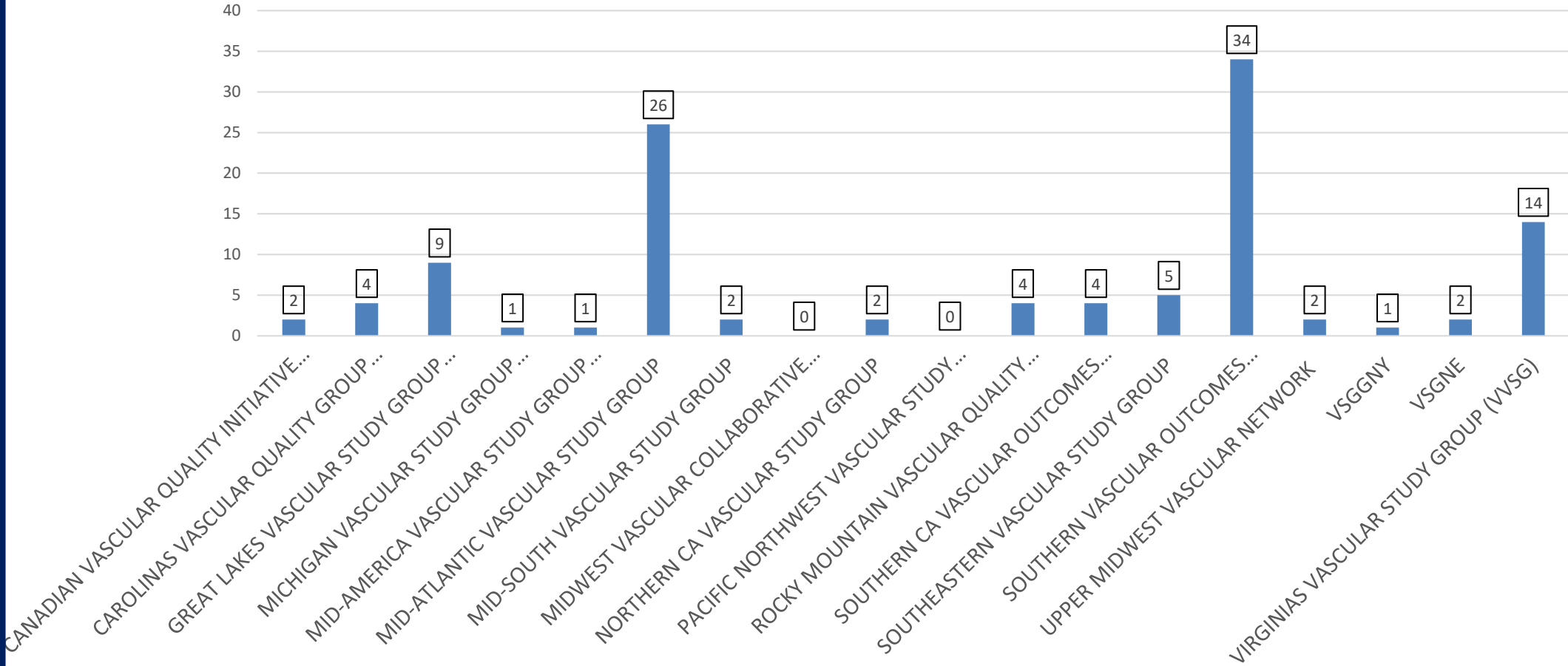


The following is a list of the four domains for the 2023 Participation Awards criteria:

- **Domain 1 – LTFU – 40% weighted**
- **Domain 2 – Regional Meeting Attendance – 30% weighted**
- **Domain 3 – QI Project – 25% weighted** 
- **Domain 4 – Registry Subscriptions – 5% weighted** 

