Upper Midwest Vascular Network (UMVN)

October 22, 2021
1:00 pm – 4:00 pm (CT)
Remote
Meeting Attendance Credit

Before we get started, please sign in.

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.

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

**SPECIAL NOTE: We do give credit to residents/fellows that don’t have a PATHWAYS user account !!!

Sign in with your Full name, MD, Name of Institution
## Agenda – UMVN – October 22, 2021

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Learning Objectives</th>
<th>CE Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1pm</td>
<td>Welcome</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
| 1:05pm| Regional Data Review – Randall DeMartino, MD, UMVN Medical Director  | • Use the VQI regional reports to establish quality improvement goals for the vascular patients (outcomes) and for their center (process).  
• Interpret and compare each centers’ VQI results to regional and national benchmarked data.  
• 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.  
• 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. | Yes       |
<p>| 2:05pm| Regional QI Proposal - Randall DeMartino, MD, UMVN Medical Director  | Yes                                                                                                                                                                                                                  |           |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>CE Credit</th>
</tr>
</thead>
</table>
| 2:35pm   | National VQI Update – Caroline Morgan, BSN, PSO Clinical Operations Associate  
Learning Objectives:  
• Use the VQI regional reports to establish quality improvement goals for the vascular patients (outcomes) and for their center (process).  
• 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. | Yes       |
| 3:05pm   | AQC Update – Peter Rossi, MD                                          | No        |
| 3:15pm   | VQC Update – Fahad Shuja, MD                                          | No        |
| 3:25pm   | RAC Update – Joseph Hart, MD                                          | No        |
| 3:35pm   | Governing Council Update – Randall DeMartino, MD                      | No        |
| 3:45pm   | Case Presentations                                                    | No        |
| 4pm      | Open Discussion/Next Meeting/Meeting Evaluation                       | No        |
No presenter has a disclosure or conflict of interest to report.
Welcome and Introductions

Abbott Northwestern Hospital (Allina)
Altru Hospital
Aspirus Wausau Hospital, Inc.
Aurora BayCare Medical Center, Green Bay
Aurora Medical Center, Grafton
Aurora Medical Center, Hartford (Washington County)
Aurora Medical Center, Kenosha
Aurora Medical Center, Manitowoc County
Aurora Medical Center, Oshkosh
Aurora Medical Center, Summit
Aurora Memorial Hospital, Burlington
Aurora Sheboygan Memorial Medical Center, Sheboygan
Aurora Sinai Medical Center, Milwaukee
Aurora St. Luke's Medical Center, Milwaukee
Aurora St. Luke's South Shore, Cudahy
Aurora West Allis Medical Center, West Allis
Avera Heart Hospital of South Dakota
Avera McKennan Hospital
Bellin Memorial Hospital, Inc.
CentraCare Health
Columbia St. Mary's Hospital Ozaukee, Inc.
Columbia St. Mary's Milwaukee Hospital, Inc.
Fairview Southdale Hospital
Fairview St. John's Hospital
Fairview St. Joseph's Hospital
Fox Valley Surgical Associates Ltd.
Froedtert Health
HealthPartners, Inc.
M Health Fairview Clinic - Woodwinds
Marshfield Clinic Health System, Inc.
Mayo Clinic Health System - Franciscan Healthcare, Inc. (in La Crosse)
Mayo Clinic Hospital - Rochester
Mayo Clinic Northwest Wisconsin
Mercy Hospital (Allina)
Monument Health Rapid City Hospital, Inc.
North Memorial Health Hospital
Radiology Associates-Fox Valley
Sacred Heart Hospital of the Hospital
Sisters of the Third Order of St. Francis
Sanford Bemidji Medical Center
Sanford Clinic Vascular Associates
Sanford Medical Center Fargo
SSM Health St. Agnes Hospital - Fond du Lac, WI
SSM Health St. Mary's Hospital - Madison
St. Luke’s Hospital - MN
St. Vincent Hospital of the Hospital
Sisters of the Third Order of St. Francis
United Hospital (Allina)
Unity Hospital (Allina)
UnityPoint Health - Meriter Hospital
University of Minnesota Medical Center (UMMC)
University of Wisconsin Hospitals and Clinics Authority
Waukesha Memorial Hospital
Data Manager Review

• Review EVAR revisions

• Open Discussion
• Clinical scenario
  – 76 year old male has a history of prior EVAR
  – There is a proximal type la endoleak with sac enlargement
• Clinical scenario
  – To treat the endoleak, the patient undergoes 4 vessel fenestrated repair with proximal seal in zone 5
• How to capture this case?

  – EVAR reintervention?

  – TEVAR/Complex EVAR?
Data Manager Review

• Enter TEVAR/Complex EVAR
  – Proximal seal in zone 5

• If the EVAR was done at your center, ideally enter a followup form for the reintervention
• Discussion

• Additional case scenarios/question
Research Discussion
Machine Learning-Driven Quality Improvement Intervention for Reducing Length Of Stay Following Elective EVAR Using The Vascular Quality Initiative Database

Authors: Ayokunle S. Olowofela, Robert A. Hieb, Michael J. Malinowski, Rodney Sparapani, Brian J. Lewis, Joseph P. Hart, Peter J. Rossi, Neel A. Mansukhani

Event: Upper Midwest Vascular Network, Fall 2021 Regional Meeting

Presenter: Ayokunle S. Olowofela, MBBS
Author Disclosures

None
Introduction

- Elective EVAR can be done safely with short hospital length of stay (LOS).
- Reducing LOS is a healthcare and local institutional priority.
- Our center is an outlier for LOS after elective EVAR.
Objectives

• Identify factors affecting LOS after elective EVAR at our center.

• Develop and implement an enhanced recovery protocol for elective EVAR.

• Assess impact of an enhanced recovery protocol for elective EVAR on LOS.
Methods

• Retrospective review of single tertiary academic medical center.

• Local SVS VQI endovascular AAA module 2013-2019.

• Inclusion: elective EVAR.

• Exclusion: symptomatic AAA, ruptured EVAR, open AAA repair, complex EVAR.
Methods

• Interviews with stakeholders.

• Univariable comparison of perioperative factors.

• Multivariable - machine learning – BART.

• Primary outcome: LOS.

• Comparison groups: LOS ≤2 days, LOS > 2 days.
Results

• 216 elective EVAR (25% female).

