SEVSG Spring 2019 Meeting Minutes

Thursday, March 21, 2019 – BayCare Morton Plant Hospital, Clearwater, Florida

BayCare intro: mission statement, multi hospital not for profit system

National VQI update:

QCentrix auditing QCentrix centers – discussion about implications of that, possibility of other auditors – alt company name to be sent to Dr. Duwayri- 8-9 cases per system across all registries, on site vs remote access, BBA agreement required, build into future contracting? Since data is being used for CMS/FDA for billing (ie stroke rates in VQI very low compared to other registries & clinical trials and we're using that data to get CMS approval & bill for TCAR) we need to make sure it's accurate, hence audit; also a frequent request of paper reviewers

Access to physician specific data across systems (not just by center) for administrators – form available from Pathways – benefits and drawbacks of being a PSO vs non-PSO

Participation awards – contact Dan if you think participation points are incorrect, certificate given to UF for 3 stars in our region

AQC update: (no VQC update available at this meeting)

Do not enter IDE as other – ie, enter 'Terumo' in text box so that procedures are being evaluated, not device – so when pulling blinded data sets, the research devices don't show up in 'other'

RAC update:

Device id policy in place because data is not risk stratified, its just data so experienced RAC members make sure that there are no implications for device companies

Projects listed on VQI website to tell if there is overlap- they'll both get data but then it's a race to see who can get it published first

Requirement for mock graphs & basically a ghost paper, just need the data to fill in the blanks – template is available; the easier ones to review are the ones with good scientific documentation on the application

DM presentation: see notes/Q&A responses recorded directly on ppt presentation

Best CLI:

133 sites out of anticipated 160, multidisciplinary, pt expectation, about one more year of enrollment (79% complete); equipoise - variability among surgeons in attendance on candidacy for endo vs open

Effects of Surgeon Experience:

Use of Medicare to overcome lack of hospital volume data in the study? How about just look at elective cases but without the risk adjustment – risk adjustment takes the clinical decision making out of it. Low volume of open infrarenal aneurysm – is it helpful data? >10,000 proc in VQI though so the procedure is still being done somewhere

Carotid Intervention Trends:

CEA - no statistical significance comparing men to women– men- many pts no patch; lots of eversion procedures, presenter has seen 1 in residency & done 1 in practice; women – fewer patches; CAS – no significant postop complication, but significant that more men died by 3 yrs following CAS than women; age & Hgb predicted death in men undergoing CAS; encouraged to get national data & make a comparison; commentary on rates of CAS in asymptomatic pts – more in VQI as have to participate in VQI to get reimbursed; discussion re: CAD fields - need to get a grasp on who is determining cardiac risk – is it cards? Data very granular (stable angina, MI recently, on meds, etc…)

AAA Guidelines:

Small aneurysms are being done for claudication or tissue loss but that data is not captured in VQI (not PVI which is fem aneurysm or beyond; EVAR excludes iliac aneurysm only)- many of our sites don't meet AAA guideline for intervention Small aneurysm/UK studies give us info on how to stratify who should get repair – small woman might need repair at 4.9cm – CTS bases interventions off of BMI, uses size guidelines to direct care- look at body size, look at gender, look at where they live (far from big center that does EVAR); pt who have malignancies per SVS guidelines get intervention in advance of chemo

QI in Limb Preservation:

De-glove & use a new kit; room full of 70-80 ppl when you think about all the ppl who have a role in care of your LE bypass pt; readmission for some databases (ie, CMS readmission database - HRRP) based off of discharge date; for this program they're looking at trigger date which they're defining as date of procedure

Utility of Quality Reporting- CV service line Medical Director:

Data without action is overhead- takes commitment of strong leader ie president who hired 20 abstractors and started pushing data to people, pushback at first but now it is appreciated & essential for future of bundled payments/macra; not easy at first, it's a journey; like building a tumor board, team approach, predict by 2025 payment will be on outcomes not how many you do; success of vqi is that the data is never punitive; you need one database; development of Frailty test to come for VQI; further discussion of access to physician specific data

Re-interventions after LE Interventions:

Recommendation not to exclude pts who had a previous infrainguinal intervention, recommend to only exclude those who had a recent procedure -is this obtainable? is medicare linkage data easily obtainable? Per UAB not easy

MI Hgb & Blood Usage:

Top trial – VA study looking at transfusion & general surgery pts – liberal & conservative arms; local data to be used next to examine if hgb is a surrogate for complex procedure which increases risk

Regional Report & Closeout:

Packed agenda precludes formal presentation but room for improvement in two national QI areas (DC meds & EVAR LTFU imaging)