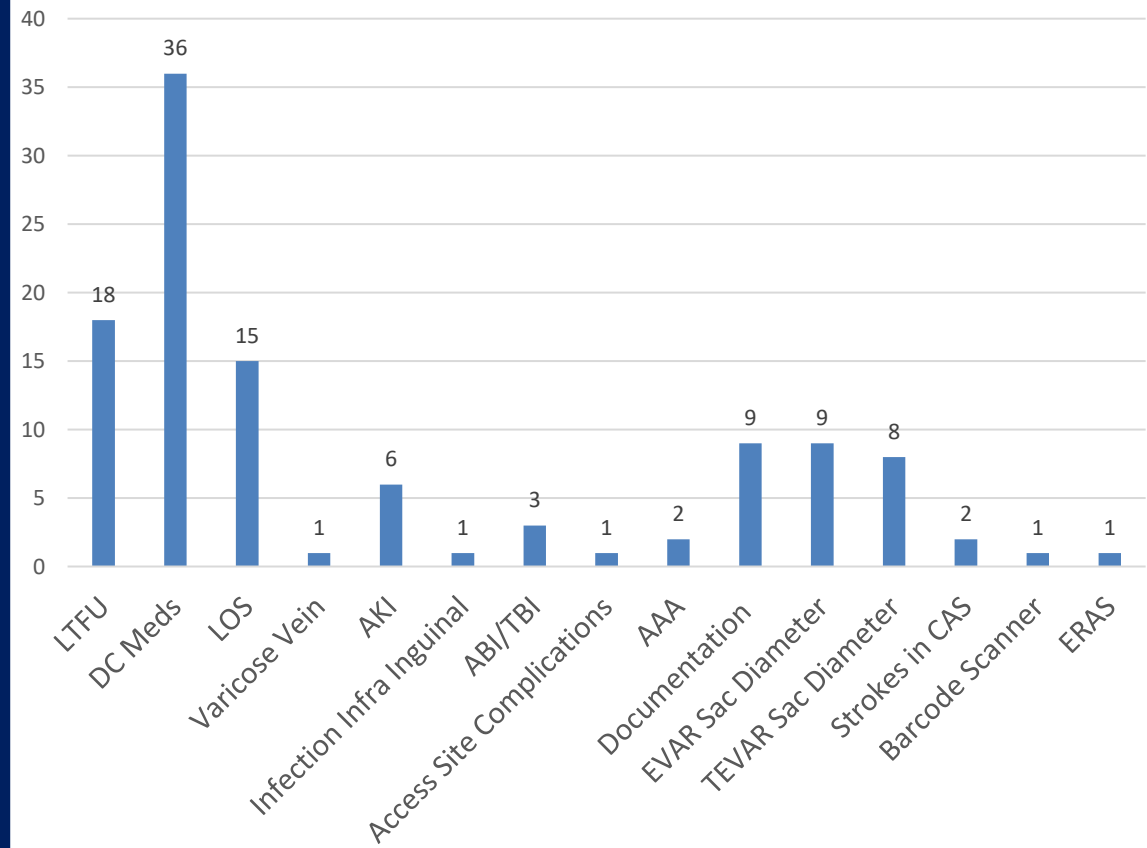
<https://www.vqi.org/quality-improvement/participation-awards/>