• Mean LOS: 3.35 days (SD 7.0), 3.2 days after exclusion of outliers (LOS > 4 days).
Results

Modifiable factors identified from stakeholder interviews

• Postoperative day 1 CBC/chemistry.
• Postoperative PT evaluation.
• SICU stay.
• Urinary retention.
• Patient expectations.
• Transportation home.
Results – Perioperative Factors

- Primary insurer.
- Prior CHF, prior COPD.
- Preop hemoglobin, creatinine.
- Unfit for open repair.
- Total procedure time, fluoroscopy time.
- Crystalloid, EBL, PRBC, access.
- ICU LOS, highest creatinine, discharge beta blocker.
Results – BART Model
Results – BART Model

AUC: 89.1% (84.6%–93.6%)
Enhanced Recovery Protocol

### ROADMAP TO RECOVERY AFTER YOUR EVAR

<table>
<thead>
<tr>
<th>Prior to Surgery</th>
<th>Day of Surgery (Post-op)</th>
<th>Day after Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>- Vital signs</td>
<td>- Vital signs</td>
</tr>
<tr>
<td></td>
<td>- Groin checks</td>
<td>- Groin checks</td>
</tr>
<tr>
<td></td>
<td>- Pulse exam</td>
<td>- Pulse exam</td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td>- Aspirin</td>
<td>- Aspirin</td>
</tr>
<tr>
<td></td>
<td>- Statin</td>
<td>- Statin</td>
</tr>
<tr>
<td><strong>Diet</strong></td>
<td>- Increase protein intake</td>
<td>- No food or drink until safe, approximately 2-6 hours</td>
</tr>
<tr>
<td></td>
<td>- No food or drink after midnight</td>
<td>- Eat breakfast</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>- Shower with surgical prep</td>
<td>- Flat bedrest post-op</td>
</tr>
<tr>
<td></td>
<td>- Stay active</td>
<td>- Up to chair after bedrest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Walk in room</td>
</tr>
<tr>
<td><strong>Urine</strong></td>
<td>- Take your Flomax as prescribed</td>
<td>- Are you able to urinate?</td>
</tr>
<tr>
<td><strong>Learning</strong></td>
<td>- Ask questions!</td>
<td>- Breathing exercises hourly</td>
</tr>
<tr>
<td></td>
<td>- Read pre-op instructions</td>
<td>- Read discharge instructions</td>
</tr>
<tr>
<td><strong>Discharge</strong></td>
<td>- Discharge will be the day after surgery</td>
<td>- Do you have a ride home?</td>
</tr>
<tr>
<td>Planning</td>
<td>- Schedule your ride home</td>
<td>- Team will remove dressings</td>
</tr>
<tr>
<td></td>
<td>- FMLA paperwork completion</td>
<td>- Shower</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Go home</td>
</tr>
</tbody>
</table>

**Follow up**
- Your appointment will be made prior to discharge and may include a CT scan.

**Note:** Above subject to change based on personalized plan of care
Enhanced Recovery Protocol

- Pre-procedure PT at the discretion of the surgeon.
- IV sedation and local anesthesia when possible.
- Correction of preoperative anemia with medications over blood products.
- Emphasis on percutaneous access rather than open surgical femoral access.
- Discontinuation of routine postoperative chemistry and CBC without clinical justification.
- Discontinuation of routine physical therapy evaluation without clinical concern on POD 1.
Enhanced Recovery Protocol

- Direct admission to the inpatient ward for recovery bypassing SICU admission.
- Protocolized management to mitigate urinary retention in the perioperative period.
- Surgeons establish realistic patient expectations for discharge on POD 1.
- Patients are instructed during pre-procedure planning to arrange for a ride home on POD 1.
Enhanced Recovery Protocol: Implementation

- Rolling implementation began August 2019.
- Current form implementation began in March 2020.
Enhanced Recovery Protocol: Implementation

• July 2020 – June 2021.
• 37 elective EVARs: 13.5% female, Median age: 73 years.
• All: PreOp Flomax and arranged transportation home.
• PreOp Anemia: 11 (29.7%). No correction required.
• PreOp PT: 1 (2.7%). PostOp PT: 3 (8.1%).
Enhanced Recovery Protocol: Implementation

• Anesthesia – Local: 5 (13.5%). General: 32 (86.5%).

• Access – Right Percutaneous Fem: 33 (89.2%), Left Percutaneous Fem: 30 (81.1%).

• PostOp Discharge Disposition – ICU: 1 (2.7%).

• PostOp CBC and Chemistry: 12 (32.4%).

• All discharged home.
Enhanced Recovery Protocol: Implementation

• All except 1 patient had LOS of ≤2 days.

• 1 patient had LOS of 9 days.

• Mean LOS: 1.3 days (SD: 1.3), 1.1 days (SD: 0.3) after exclusion of 1 outlier.

• Our proportion of elective EVAR with LOS of >2 days reduced from 39% to 2.7%.
Conclusions

- EVAR can be completed with short LOS.

- Individual center data cannot be applied to all centers, but approach is generalizable.

- Multimethod approach combining interviews, standard statistical methods, and novel machine learning techniques can identify areas for QI.
Acknowledgements
Thank You
LTFU and EVAR Sac Reporting Discussion
Randall DeMartino, MD

VQI Regional Quality Report

Fall 2021

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

About the Report

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 report is organized into separate reports that can be quickly accessed by clicking on the report names in the table of contents on the left.

For drill-down and data feedback on your center’s cases, click on “VQI Case Appendix” in the table of contents on the left.
Important Notes

- All results are based on data entered into the VQI as of June 30, 2021. Any subsequent changes or updates to data after that date will not be reflected in this report.

- Procedure timeframes and inclusion/exclusion criteria are given at the top of each report. Cases are also excluded if outcomes are missing or not enough data was entered to determine whether the case met inclusion/exclusion criteria.

- Regions must have at least 3 centers with included cases for regional results to be displayed in tables and line charts.

- Regions must have at least 3 centers with at least 10 included cases per center for regional results to be displayed in bar charts. It is therefore possible for a region’s results to be displayed in tables and line charts, but not in bar charts.

- For risk-adjusted reports, regions must have at least 3 centers with at least 10 complete cases per center for regional results to be displayed in bar charts. It is therefore possible for a region’s results to be displayed in tables and line charts, but not in bar charts.

- In all graphics, "**" indicates a p-value <.05.
Fall 2021 Important Report Updates:

- **Display of 10\textsuperscript{th}/90\textsuperscript{th} percentiles**
  The 10\textsuperscript{th} and 90\textsuperscript{th} percentiles for center rates in your region and across VQI are now provided in the dashboard. These percentiles give users a broader picture of the distribution of center-level rates and may provide opportunities for more targeted monitoring of outcomes.

- **Region Volume Appendix**
  A new Region Volume Appendix is now provided as part of your regional slide deck. This new appendix provides your region’s case volumes for each report. In addition, the number of centers contributing data to each report is given.

- **Long-Term Follow-up**
  Mandatory fields for long-term follow-up were released in PATHWAYS in September 2018 to provide a more accurate assessment of long-term follow-up rates. While no changes have been made to the long-term follow-up report, centers and regions should note that long-term follow-up rates for more recent procedure timeframes (e.g., July 2018-June 2019) are reflective of these mandatory fields.
Fall 2021 Important Report Updates:

- **TCAR**
  Changed inclusion/exclusion criteria – Procedures with an approach other than Carotid Percutaneous or Carotid Open are now excluded from both ASYMP and SYMP reports.

- **OAAA**
  Low procedure volumes for OAAA have historically resulted in only a small number of regions having access to their regional OAAA results. To remedy this situation and provide more meaningful feedback to centers and regions alike, the procedure timeframe for assessment in OAAA reports has been extended from 1 year to 4 years. Accordingly, all assessments in these reports are now based on 4 years of data. Centers and regions should note the following additions to the line charts associated with these reports:
  
  - For center-specific reports, the center’s aggregate 4-year rate is now displayed with a dashed yellow line.
  - For regional slide decks, the region’s aggregate 4-year rate is now displayed with a dashed light-blue line.
Dashboard

The dashboard provides a high-level summarization of your center’s results for each of 25 reports, and gives both regional and VQI-wide benchmarks for comparison. The “Your Center” column gives the percentage of your center’s cases with the noted outcome. Numbers in parentheses give the number of cases with the outcome and the total number of cases meeting the inclusion criteria for that report. The “Your Region” and “VQI Overall” columns give the aggregate percentage of cases with the noted outcome, as well as the 10th, 25th, 50th (median), 75th, and 90th percentiles for centers in your region and VQI, respectively ([10th|25th|50th|75th|90th]). Your center’s results are highlighted blue if your center is in the “top” 25th percentile for VQI Overall, and coral if your center is in the “bottom” 25th percentile for VQI Overall.

