I. Welcome and Introductions: Dr. Joe Schneider

II. National SVS PSO update: Cheryl Jackson

- Current Stats:
  - 467 Centers, 46 States + Canada
  - 469,847 procedures as of 2/1/2018
  - 18 regional groups, including the newest one in Canada

- VQI@VAM:
  - Date: Wednesday, June 20, through Thursday, June 21, 2018
  - Place: Hynes Convention Center, Boston, MA

- VQI Approved by CMS as a 2018 Qualified Clinical Data Registry (QCDR)
  - MIPS Quality Component is 50% of the total MIPS score
  - VQI QCDR offers 25 measures

- Data Audits starting in 2018!!
  - Inter-rater reliability exercise
  - Random data audits
  - New PSO-Center Communication Tool for Data Cleanup

- 2018 Participation Award:
  - There will be 4 categories scored, each on a 0-6 point scale:
    - LTFU
    - Meeting attendance
    - QI project involvement
    - Number of registry subscriptions

- Educational Webinars:
  - February: Merit-Based Incentive Payment System (MIPS) for your Vascular Team
  - February: Starting a QI project
  - March: Validation
  - April: Audit Tool and Med Center Characteristics
  - May: Quality Improvement
  - June: VQI@VAM

- 2018 Registry updates:
  - Hemodialysis Access: Under major revision with release in 2018 (TBD)
  - Vascular Medicine Registry: Finalizing changes for release in 2018 (TBD)
  - 30-day Follow-up Measures
  - LTFU required fields
  - Varicose Vein: Under revisions to only collect data on treated leg (shorten the form)
Venous Stent Registry: Under development

PVI short form: Under development

Social Security Number needed in VQI:
- Including SSN in VQI:
  - Having SSN in the record purpose was originally to confirm pt identity. Now we are using it to query administrative databases to figure out whether or not pt is alive, has been seen in a different hospital, has received imaging, etc. The PSO has been approved legislatively to receive SSNs. W/ a SSN, the VQI can run checks against the SS death index, and find out if the pt died. If pt is a Medicare pt, we can find out if pt was admitted to a different hospital with the dx of stroke. For example, clinicians are unable to view SSNs at UoU. Only about 50% of VQI hospitals are entering valid SSNs. The next iteration of participation awards will involve the inclusion of the SSN. They really need the full number. The Medicare number is sometimes the SSN. They are working on discovering the value of the last 4 digits. Medicare needs all digits. SS death index just needs last 4.

III. Arterial Quality Council update:
- Finalizing Common Variable select options and helptext amongst registries where applicable
- Completing all “missing helptext”
- Clinically reviewing all helptext to site scientific support where applicable
- 30 day variables for all registries are being reviewed
- LTFU required fields are complete and M2S is in the process of development for 2018 release
- Physician and Center Dashboards: Physician and center stats on critical outcomes by registry over the past year, including regional and VQI benchmarks. First physician reports delivered in February and will be updated in fall. Center-level dashboards planned for June.
- Comparative COPI Reports: We will update prior COPI reports with new data to check centers’ improvement. EVAR LOS planned for May, INFRA LOS for August and INFRA SSI in September.
- National QI Initiative Updates: Reports will be issued quarterly starting in March tracking centers’ progress on Discharge Medications and Follow-Up Imaging After EVAR.

IV. Presentations:
- Results of Carotid Endarterectomy in Patients with Contralateral Internal Carotid Artery Occlusion from the SVS VQI. Joe Schneider, MD
- QI Project using our experience with the SVS VQI Audit. Cynthia Bik, BSN
V. **Venous Quality Council update:**  
- Varicose Vein Appropriateness Project  
- Development of NEW Venous Stent registry

VI. **Research Advisory Council update:**  
- **National Research Process:**  
  Projects are reviewed on a quarterly basis. There are 2 levels of approval. Regional and National. Go to VQI website and pull a list of the approved projects to prevent duplication. Approved projects have a time limit, 2-3 years max to accomplish, then others can work on that topic.

VII. **Regional Medical Director** – During the Fall 2017 meeting, Joe Schneider, MD stated he would not seek re-election as Reg. Med. Director. Joe has been MAVSG Medical Director for the last six years (since the beginning of MAVSG). Emails went out for nominations. Dr. Chew and Dr. Ebaugh of Iowa Heart were nominated as co-directors. Both agreed to be nominees. Both were elected as co-directors for the MAVSG. Thanks to Joe Schneider, MD for his leadership for the MAVSG.

**MAVSG RAC Chair** – Andy Hoel, MD is stepping down as RAC chair. Ryan (Nick) Nolte, MD of OSF was nominated and elected as Regional RAC Chair.

**Regional Lead Data Manager** – Cynthia Bik, RN is replacing Cheryl Jackson as Regional Data Manager. Cynthia reminded data managers to update their users in the Pathways registry. Cynthia provided a detailed presentation of “QI Project using our experience with the SVS VQI Audit”, which she gave a quick review to the full group.