Regions with Charters n=113

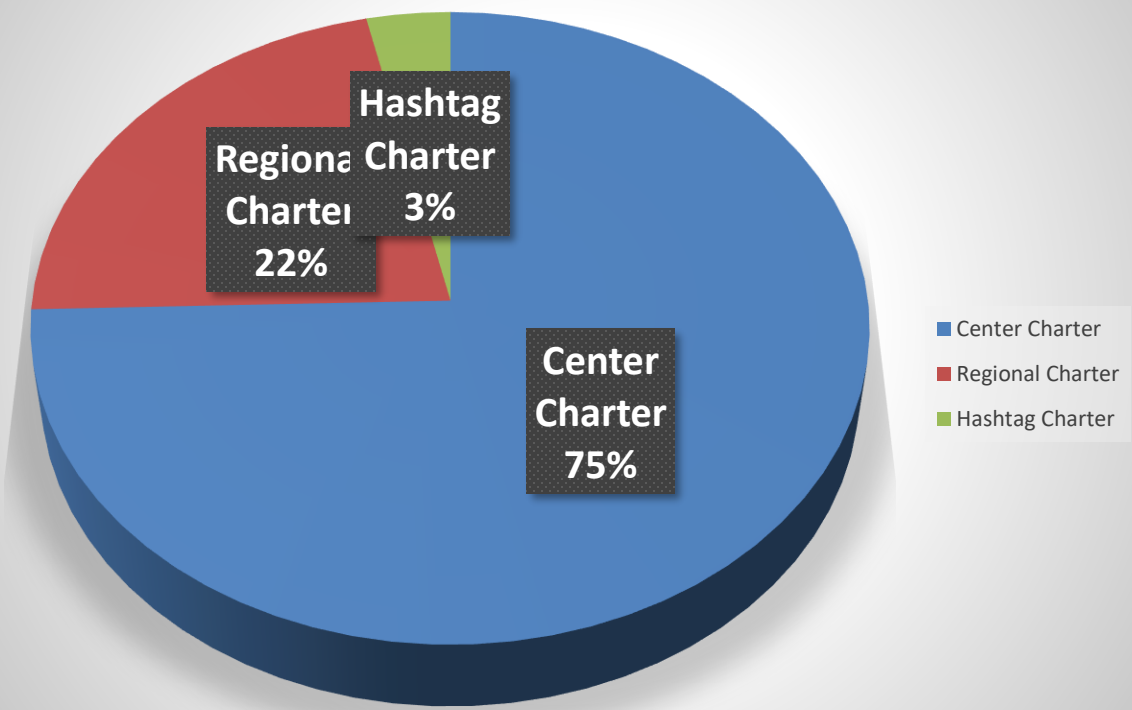


# Quality Improvement – Charter Breakdown

Charter Topics



Charter Types



- Quarterly Webinars (Charter and QI)
  - [www.vqi.org/quality-improvement-members-only/#upcoming-events](http://www.vqi.org/quality-improvement-members-only/#upcoming-events)
- Sample Charters
  - [www.vqi.org/quality-improvement/quality-improvement-tools/#qi-charters](http://www.vqi.org/quality-improvement/quality-improvement-tools/#qi-charters)
- Toolkits (VQI@VAM, Data Manager, LTFU)
  - [www.vqi.org/quality-improvement/quality-improvement-tools/#qi-toolkits](http://www.vqi.org/quality-improvement/quality-improvement-tools/#qi-toolkits)
- New improved VQI website
  - [www.vqi.org](http://www.vqi.org)
- 1:1 Calls
  - [bwymmer@svspso.org](mailto:bwymmer@svspso.org)