*For details on a particular report, click on the report name in the table of contents on the left.*

Legend: Blue = “Top” 25th percentile  Coral = “Bottom” 25th percentile

*Note that procedure volume results are not highlighted.*
<table>
<thead>
<tr>
<th>Procedure Group</th>
<th>Outcome</th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Procedure Volume</td>
<td>[6</td>
<td>34</td>
<td>116</td>
</tr>
<tr>
<td>Procedure Volume, All Years</td>
<td></td>
<td>[23</td>
<td>102</td>
<td>448</td>
</tr>
<tr>
<td>Multiple</td>
<td>Long-Term Follow-up</td>
<td>77.7% [40</td>
<td>68</td>
<td>77</td>
</tr>
<tr>
<td>Discharge Medications</td>
<td></td>
<td>89.5% [80</td>
<td>86</td>
<td>90</td>
</tr>
<tr>
<td>TFEM CAS ASYM</td>
<td>Stroke/Death</td>
<td>1.9% [0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TFEM CAS SYMP</td>
<td>Stroke/Death</td>
<td>5.9% [0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TCAR ASYM</td>
<td>Stroke/Death</td>
<td>1.5% [0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TCAR SYMP</td>
<td>Stroke/Death</td>
<td>2.5% [0</td>
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<td>0</td>
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<td>Stroke/Death</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Postop LOS&gt;1 Day</td>
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<td>22.9% [7</td>
<td>13</td>
<td>27</td>
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<tr>
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<td>Stroke/Death</td>
<td>0.6% [0</td>
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<td>0</td>
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<td>Postop LOS&gt;1 Day</td>
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<tr>
<td>EVAR</td>
<td>Postop LOS&gt;2 Days</td>
<td>12.1% [0</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Sac Diameter Reporting</td>
<td></td>
<td>62.2% [37</td>
<td>47</td>
<td>61</td>
</tr>
<tr>
<td>SVS Sac Size Guideline</td>
<td></td>
<td>82% [67</td>
<td>75</td>
<td>86</td>
</tr>
<tr>
<td>TEVAR</td>
<td>Sac Diameter Reporting</td>
<td>86.6% [41</td>
<td>73</td>
<td>75</td>
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<tr>
<td>OAAA</td>
<td>In-Hospital Mortality</td>
<td>2.6% [0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SVS Cell-Saver Guideline</td>
<td></td>
<td>96.3% [90</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>SVS Iliac Inflow Guideline</td>
<td></td>
<td>96.8% [96</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>PVI CLAUD</td>
<td>ABI/Toe Pressure</td>
<td>73.3% [44</td>
<td>62</td>
<td>82</td>
</tr>
<tr>
<td>INFRA CLTI</td>
<td>Major Complications</td>
<td>4.7% [0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>SUPRA CLTI</td>
<td>Major Complications</td>
<td>4.5% [0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>LEAMP</td>
<td>Postop Complications</td>
<td>8.8% [0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>HDA</td>
<td>Primary AVF vs. Graft</td>
<td>79.3% [63</td>
<td>67</td>
<td>75</td>
</tr>
<tr>
<td>IVCF</td>
<td>Filter Retrieval Reporting</td>
<td>NA (&lt;3 centers)</td>
<td>56% [13</td>
<td>36</td>
</tr>
</tbody>
</table>

Legend: Blue = “Top” 25th percentile  Coral = “Bottom” 25th percentile

Note that procedure volume results are not highlighted.
About the Appendix

The Region Volume Appendix provides your region’s case volumes for each report. In addition, the number of centers with cases contributing to each report is given. Note that columns referencing complete cases are appropriately left blank for non risk-adjusted reports.

<table>
<thead>
<tr>
<th>Report</th>
<th>Included Cases</th>
<th>Centers with Included Cases</th>
<th>Centers with at least 10 Included Cases</th>
<th>Complete Cases</th>
<th>Centers with Complete Cases</th>
<th>Centers with at least 10 Complete Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Term Follow-up</td>
<td>6484</td>
<td>34</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Medications</td>
<td>6777</td>
<td>45</td>
<td>39</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TFEM CAS ASYMP: Stroke/Death</td>
<td>108</td>
<td>14</td>
<td>5</td>
<td>102</td>
<td>13</td>
<td>5</td>
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<tr>
<td>TFEM CAS SYMP: Stroke/Death</td>
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<td>17</td>
<td>5</td>
<td>159</td>
<td>16</td>
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<tr>
<td>TCAR ASYMP: Stroke/Death</td>
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<td>21</td>
<td>6</td>
<td>130</td>
<td>21</td>
<td>6</td>
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<td>TCAR SYMP: Stroke/Death</td>
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<td>2</td>
<td>78</td>
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<td>21</td>
<td>773</td>
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<td>20</td>
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<td>CEA ASYMP: Postop LOS&gt;1 Day</td>
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<td>29</td>
<td>21</td>
<td>775</td>
<td>29</td>
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<td>18</td>
<td>465</td>
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<td>467</td>
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<td>2</td>
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<tr>
<td>OAAA: In-Hospital Mortality</td>
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<td>13</td>
<td>9</td>
<td>250</td>
<td>13</td>
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<td>OAAA: SVS Cell-Saver Guideline</td>
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<td>12</td>
<td>7</td>
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<td>OAAA: SVS Iliac Inflow Guideline</td>
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<td>9</td>
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<td>PVI CLAUD: ABI/Toe Pressure</td>
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<td>22</td>
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<td>INFRACLTI: Major Complications</td>
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<td>19</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUPRA CLTI: Major Complications</td>
<td>67</td>
<td>9</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEAMP: Postop Complications</td>
<td>410</td>
<td>17</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDA: Primary AVF vs. Graft</td>
<td>92</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IVCF: Filter Retrieval Reporting</td>
<td>98</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Procedure Volume

Procedures performed between July 1, 2020 and June 30, 2021

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

<table>
<thead>
<tr>
<th></th>
<th>Your Center (N)</th>
<th>Your Region (N)</th>
<th>VQI Overall (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS (TFEM CAS &amp; TCAR)</td>
<td>700</td>
<td>13121</td>
<td></td>
</tr>
<tr>
<td>CEA</td>
<td>1514</td>
<td>17107</td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td>544</td>
<td>7240</td>
<td></td>
</tr>
<tr>
<td>HDA</td>
<td>127</td>
<td>6639</td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
<td>490</td>
<td>7065</td>
<td></td>
</tr>
<tr>
<td>IVCF</td>
<td>NA (&lt;3 centers)</td>
<td>1525</td>
<td></td>
</tr>
<tr>
<td>LEAMP</td>
<td>411</td>
<td>3077</td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td>100</td>
<td>1305</td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td>3157</td>
<td>41369</td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td>117</td>
<td>1870</td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td>133</td>
<td>2831</td>
<td></td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>NA (&lt;3 centers)</td>
<td></td>
<td>6196</td>
</tr>
<tr>
<td>Overall (July 2020-June 2021)</td>
<td>7581</td>
<td>109345</td>
<td></td>
</tr>
<tr>
<td>Overall (July 2019-June 2020)</td>
<td>6956</td>
<td>112761</td>
<td></td>
</tr>
</tbody>
</table>
**Procedure Volume by Center in Your Region (July 2020–June 2021)**