VIII. **SVS PSO Governing Council Meeting at VEITH:**  
Last year SVS program committee discovered errors in blinded datasets prepared for research. Reviewed all of the blinded data sets internally. Internally consistency for what was entered into VQI vs. what was coming out of the datasets. Found definition errors, coding errors, etc. 160 million data points. 400k pts. No errors in key outcome variables. Have developed new quality control measures.

IX. **VQI Approved by CMS as a 2018 QCDR:**  
VQI meets quality improvement requirements for MIPS. We can only do it at the physician level and it is attached to your NPI. Does your institution do this for you already? Those in private practice would benefit from doing this through SVS VQI. The cost is about $599 per physician.

X. **Regional Report Highlights:**  
- Region’s LTFU(81%) is higher than the VQI (71%). Great job to Northshore Hospital for being on top  
- Region’s D/C Medications rate is slightly higher than VQI overall rate which is 80%  
- Region’s Hemodialysis Access: Percentage of Primary AVF vs. Graft is lower (72%) than the VQI overall (81%). Comments – Autogenous veins are better to start with than a
Some physicians are using liposuction of the arms to make veins or grafts easier for access.

- Carotid Artery Stent: Stroke or Death in Hospital is about even 1.5 vs. 1.6%
- Carotid Endarterectomy: Stroke or Death in Hospital: MAVSG at 1.1 vs. VQI at 1.3%
- Carotid Endarterectomy: LOS>1 day: MAVSG at 23% vs. VQI at 24%
- Region is lower for Endovascular AAA Repair: Percentage of Patients with LOS>2: MAVSG at 10% vs. VQI at 14%
- Region is higher for EVAR: Sac diameter for LTFU: MAVSG at 63% vs. VQI at 54%.
  Discussion around sac diameter measurement. Decision was that the surgeon should measure sac diameter for self, because different specialties measure diameters differently.
- Infrainguinal bypass: Percentage of Procedures with Chlorhexidine or Chlorhexidine+Alcohol Skin Prep: MAVSG at 89% vs. VQI at 87%
- Infrainguinal Bypass: Rate of Major Complications MAVSG at 3.5% vs. VQI at 5.1%
- Region is significantly higher for IVCF: Percentage of Temporary Filters With Retrieval or Attempt at Retrieval: MAVSG at 73% vs. VQI at 39%
- Region is higher for Lower-Extremity Amputation: Rate of Post-op Complications: MAVSG 25% vs. VQI 19%
- Region is higher for Non-Ruptured Open AAA: In-Hospital Mortality: MAVSG 10.4% vs. VQI 3.9%
- Region is significantly lower for PVI: Percentage of Percutaneous Femoral Procedures Using Ultrasound Guidance MAVSG 31% vs. VQI 74%
- Region is higher for PVI: Percentage of Claudicants With ABI or TBI Reported Before Procedure: MAVSG 82% vs. VQI 76%
- Region is slightly lower for Supra-Inguinal Bypass: Rate of Postop Complications: MAVSG 24% vs. VQI 26%

XI. **Ideas for discussion at next meeting:** MAVSG By-Laws. The By-laws are being revised by the PSO and distributed in June. One item that was brought up is the statement pertaining to the RAC chair being listed on every article that uses VQI data.

XII. **General discussion:** To be taken back to the PSO and M2S:
  - Like the Center level dashboards. Would like to see it on the regional dashboard.
  - Want the reports in PDF format. The current format is impossible to print.
  - Help Text – need specifics with measuring sac diameter.
  - TVAR – Do dissections still get sac diameter measurements?
  - How is SVS keeping membership informed of practice guidelines?
    - Answer – The SVS published the AAA guidelines in the JVS, they publicized in The Pulse, VQI publicized it in The VQI News and probably email notification.
  - CAS/CEA with CABG cases - Will centers be able to go in and change cases that were entered that should have been excluded?
    - Answer – Carrie will be running a report so see how many cases are questionable and contact those centers to verify that the cases were actually concomitant or not. Cases will be deleted accordingly.
• Would like this question to go to the AQC – Post-op ABIs should not be assessed in the hospital, but during the first post-op visit. Some insurance companies won’t cover in-hospital ABI’s, however to wait to collect ABI's with the first post op visit may create a burden/delay collecting the data and may not be the intention of the original question in the module for that hospitalization/surgery.

• Ultrasound guidance metric should include EVAR, not just PVI.

• Concern from data managers regarding slow response time from Pathways to answer questions. The FAQs hasn’t been updated in over a year.

• By-laws statement pertaining to the RAC chair being listed on every article that uses VQI data.

“Fall Meeting”:
Fall Meeting in conjunction with MWVVS -September 12, 2018 in St. Louis, MO. Details to come.