SVS Clinical Practice Guidelines

SVS | VQI

In collaboration with NCDR®

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Trainees & Students

Patients and Referring Physicians

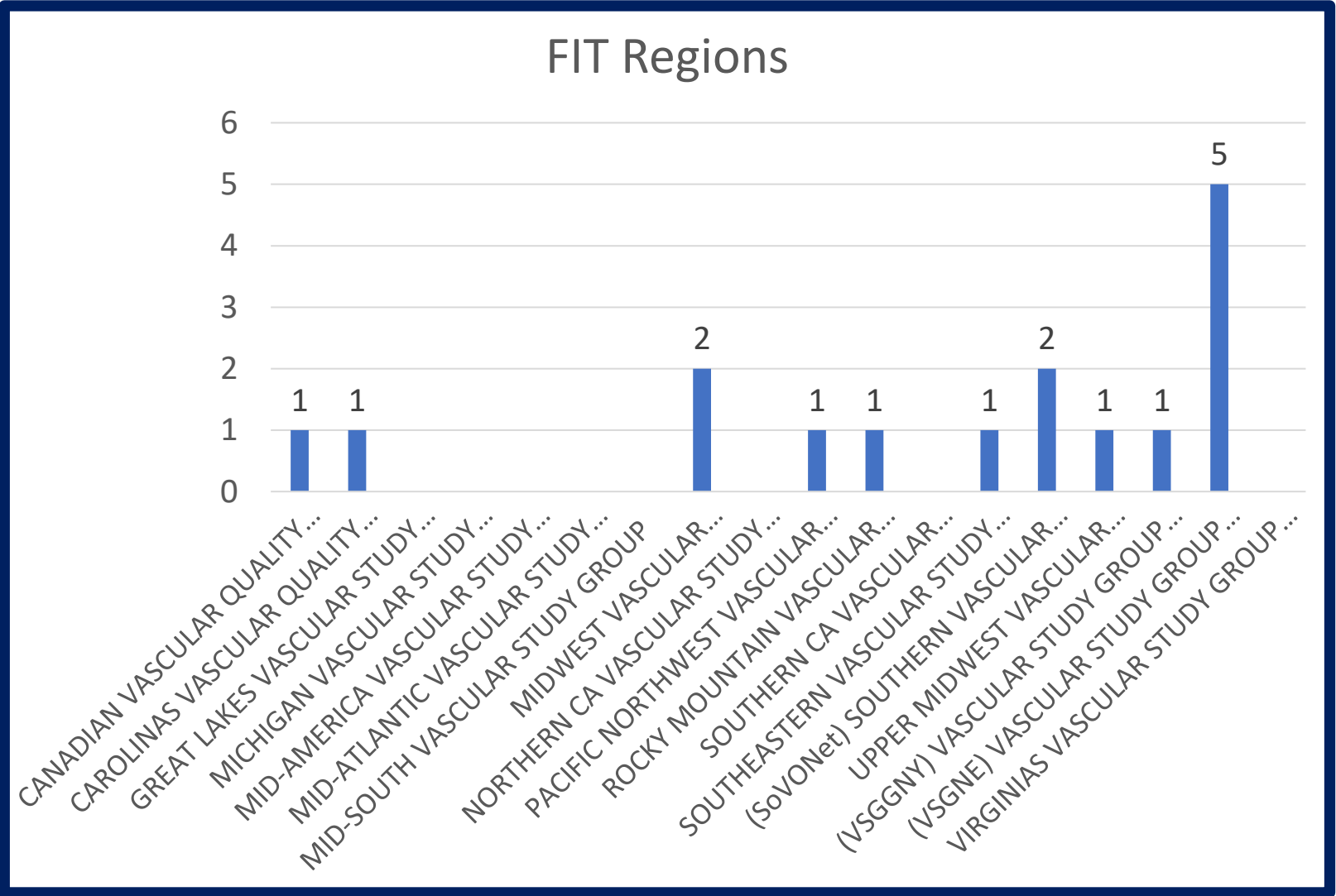
Home

Clinical Practice Guidelines

Enabling healthcare providers to select the best care for a unique individual based on patient preferences.

- Existing FIT Trainees Jack Cronenwett Scholarship Application
  - Applications accepted January 9 – February 28
  - FIT Committee Review March – April
  - Scholarship winners announced at VQI@VAM 2023
- FIT Trainee 2023 Applications
  - Applications accepted January 9 - February 28
  - FIT Committee Review April – May
  - FIT Trainees with FIT Mentors announced at VQI@VAM 2023
- FIT Mentors
  - Accepted at any time
  - Contact [bwymmer@svspso.org](mailto:bwymmer@svspso.org)
- [www.vqi.org/quality-improvement/quality-fellowship-in-training-fit-program/](http://www.vqi.org/quality-improvement/quality-fellowship-in-training-fit-program/)





# Arterial Quality Council:

**Trissa Babrowski, MD**



- Open AAA Major Revision
  - Will be renamed to accurately capture intent of the registry
  - Iliac to Left Subclavian
- Registry Committee updates
- Review Smoking Cessation and inclusion of vaping variables.  
Grp decided not at this time
- Introduction of the Data Integrity Program

# Venous Quality Council:

**Ravi Hasanadka, MD**

- Last Meeting February 22, 2023
- Re-engagement of the venous registry committees
  - Focus on new center recruitment
  - Review of current reporting
  - Brainstorming & discussion for addition of new reporting measures for bi-annual reports, Quarterly Dashboards and follow-up reports

# IVC Filter Follow Up Report

## IVC Follow-up Outcomes Report

1m ago



Procedure Date

Planned Filter Duration

2019/01/01 – 2021/12/31

is any value

2019/01/01 – 2021/12/31



Temporary



Permanent

Prepared for Demo Medical Center on 02/01/2023

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

### Follow-Up Rate

	My Center	My Region	All VQI
Cases with any follow-up	83.3% (5/6)	NA (<3 centers)	NA (<3 centers)
Cases with follow-up >= 9 & <= 21 ...	50% (2/4)	NA (<3 centers)	NA (<3 centers)
Cases with follow-up >= 9 & <= 21 ...	50% (2/4)	NA (<3 centers)	NA (<3 centers)

Fictitious Data

# Varicose Vein Follow-up Report

Varicose Vein Follow-Up Outcomes Report

22m ago

Procedure Date

2020/01/01 – 2022/12/31

2020/01/01 – 2022/12/31

Leg Treated

is any value

☐ Right only

☐ Left only

☐ Bilateral

Treatment Type

is any value

☐ Thermal\_RF

☐ Thermal\_Laser

☐ Mechanochemical

☐ Chemical

☐ Embolic adhesive

☐ High ligation and stripping

☐ Stripping

☐ Stab phlebectomy

☐ Trivex phlebectomy

☐ Open ligation

☐ Endoscopic ligation

Vein Type

is any value

☐ Truncal

☐ Perforator

☐ Cluster

Treatment Region

any value

Thigh

Calf/Ankle

Both

This report is a patient safety work product. It was created within the SVS PSO, LLC, and is considered privileged and confidential.

Follow-Up Rate

	My Center	My Region	All VQI
Cases with early follow-up 0-3 months	33.33% (2/6)	NA	NA (<3 centers)
Cases with late follow-up >3 months	33.33% (2/6)	NA	NA (<3 centers)
Venous ulcers patients with late follow-up >= 3 months	0.00% (0/6)	NA	NA (<3 centers)

Fictitious Data

- Melissa Latus is your PSO primary point of contact on the status or refresh request. [mlatus@svspso.org](mailto:mlatus@svspso.org)
- An **ACTIVE** pathways account & privileges to '*Share a File*' is required in order to receive your requested Blinded Data Set (BDS)
- Always included your RAC proposal number in any communications please.