- **Other centers in your region**
- **Your center**

Centers (centers with <10 cases not shown)

**Procedure Volume Across VQI (July 2020–June 2021)**

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

“Others” indicates centers that do not belong to a regional group.
Procedure Volume, All Years

Includes all procedures with procedure date through June 30, 2021

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

<table>
<thead>
<tr>
<th>Your Center (N)</th>
<th>Your Region (N)</th>
<th>VQI Overall (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS (TFEM CAS &amp; TCAR)</td>
<td>2924</td>
<td>57614</td>
</tr>
<tr>
<td>CEA</td>
<td>10810</td>
<td>158265</td>
</tr>
<tr>
<td>EVAR</td>
<td>4228</td>
<td>63655</td>
</tr>
<tr>
<td>HDA</td>
<td>340</td>
<td>62972</td>
</tr>
<tr>
<td>INFRA</td>
<td>3465</td>
<td>66699</td>
</tr>
<tr>
<td>IVCF</td>
<td>NA (&lt;3 centers)</td>
<td>15864</td>
</tr>
<tr>
<td>LEAMP</td>
<td>3196</td>
<td>21477</td>
</tr>
<tr>
<td>OAAA</td>
<td>802</td>
<td>14897</td>
</tr>
<tr>
<td>PVI</td>
<td>21198</td>
<td>274908</td>
</tr>
<tr>
<td>SUPRA</td>
<td>1146</td>
<td>21514</td>
</tr>
<tr>
<td>TEVAR</td>
<td>1269</td>
<td>20751</td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>394</td>
<td>46683</td>
</tr>
<tr>
<td>Overall</td>
<td>50626</td>
<td>825299</td>
</tr>
</tbody>
</table>
"Others" indicates centers that do not belong to a regional group.
Physician Specialties

Physician Specialties Across VQI (as of July 31, 2021, N=6074 Physicians)

- Vascular Surgery
- Cardiology
- Radiology
- General Surgery
- Cardiothoracic Surgery
- Neurosurgery
- None
- Podiatry
- Other
- Orthopedic Surgery
- Neurology
Physician Specialties Across Your Region (as of July 31, 2021, N=461 Physicians)
Long-Term Follow-up

Procedures performed between July 1, 2018 and June 30, 2019

Includes CAS (TFEM CAS and TCAR), CEA, EVAR, HDA, INFRA, IVCF, LEAMP, OAAA, PVI, SUPRA, and TEVAR procedures only. Excludes cases 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.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS</td>
<td>423 (74%)</td>
<td></td>
<td>9602 (62%)</td>
</tr>
<tr>
<td>CEA</td>
<td>1463 (80%)</td>
<td>18987 (70%)</td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td>474 (79%)</td>
<td>7432 (69%)</td>
<td></td>
</tr>
<tr>
<td>HDA</td>
<td></td>
<td>NA (&lt;3 centers)</td>
<td>8030 (64%)</td>
</tr>
<tr>
<td>INFRA</td>
<td>396 (80%)</td>
<td>7148 (72%)</td>
<td></td>
</tr>
<tr>
<td>IVCF</td>
<td></td>
<td>NA (&lt;3 centers)</td>
<td>1922 (76%)</td>
</tr>
<tr>
<td>LEAMP</td>
<td>405 (80%)</td>
<td>3272 (66%)</td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td>74 (84%)</td>
<td>1286 (74%)</td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td>2774 (74%)</td>
<td>36370 (67%)</td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td>116 (88%)</td>
<td>2286 (70%)</td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td>194 (90%)</td>
<td>2852 (65%)</td>
<td></td>
</tr>
<tr>
<td>Overall (July 2018-June 2019)</td>
<td>6484 (78%)</td>
<td>99187 (68%)</td>
<td></td>
</tr>
<tr>
<td>Overall (July 2017-June 2018)</td>
<td>5905 (91%)</td>
<td>90835 (73%)</td>
<td></td>
</tr>
</tbody>
</table>
Long-Term Follow-Up by Center in Your Region (July 2018–June 2019)

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

Long-Term Follow-Up by Region Across VQI (July 2018–June 2019)

**Indicates region’s rate differs significantly from the VQI rate.**
Discharge Medications

Procedures performed between July 1, 2020 and June 30, 2021

Includes CAS (TFEM CAS and TCAR), CEA, EVAR, INFRA, LEAMP, OAAA, PVI, SUPRA, and TEVAR procedures only. Antiplatelet is defined as ASA or P2Y12 inhibitor. Cases are excluded if (1) Discharge Statin = “No, for medical reason” OR (2) Both Discharge ASA = “No, for medical reason” AND Discharge P2Y12 inhibitor = “No, for medical reason” OR (3) An in-hospital death occurred.

The table below gives the number of procedures meeting the inclusion criteria, and the percentage of those procedures where patients received discharge medications.

<table>
<thead>
<tr>
<th></th>
<th>Number of Procedures at Your Center</th>
<th>Antiplatelet+Statin</th>
<th>Antiplatelet Only</th>
<th>Statin Only</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS</td>
<td>6777</td>
<td>89%</td>
<td>7%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>CEA</td>
<td>89002</td>
<td>86%</td>
<td>9%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>EVAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEAMP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Center Overall</td>
<td>6777</td>
<td>89%</td>
<td>7%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Your Region Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VQI Overall</td>
<td>89002</td>
<td>86%</td>
<td>9%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Discharge Antiplatelet+Statin by Center in Your Region (July 2020–June 2021)

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

Discharge Antiplatelet+Statin by Region Across VQI (July 2020–June 2021)

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

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

*** Indicates region's rate differs significantly from the VQI rate.
**TFEM CAS ASYMPP: Stroke/Death**

Procedures performed between July 1, 2020 and June 30, 2021

Includes asymptomatic admissions for Transfemoral Carotid Artery Stenting (TFEM CAS) only. Asymptomatic admissions are admissions where the patient had 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 Femoral are also excluded.

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

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TFEM CAS procedures meeting inclusion criteria</td>
<td>108</td>
<td>1751</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>1.9%</td>
<td>1.8%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>102</td>
<td>1610</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>2%</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>1.9%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.72</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“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 Asymptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after TFEM CAS for Asymptomatic Admissions in Your Region (July 2020–June 2021)

- Other centers in your region
- Your center
- Observed
- Expected

Rates shown are among complete cases. *** indicates center’s observed rate differs significantly from its expected rate.

Stroke or Death after TFEM CAS for Asymptomatic Admissions by Region Across VQI (July 2020–June 2021)

- Observed
- Expected

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

Rates shown are among complete cases. *** indicates region’s observed rate differs significantly from its expected rate.
TFEM CAS SYMP: Stroke/Death

Procedures performed between July 1, 2020 and June 30, 2021

Includes symptomatic admissions for Transfemoral Carotid Artery Stenting (TFEM CAS) only. Symptomatic admissions are admissions where the patient had 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 Femoral are also excluded.

