I. Welcome and Introductions

II. Regional Report Highlights: Ankur Chandra, MD

- Region’s LTFU (66%) is lower than the VQI (71%). Discussion on how to improve, changing standard 6 month follow up to 9 month if the pt safety and quality are the same.
- Cheryl to take back color coding the region for future meetings
- Region’s D/C Medications rate is slightly lower than VQI overall rate which is 80%
- Region’s Hemodialysis Access: Percentage of Primary AVF vs. Graft is lower (52%) than the VQI overall (81%).
- Carotid Artery Stent: Stroke or Death in Hospital is lower<0.5 vs. 1.6%. SoCal does not have 3 centers with at least 10 procedures.
- Carotid Endarterectomy: Stroke or Death in Hospital: 0.6 vs. VQI at 1.1%.
- Carotid Endarterectomy: LOS>1 day: SoCal at 27% vs. VQI at 24%
- Region is lower for Endovascular AAA Repair: Percentage of Patients with LOS>2: SoCal at 12% vs. VQI at 14%
- Region is lower for EVAR: Sac diameter for LTFU: SoCal at 46% vs. VQI at 55%. This should be a concentration for VOICe. Cheryl to take back the feedback of breaking out the reasons for LTFU for EVAR – unable to reach, insurance, etc
- Infrainguinal bypass: Percentage of Procedures with Chlorhexidine or Chlorhexidine+Alcohol Skin Prep: SoCal at 77% vs. VQI at 87%
- Infrainguinal Bypass: Rate of Major Complications SoCal at >6% vs. VQI at 4%. SoCal does not have 3 centers with at least 10 procedures.
- IVCF: Percentage of Temporary Filters with Retrieval or Attempt at Retrieval: SoCal does not have 3 centers with at least 10 Procedures. Registry could look if there has been an increase of retrievals since reminders started happening in VQI.
- Lower-Extremity Amputation: Rate of Post-op Complications: SoCal does not have 3 centers with at least 10 procedures.
- Region is lower for Non-Ruptured Open AAA: In-Hospital Mortality: SoCal <1% vs. VQI 3.9%
- Region is significantly higher for PVI: Percentage of Percutaneous Femoral Procedures Using Ultrasound Guidance SoCal 84% vs. VQI 74%
- Region is close to VQI for PVI: Percentage of Claudicants With ABI or TBI Reported Before Procedure: SoCal 73% vs. VQI 76%
- Region is higher for Supra-Inguinal Bypass: Rate of Postop Complications: SoCal 35% vs. VQI 26%

III. National SVS PSO update: Cheryl Jackson

- Current Stats:
  - 467 Centers, 46 States + Canada
  - 469,847 procedures as of 4/1/2018
- 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

- **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.
IV. Arterial Quality Council update: Ankur Chandra, MD
- 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.

V. MIPS/MACRA Update: Karen Woo, MD
- VQI Approved by CMS as a 2018 Qualified Clinical Data Registry (QCDR)
- PNWMIPS Quality Component is 50% of the total MIPS score
- VQI QCDR offers 25 measures
- VQI meets quality improvement requirements for MIPS.
- 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.

VI. Research Advisory Council update: Gregg Magee, MD
- **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.
  - **Regional Research Projects – New Ideas?**
    - Angiosome Therapy - USC

VII. Venous Quality Council update: Ahmed Abou-Zamzam, MD
- Varicose Vein Appropriateness Project
- Development of NEW Venous Stent registry
- Need a Regional Chair

VIII. SVS PSO Governing Council Meeting at VEITH: Ahmed Abou-Zamzam, MD
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. **Data Manager’s update: Kelsi Ostenson, RN**
- Review of regional data managers’ meeting
- Discussed use of #hashtags

X. **Pathways Update: Cheryl Jackson, SVS PSO**
- IVCF Update
- NPI Validation
- Registry Projects

XI. **Presentations:**
- Changes in CEA LOS in VOICe – Ankur Chandra, MD
  i. Dr. Chandra presented some follow-up data from the region regarding LOS following elective CEA. There has been a slight drop in overall LOS in the region, but the causes are unclear. He will circulate the best practices developed at Scripps for other member’s use.
- Timing of symptomatic CEA – Ahmed Abou-Zamzam, MD
  i. The timing to CEA in symptomatic patients was presented. Median time is 14 days. Periop complications are highest in the < 2 day group. While 3-14 days and >14 day groups had similar periop risks. The reasons for this are unclear but this supports other data that very early CEA confers a higher risk. There is variation among centers with early CEA constituting between 0-50% in centers reporting CEA. These data were discussed and are felt to provide a baseline in the region for future study.

- Update by Dr. Magee on Angiosome-based revascularization and proposal for a region-wide study.
- Review of 2016/2017 Best Practice articles from fellows and residents from Loma Linda and USC (Anastasia Plotkin and Narek Veranyan from USC and Cassra Arbabi and Hans Boggs from Loma Linda)

XII. **General discussion**
- Align guidelines with timelines for VQI LTFU (or vice versa)
- Color code the regional dashboard
- If no LTFU, should breakdown lost to follow-up to find out barriers. Then provide solutions
- What’s the effect of IVCF reminders (before and after data)
- Per Dr. Woo – add to the AQC agenda; How can data managers get physician level reports so they can aggregate for their centers?
- Can a region make a marketing plan to say “As a region, by participating in the VQI, we decreased CEA LOS and saved X amount?”
  i. VQI should provide speaking points for promoting VQI so that regions and centers can stay within PSO rules
- VQI should communicate more with Quality Depts at centers. Many centers having to defend keeping multiple registries, especially VQI.
- Suggested changes to regional reports:
i. 1 year re-intervention rate for PVI and Infra-inguinal (stemmed from decreasing volume of Infra-inguinal)
ii. Breakdown CEA stroke/death into symptomatic vs asymptomatic
iii. Add to CEA – symptomatic or symptomatic choice. Type of CVA or TIA too confusing and vague.

Fall Meeting: Tentatively – November 2, 2018
Host - UCLA has offered to host; site TBD

Attendees:
Cheryl Jackson (SVS/PSO), Ahmed Abou-ZamZam (LLU), Ankur Chandra (Scripps), Kelsi Ostenson (Sharp Grossmont), Vincent Guzzetta (Sharp Grossmont), Karen Heaney (Sharp Grossmont), Wendy Chiodo (Sharp Grossmont), Carol Psahoulias (Sharp Memorial), Karen Woo (UCLA), Gregory Magee (UCLA), Isabella Kuo (UCI), Fred Weaver (USC), Peter Lawrence (UCLA), Sung Ham (USC), Gabriela Flores (UCLA), Anastasia Plotkin (USC), Narek Veranyan (USC), Cassra Arbabi (Loma Linda), Hans Boggs (Loma Linda)