# Arterial Research Advisory Council:

**Kamal Gupta, MD**

<https://www.vqi.org/svs-vqi-national-arterial-rac-schedule/>

- PSO Arterial RAC - April 2023 Proposal Submission
- Call for Proposals: February 28, 2023
- Submission Deadline: March 28, 2023
- Meeting: April 10, 2023
- 
- PSO Arterial RAC - June 2023 Proposal Submission
- Call for Proposals: May 2, 2023
- Submission Deadline: May 30, 2023
- Meeting: June 12, 2023
- 
- PSO Arterial RAC – August 2023 Proposal Submission
- Call for Proposals: July 4 ,2023
- Submission Deadline: August 1, 2023
- Meeting: August 14, 2023



## 194 Publications in 2022

- **Data Security:** All investigators/team members are responsible for security of datasets, which are only to be used for the project for which they were approved.
- **Dataset Access:** Investigators have free access to the datasets to which their center has subscribed, providing that their center has at least 50% Long Term Follow-Up for the registry data being requested. Please confirm that your center subscribes to the dataset(s) you wish to analyze before submitting your proposal.
- **Comparison of Specialties:** The SVS VQI is a multi-specialty registry, therefore the SVS PSO Executive Committee does not allow comparisons between specialties in submission topics.

# Venous Research Advisory Council:

**Kamal Gupta, MD**

# Venous RAC Update:

Created a separate Venous RAC in July 2020

[The Vascular Quality Initiative - National Venous RAC Schedule \(vqi.org\)](https://vqi.org)

2020: 3 proposals

- The impact of vein size on closure rate in treatment of the saphenous vein for venous insufficiency: **Jaime Benarroch-Gampel, MD**
- Comparison of complication rates of IVC filters based on anticoagulant and indication: **Emily Spangler, MD**
- Effect of Access Site Choice on Angulation of IVC filter and Impact on retrieval rates: **Khalil Qato, MD**

2021: 3 proposals

- Incidence of venous thromboembolic events (VTE) after endovenous ablation in patients with venous stasis ulcers (C6 disease): **Jaime Benarroch-Gampel, MD**
- Impact of Treatment Length and Treatment Region on Clinical Outcomes after Varicose Vein Procedures: **Halbert Bai, MD**
- Safety and efficacy of Endovenous ablation in patients with a history of DVT: **Mikel Sadek, MD**

2022: Proposals

- Impact of IAC Vein Treatment Center Accreditation on practice habits, utilization index, and patient outcomes: ProMedica Toledo Hospital
- Patient, Provider, and Geographical Factors Influencing Appropriate Use of Endovenous Ablation Therapy
- Outcomes following endovenous ablation therapy for obese patients with CEAP C2 and C3 venous disease

## National Venous RAC Schedule

Submissions are made separately to the National Arterial RAC and the National Venous RAC – see the schedule below and the link to Abstracts123: <http://abstracts123.com/svs1/>

(If you do not have a login for Abstracts123, you can create one through the same link)

### Bi-Monthly Schedule for National Venous RAC Proposal Submissions

#### May 2023

Call for Proposals: March 28, 2023

Submission Deadline: April 25, 2023

Meeting: May 8, 2023

#### July 2023

Call for Proposals: May 30, 2023

Submission Deadline: June 27, 2023

Meeting: July 10, 2023

<https://www.vqi.org/national-venous-rac-schedule/>

# Governing Council:

**Ashley Vavra, MD**

## Meeting November 18, 2022

- Quality Improvement Update
  - Smoking Cessation as a National Quality Initiative
  - 2022 ended with a record # of charters 113
- RAC Submission
  - 5 proposals per cycle from each institution
  - Once a center reaches 15 Arterial RAC proposals, faculty member will be expected to serve on RAC as an at large member
- Frailty variable development
- OBL Registry Refinement; enhanced value, reporting/reimbursement, ease data burden
- Discussion - Data burden within registry
  - Committee member engagement/expectations
  - Each Committee will have an associate chair
  - Enhance reporting measures
  - Review current variables; consider required fields; elimination of data variables

# Regional Leadership Update

# 2023 Fall Regional Meeting

- Wednesday September 6
- Minneapolis, MN (In conjunction with Midwestern Vascular Annual Meeting)



- Industry Supporters
  - Cook Medical
  - W.L. Gore
- CME/CE Accrediting Entity – Des Moines University
- Regional Membership Team



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