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

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TFEM CAS procedures meeting inclusion criteria</td>
<td>170</td>
<td>1717</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>5.9%</td>
<td>5.9%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>159</td>
<td>1595</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>5.7%</td>
<td>6.1%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>5.3%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.86</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“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 Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Rates shown are among complete cases. "***" indicates center's observed rate differs significantly from its expected rate.
TCAR ASYMP: Stroke/Death

Procedures performed between July 1, 2020 and June 30, 2021

Includes asymptomatic admissions for TransCarotid Artery Revascularization (TCAR) only. Asymptomatic admissions are admissions where the patient had 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 admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TCAR procedures meeting inclusion criteria</td>
<td>132</td>
<td>4432</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>1.5%</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>130</td>
<td>4239</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>1.5%</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>1.1%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.66</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“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 TCAR for Asymptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after TCAR for Asymptomatic Admissions in Your Region (July 2020–June 2021)

Other centers in your region  Your center

Observed  Expected

Centers (centers with <10 complete cases not shown)

Rates shown are among complete cases. ** Indicates center’s observed rate differs significantly from its expected rate.

Stroke or Death after TCAR for Asymptomatic Admissions by Region Across VQI
(July 2020–June 2021)


Observed  Expected

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

Rates shown are among complete cases. ** Indicates region’s observed rate differs significantly from its expected rate.
TCAR SYMP: Stroke/Death

Procedures performed between July 1, 2020 and June 30, 2021

Includes symptomatic admissions for TransCarotid Artery Revascularization (TCAR) only. Symptomatic admissions are admissions where the patient had 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 admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TCAR procedures meeting inclusion criteria</td>
<td>80</td>
<td>2253</td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>2.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>78</td>
<td>2164</td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>2.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>2.6%</td>
<td>NA</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>1</td>
<td>NA</td>
</tr>
</tbody>
</table>

*“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 TCAR for Symptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
CEA ASYMP: Stroke/Death

Procedures performed between July 1, 2020 and June 30, 2021

Includes asymptomatic admissions for Carotid Endarterectomy (CEA) only. Asymptomatic admissions are admissions where the patient had 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 admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CEA procedures meeting inclusion criteria</td>
<td>812</td>
<td>9795</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>1.2%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>773</td>
<td>9313</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>1.2%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>1%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.72</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“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 Asymptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after CEA for Asymptomatic Admissions in Your Region (July 2020–June 2021)

Other centers in your region  Your center  Observed  Expected

Centers (centers with <10 complete cases not shown)

Rates shown are among complete cases. *** Indicates center’s observed rate differs significantly from its expected rate.

Stroke or Death after CEA for Asymptomatic Admissions by Region Across VQI (July 2020–June 2021)

Observed  Expected

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

Rates shown are among complete cases. *** Indicates region’s observed rate differs significantly from its expected rate.
CEA SYMP: Stroke/Death

Procedures performed between July 1, 2020 and June 30, 2021

Includes symptomatic admissions for Carotid Endarterectomy (CEA) only. Symptomatic admissions are admissions where the patient had 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 admissions) meeting the inclusion criteria, and the observed and expected rates of in-hospital stroke or death for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CEA procedures meeting inclusion criteria</td>
<td>482</td>
<td>4843</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>0.6%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>465</td>
<td>4660</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>0.6%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>2.1%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.03</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“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 Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after CEA for Symptomatic Admissions in Your Region (July 2020-June 2021)

- Other centers in your region
- Your center
- Observed
- Expected

Rates shown are among complete cases. "**" indicates center's observed rate differs significantly from its expected rate.

Stroke or Death after CEA for Symptomatic Admissions by Region Across VQI (July 2020-June 2021)

- Observed
- Expected

Rates shown are among complete cases. "***" indicates region's observed rate differs significantly from its expected rate.
CEA ASYMP: Postop LOS>1 Day

Procedures performed between July 1, 2020 and June 30, 2021

Includes asymptomatic admissions for Carotid Endarterectomy (CEA) only. Asymptomatic admissions are admissions where the patient had 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 CAGB, proximal endovascular, distal endovascular, or “Other” arterial procedure. Procedures where in-hospital death occurred with postoperative LOS<=1 day 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 admissions) meeting the inclusion criteria, and the observed and expected rates of postoperative LOS>1 Day for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CEA procedures meeting inclusion criteria</td>
<td>812</td>
<td>9798</td>
<td></td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among procedures meeting inclusion criteria</td>
<td>22.9%</td>
<td>22.1%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>775</td>
<td>9330</td>
<td></td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among cases with complete data</td>
<td>22.3%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of LOS&gt;1 day among cases with complete data</td>
<td>22.2%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.93</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“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 Asymptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
### Postop LOS>1 Day after CEA for Asymptomatic Admissions in Your Region (July 2020-June 2021)

- **Other centers in your region**
- **Your center**
- **Observed**
- **Expected**

*Centers (centers with <10 complete cases not shown)*

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

### Postop LOS>1 Day after CEA for Asymptomatic Admissions by Region Across VQI (July 2020-June 2021)

- **Observed**
- **Expected**

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

Rates shown are among complete cases. ** Indicates region's observed rate differs significantly from its expected rate.
CEA SYMP: Postop LOS>1 Day

Procedures performed between July 1, 2020 and June 30, 2021

Includes symptomatic admissions for Carotid Endarterectomy (CEA) only. Symptomatic admissions are admissions where the patient had 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 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 admissions) meeting the inclusion criteria, and the observed and expected rates of postoperative LOS>1 Day for those cases.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CEA procedures meeting inclusion criteria</td>
<td>481</td>
<td>4844</td>
<td></td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among procedures meeting inclusion criteria</td>
<td>38.3%</td>
<td>40.8%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>467</td>
<td>4681</td>
<td></td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among cases with complete data</td>
<td>37.9%</td>
<td>40.9%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of LOS&gt;1 day among cases with complete data</td>
<td>42.1%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.07</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

**“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 Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Rates shown are among complete cases. "***" indicates center's observed rate differs significantly from its expected rate.

Rates shown are among complete cases. "***" indicates region's observed rate differs significantly from its expected rate.
EVAR: Postop LOS>2 Days

Procedures performed between July 1, 2020 and June 30, 2021
Includes Endovascular AAA Repair (EVAR) procedures only. Excludes any procedure with ruptured aneurysm. Procedures where in-hospital death occurred with postoperative LOS≤2 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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of EVAR procedures meeting inclusion criteria</td>
<td>511</td>
<td>6745</td>
<td></td>
</tr>
<tr>
<td>Observed rate of LOS&gt;2 days among procedures meeting inclusion criteria</td>
<td>12.1%</td>
<td>15.8%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>467</td>
<td>6187</td>
<td></td>
</tr>
<tr>
<td>Observed rate of LOS&gt;2 days among cases with complete data</td>
<td>12.2%</td>
<td>15.7%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of LOS&gt;2 days among cases with complete data</td>
<td>14.8%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.13</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

**“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>2 Days after EVAR by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Postop LOS>2 Days after EVAR in Your Region (July 2020-June 2021)

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

Postop LOS>2 Days after EVAR by Region Across VQI (July 2020-June 2021)

Rates shown are among complete cases. "***" Indicates region's observed rate differs significantly from its expected rate.
EVAR: Sac Diameter Reporting

Procedures performed between July 1, 2018 and June 30, 2019

Includes Endovascular AAA Repair (EVAR) procedures only. 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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of EVAR procedures meeting inclusion criteria</td>
<td>436</td>
<td>6878</td>
<td></td>
</tr>
<tr>
<td>Percentage with sac diameter reported between 9 and 21 months post-procedure</td>
<td>62.2%</td>
<td>56.1%</td>
<td></td>
</tr>
</tbody>
</table>
EVAR Sac Diameter Reporting in Your Region (July 2018-June 2019)

EVAR Sac Diameter Reporting Unblinding Legend for Your Region

<table>
<thead>
<tr>
<th>Index</th>
<th>Medical Center Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Waukesha Memorial Hospital</td>
</tr>
<tr>
<td>2</td>
<td>Froedtert Health</td>
</tr>
<tr>
<td>3</td>
<td>Fairview Southdale Hospital</td>
</tr>
<tr>
<td>4</td>
<td>Aurora Medical Center, Grafton</td>
</tr>
<tr>
<td>5</td>
<td>United Hospital (Allina)</td>
</tr>
<tr>
<td>6</td>
<td>Mayo Clinic Northwest Wisconsin</td>
</tr>
<tr>
<td>7</td>
<td>Aurora BayCare Medical Center, Green Bay</td>
</tr>
<tr>
<td>8</td>
<td>Mayo Clinic Hospital - Rochester</td>
</tr>
<tr>
<td>9</td>
<td>SSM Health St. Mary’s Hospital - Madison</td>
</tr>
<tr>
<td>10</td>
<td>University of Minnesota Medical Center (UMMC)</td>
</tr>
<tr>
<td>11</td>
<td>Aurora Memorial Hospital, Burlington</td>
</tr>
<tr>
<td>12</td>
<td>Mercy Hospital (Allina)</td>
</tr>
<tr>
<td>13</td>
<td>University of Wisconsin Hospitals and Clinics Authority</td>
</tr>
<tr>
<td>14</td>
<td>Aurora St. Luke’s Medical Center, Milwaukee</td>
</tr>
<tr>
<td>15</td>
<td>Fairview St. Joseph’s Hospital</td>
</tr>
<tr>
<td>16</td>
<td>St. Luke’s Hospital - MN</td>
</tr>
</tbody>
</table>

** indicates center's rate differs significantly from the regional rate.
EVAR Sac Diameter Reporting by Region Across VQI (July 2018-June 2019)

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

**"** Indicates region’s rate differs significantly from the VQI rate.
EVAR: SVS Sac Size Guideline

Procedures performed between July 1, 2020 and June 30, 2021

Includes Endovascular AAA Repair (EVAR) procedures only. Excludes any non-elective procedure. SVS sac size guideline is ≥5 cm for Women and ≥5.5cm 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 sac size guideline.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of EVAR procedures meeting inclusion criteria</td>
<td></td>
<td>477</td>
<td>6031</td>
</tr>
<tr>
<td>Percentage meeting SVS sac size guideline</td>
<td></td>
<td>82%</td>
<td>74.3%</td>
</tr>
</tbody>
</table>
EVAR Sac Size Guideline in Your Region (July 2020–June 2021)

Other centers in your region
Your center

Centers (centers with <10 cases not shown)

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

EVAR Sac Size Guideline by Region Across VQI (July 2020–June 2021)

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

*** Indicates region’s rate differs significantly from the VQI rate.
TEVAR: Sac Diameter Reporting

Procedures performed between July 1, 2018 and June 30, 2019

Includes Thoracic Endovascular Aortic Repair (TEVAR) procedures for aneurysm or aneurysm from dissection only. Excludes cases 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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TEVAR procedures meeting inclusion criteria</td>
<td>119</td>
<td>1590</td>
<td></td>
</tr>
<tr>
<td>Percentage with sac diameter reported between 9 and 21 months post-procedure</td>
<td>86.6%</td>
<td>55.7%</td>
<td></td>
</tr>
</tbody>
</table>
TEVAR Sac Diameter Reporting by Year


Your Center  Your Region  VQI Overall
OAAA: In-Hospital Mortality

Procedures performed between July 1, 2017 and June 30, 2021
Includes Open AAA (OAAA) procedures only. 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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of OAAA procedures meeting inclusion criteria</td>
<td>269</td>
<td>4436</td>
<td></td>
</tr>
<tr>
<td>Observed rate of In-Hospital Mortality among procedures meeting inclusion criteria</td>
<td>2.6%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>250</td>
<td>4139</td>
<td></td>
</tr>
<tr>
<td>Observed rate of In-Hospital Mortality among cases with complete data</td>
<td>2.8%</td>
<td>4.2%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of In-Hospital Mortality among cases with complete data</td>
<td>4%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.42</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*“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.
In-Hospital Death after OAAA by Year

Rates shown are observed rates among cases meeting inclusion criteria.
In-Hospital Death after OAAA in Your Region (July 2017-June 2021)

Centers (centers with <10 complete cases not shown)

Rates shown are among complete cases. ** indicates center’s observed rate differs significantly from its expected rate.

In-Hospital Death after OAAA by Region Across VQI (July 2017-June 2021)

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

Rates shown are among complete cases. ** indicates region’s observed rate differs significantly from its expected rate.
OAAA: SVS Cell-Saver Guideline

Procedures performed between July 1, 2017 and June 30, 2021
Includes Open AAA (OAAA) procedures only. 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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of OAAA procedures meeting inclusion criteria</td>
<td>294</td>
<td>4545</td>
<td></td>
</tr>
<tr>
<td>Percentage meeting SVS cell-saver guideline</td>
<td>96.3%</td>
<td>92.4%</td>
<td></td>
</tr>
</tbody>
</table>
OAAA: SVS Iliac Inflow Guideline

Procedures performed between July 1, 2017 and June 30, 2021

Includes Open AAA (OAAA) procedures only. 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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of OAAA procedures meeting inclusion criteria</td>
<td>324</td>
<td></td>
<td>5087</td>
</tr>
<tr>
<td>Percentage meeting SVS iliac inflow guideline</td>
<td>98.8%</td>
<td></td>
<td>97.4%</td>
</tr>
</tbody>
</table>
OAAA Iliac Inflow Guideline in Your Region (July 2017–June 2021)

Other centers in your region  Your center

Centers (centers with <10 cases not shown)

OAAA Iliac Inflow Guideline by Region Across VQI (July 2017–June 2021)


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

**** Indicates region’s rate differs significantly from the VQI rate.
PVI CLAUD: ABI/Toe Pressure

Procedures performed between July 1, 2020 and June 30, 2021

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

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PVI procedures meeting inclusion criteria</td>
<td></td>
<td>1024</td>
<td>13720</td>
</tr>
<tr>
<td>Percentage with ABI/toe pressure assessment</td>
<td></td>
<td>73.3%</td>
<td>75.4%</td>
</tr>
</tbody>
</table>
ABI/Toe Pressure Assessment before PVI for Claudication by Year

- Your Center
- Your Region
- VQI Overall

July 2017–June 2018: Approximately 75%
July 2018–June 2019: Approximately 75%
July 2019–June 2020: Approximately 75%
July 2020–June 2021: Approximately 75%
**ABI/Toe Pressure Assessment before PVI for Claudication in Your Region (July 2020-June 2021)**

- **Other centers in your region**
- **Your center**

### Centers (centers with <10 cases not shown)

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

**ABI/Toe Pressure Assessment before PVI for Claudication by Region Across VQI (July 2020-June 2021)**

- **G. Lakes**
- **Virginia**
- **Pacific NW**
- **Carolina**
- **MidSouth**
- **Mid Atlantic**
- **Midwest**
- **Canada**
- **Nor Cal**
- **NQb**
- **Up Midwest**
- **SoVOnet**
- **So Cal**
- **New England**
- **Rocky Mtns**
- **NY**
- **Southeast**

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

- **** Indicates region's rate differs significantly from the VQI rate.
INFRA CLTI: Major Complications

Procedures performed between July 1, 2020 and June 30, 2021

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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of INFRA procedures meeting inclusion criteria</td>
<td></td>
<td>380</td>
<td>5410</td>
</tr>
<tr>
<td>Percentage with major complications</td>
<td></td>
<td>4.7%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>
Major Complications after INFRA for CLTI by Year

- Your Center
- Your Region
- VQI Overall
Major Complications after INFRA for CLTI in Your Region (July 2020–June 2021)

* Other centers in your region  •  Your center

Centers (centers with <10 cases not shown)

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

Major Complications after INFRA for CLTI by Region Across VQI (July 2020–June 2021)

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

*** Indicates region’s rate differs significantly from the VQI rate.
SUPRA CLTI: Major Complications

Procedures performed between July 1, 2020 and June 30, 2021

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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of SUPRA procedures meeting inclusion criteria</td>
<td>67</td>
<td>1143</td>
<td></td>
</tr>
<tr>
<td>Percentage with major complications</td>
<td>4.5%</td>
<td>8%</td>
<td></td>
</tr>
</tbody>
</table>
Major Complications after SUPRA for CLTI by Year

July 2017-June 2018
July 2018-June 2019
July 2019-June 2020
July 2020-June 2021

Your Center
Your Region
VQI Overall
Major Complications after SUPRA for CLTI in Your Region (July 2020-June 2021)

<table>
<thead>
<tr>
<th>Region</th>
<th>Rate (Other centers in your region)</th>
<th>Rate (Your center)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>Up. Midwest</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>VQI</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>New England</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>G. Lakes</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Southeast</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Carolinas</td>
<td>0%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Centers (centers with <10 cases not shown)

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

Major Complications after SUPRA for CLTI by Region Across VQI (July 2020-June 2021)

<table>
<thead>
<tr>
<th>Region</th>
<th>Rate (Regions with &lt;3 centers with at least 10 cases not shown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia</td>
<td>2%</td>
</tr>
<tr>
<td>Up. Midwest</td>
<td>4%</td>
</tr>
<tr>
<td>VQI</td>
<td>0%</td>
</tr>
<tr>
<td>New England</td>
<td>5%</td>
</tr>
<tr>
<td>G. Lakes</td>
<td>7%</td>
</tr>
<tr>
<td>Southeast</td>
<td>8%</td>
</tr>
<tr>
<td>Carolinas</td>
<td>10%</td>
</tr>
</tbody>
</table>

*** Indicates region’s rate differs significantly from the VQI rate.
LEAMP: Postop Complications

Procedures performed between July 1, 2020 and June 30, 2021

Includes Lower-Extremity Amputation (LEAMP) procedures only. Postoperative complications are defined as myocardial infarction, dysrhythmia, congestive heart failure, surgical site infection, renal complication, or respiratory complication.

The table below gives the number of LEAMP procedures meeting the inclusion criteria, and the percentage of those procedures that resulted in a postoperative complication.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of LEAMP procedures meeting inclusion criteria</td>
<td>410</td>
<td></td>
<td>3071</td>
</tr>
<tr>
<td>Percentage with postoperative complications</td>
<td>8.8%</td>
<td></td>
<td>10.6%</td>
</tr>
</tbody>
</table>
Postop Complications after LEAMP by Year

- July 2017-June 2018
- July 2018-June 2019
- July 2019-June 2020
- July 2020-June 2021

- Your Center
- Your Region
- VQI Overall
Postop Complications after LEAMP in Your Region (July 2020–June 2021)

Other centers in your region | Your center
---|---
0% | 0%
2% | 2%
4% | 4%
6% | 6%
8% | 8%
10% | 10%
12% | 12%
14% | 14%
16% | 16%
18% | 18%

Centers (centers with <10 cases not shown)

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

Postop Complications after LEAMP by Region Across VQI (July 2020–June 2021)

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 July 1, 2020 and June 30, 2021

Includes Hemodialysis Access (HDA) procedures only. 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.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of HDA procedures meeting inclusion criteria</td>
<td></td>
<td>92</td>
<td>5342</td>
</tr>
<tr>
<td>Percentage with primary AVF</td>
<td></td>
<td>79.3%</td>
<td>81.8%</td>
</tr>
</tbody>
</table>
Primary AVF Access by Year


- Your Center
- Your Region
- VQI Overall
Primary AVF Access in Your Region (July 2020-June 2021)

Centers (centers with <10 cases not shown)

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

Primary AVF Access by Region Across VQI (July 2020-June 2021)

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

*** Indicates region's rate differs significantly from the VQI rate.
National VQI Update:
Caroline Morgan
PSO Clinical Operations Associate
Number of Participating Centers

- 861 VQI Centers
- 860 centers in North America
- 1 center in Singapore

Location of VQI Participating Centers

861 VQI Centers
860 centers in North America
1 center in Singapore
18 Regional Quality Groups

Michigan Vascular Study Group

Vascular Study Group of Greater New York

Great Lakes Vascular Study Group

Puerto Rico

Canadian Vascular Quality Initiative

AK

HI
Total Procedures Captured
(as of 10/1/2021) 873,059

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral Vascular Intervention</td>
<td>293,316</td>
</tr>
<tr>
<td>Carotid Endarterectomy</td>
<td>163,871</td>
</tr>
<tr>
<td>Infra-Inguinal Bypass</td>
<td>70,071</td>
</tr>
<tr>
<td>Endovascular AAA Repair</td>
<td>67,405</td>
</tr>
<tr>
<td>Hemodialysis Access</td>
<td>66,675</td>
</tr>
<tr>
<td>Carotid Artery Stent</td>
<td>62,732</td>
</tr>
<tr>
<td>Varicose Vein</td>
<td>49,015</td>
</tr>
<tr>
<td>Supra-Inguinal Bypass</td>
<td>22,661</td>
</tr>
<tr>
<td>Thoracic and Complex EVAR</td>
<td>22,541</td>
</tr>
<tr>
<td>Lower Extremity Amputations</td>
<td>22,572</td>
</tr>
<tr>
<td>IVC Filter</td>
<td>16,407</td>
</tr>
<tr>
<td>Open AAA Repair</td>
<td>15,509</td>
</tr>
<tr>
<td>Vascular Medicine Consult</td>
<td>232</td>
</tr>
<tr>
<td>Venous Stent</td>
<td>52</td>
</tr>
</tbody>
</table>

VQI Total Procedure Volume

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

- VQI wants to help medical students, residents and fellows learn about quality improvement
Purpose:
To foster understanding of quality process and metrics among Vascular Surgery Residents, Fellow and Medical Students (‘trainees’) through mentorship in the Vascular Quality Initiative (VQI) in collaboration with the Association of Program Directors in Vascular Surgery (APDVS).

Proposal:
The SVS/PSO proposes a mentorship program for trainees to learn about surgical quality improvement and research with a focus on vascular disease. Selection of FITs would come from application to the Society for Vascular Surgery (SVS) Patient Safety Organization (PSO) VQI. FITs will be assigned a mentor(s) within one of eighteen VQI Regional Quality Groups as directed by the SVS PSO Governing Council and staff. Any active VQI member meeting requirements can volunteer to serve as a mentor in the program. Regional or Associate Medical Directors are strongly encouraged to take a leadership role in this initiative. The program will eventually be offered to medical students.
Trainee Development Workgroup

- Dr. Gary Lemmon – Chair
- Herb Aronow – SVM
- Dr. Faisal Aziz - PSO Governing Council
- Dr. Mina Boutros – SVS DEI
- Dr. Ashley Gutwein – IU Health 5th Year Resident
- Dr. Beau Hawkins – SCAI
- Dr. Jeff Indes – PSO Governing Council
- Dr. Brigitte Smith - APDVS
- Dr. Gabriella Velazquez - APDVS
- Dr. Ashley Vavra - PSO Governing Council
- Jim Wadzinski – PSO
- Betsy Wymer - PSO
VQI Representatives
- Dr. Leila Mureebe – Chair
- Dr. Carla Moreiro – Vice-Chair
- Dr. Samantha Minc
- Dr. Patricia Fernandez
- Dr. Mina Boutros
- Dr. Rafael Malgor
DEI Committee Inclusion Criteria

• Broad representation
  ➢ Years in practice
  ➢ Region
  ➢ Gender
  ➢ Race
SVS PSO DEI Committee:

**Purpose:**

Recognizing the need for diversity of perspectives to help eliminate bias in the governance and leadership activities of the SVS PSO, the SVS PSO Diversity Committee will work with SVS PSO Councils and Committees to ensure representation of all VQI stakeholders.

**Major Initial Initiative:**

The initial task for the PSO DEI Committee is to develop a baseline understanding of the demographics of the physicians participating in the VQI. The Committee has developed the construct of a survey instrument, which will be launched in February 2022.
The 2021 VQI Annual Meeting was a huge success!

This year, VQI@VAM was a hybrid meeting with all sessions live-streamed. The meeting had approximately 175 attendees participating either remotely or in person throughout the two days.

Thank you to each of our presenters. We appreciate the time and talents you contribute to making this meeting better every year. The information presented was excellent.

Once again, we had amazing poster presentations! Congratulations to Priya Padmanabhan, MHA; Rosha Nodine, BAAS from Baylor Scott & White Health System for winning the ‘VQI member favorite poster’ with their poster “VQI Summary Report Tool in EPIC”.

This year, we added a new poster award called the ‘PSO Director Award’. Congratulations to Donna Fleming, MSN, RN, from Cleveland Clinic for winning this new award with her poster “AAA Size Appropriateness Quality Project”.

**Reminder – If you did a quality presentation using VQI data at any SVS sessions during VAM, you must email bwymer@svspso.org to receive credit for that presentation. Please provide your presentation, as well as your center name. All VQI@VAM presentations have already been given credit.**
We have achieved this remarkable milestone because of your participation and efforts. Thank you for all that you do to make the VQI a success.
COVID-19 Update

Review of primary outcomes in VQI Registry Data since insertion of COVID variables (Sept ’20 through Feb ’21) yielded the following results:

- Overall, > 97% of variable inclusion rate for COVID status in all registries
- Only 1.2% of patients tested positive for COVID-19 → restrictive practices in place and/or patient hesitation/reluctance to seek treatment during pandemic
- Baseline overall mortality across registries of 1.4% rose to 1.6% during time interval while baseline mortality for elective patients who were asymptomatic and COVID (Test negative) remained unchanged
- Patients having a COVID (Test positive) yet Asymptomatic had mortality > twice that of -COVID test patients (OR 2.4)
- Presence of any COVID symptom (aggregate) had mortality of ~4.6 times that of an Asymptomatic and (Test negative) patient (OR 5)
- Mortality of Symptomatic and Intubated patient exceeded 33% across registries
- There was minimal difference in mortality across geographic regions
- Further evaluation will be done on secondary procedure outcomes such as MI, CHF, respiratory failure, graft failure etc.
- LTFU analysis of COVID variable data will require waiting until Sept 2023 for completeness.
The SVS VQI recognizes that traditional outcomes such as patency and reintervention may not fully capture the quality of care or the experience of PAD patients. There is an important need to learn and measure the patient’s perspective.

The My PAD pilot launched April 2021 and includes 20 SVS VQI centers participating in the Peripheral Vascular Intervention Registry. The pilot will test center workflow and seeks to improve PRO collection in the least burdensome manner by leveraging technology, such as smart phones and tablets.
Highlights

- Outpatient peripheral vascular interventions (PVI) for claudication or chronic limb threatening ischemia
- Collect VascuQoL-6 and EuroQoL 5D-5L (estimated completion time 10-15 minutes)
- Collection at three time points: pre-procedure, one month and one year postoperatively
- PRO data entry options include paper forms, computer, tablet and smartphone
- Educational materials for direct from patient data entry
- PRO feedback to participating physicians
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.**
REMEMBER TO PSO:

• **P**UT your FULL NAME in RingCentral to get credit for attendance and CME/CE credit (no exceptions will be made)

• **S**END an email to ljohnson@svspso.org with names of group members that are sharing 1 device

• **O**FFICIALLY apply for CME/CE credit by clicking this link:
  https://dmu.co1.qualtrics.com/jfe/form/SV_4GuwK2nLMqdttPw

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
TAKE A BREAK!
Quality Improvement Update

Fall 2021
Welcome to our new SVS PSO Director of Quality!!

Over the years, Betsy has developed innovative approaches to quality and education for various populations. She has twenty plus years of clinical expertise! As a doctorate prepared nurse, she will apply theory, quality, and research to support the VQI Mission!

Betsy comes to us from ACC/NCDR and we look forward to having her on the VQI team!
Quality Improvement Resources:

- Quarterly Webinars
- Monthly “VQI News”
- QI Project Guide Supplement

The Vascular Quality Initiative | Quality Improvement Tools (vqi.org)
<table>
<thead>
<tr>
<th>Poster/QI PROJECT</th>
<th>Primary Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA Size Appropriateness Quality Project</td>
<td>Donna Fleming, RN</td>
</tr>
<tr>
<td>Decreasing Post-Operative Length of Stay after Lower Extremity Bypass</td>
<td>Tracy Campin, RN</td>
</tr>
<tr>
<td>Implementation of an Infection Prevention Bundle for Patients Undergoing</td>
<td>Mark Abel, MD</td>
</tr>
<tr>
<td>Vascular Lower Extremity Bypass Surgical Procedures at Dartmouth-Hitchcock</td>
<td></td>
</tr>
<tr>
<td>Medical Center: A Quality Improvement Project to Reduce Surgical Site Infections</td>
<td></td>
</tr>
<tr>
<td>EVAR LTFU at UW Medicine</td>
<td>Amanda Sigala, RN/Nam Tran, MD</td>
</tr>
<tr>
<td>Multi-center implementation of the Clinical Frailty Scale within the vascular</td>
<td>Julie Beckstrom, RN</td>
</tr>
<tr>
<td>surgery clinic workflow for VQI hashtag data collection</td>
<td></td>
</tr>
<tr>
<td>VQI Summary Report Tool in EPIC</td>
<td>Priya Padmananbhan, RN/Rosha Nodine, BAAS</td>
</tr>
<tr>
<td>Leveraging technologies to improve VQI Long term follow up compliance and data</td>
<td>Lillian Camino</td>
</tr>
<tr>
<td>documentation: a centralized metadata approach.</td>
<td></td>
</tr>
<tr>
<td>Best Practices for Complex Endovascular Procedures</td>
<td>Amanda Sigala,RN/Ben Starnes, MD</td>
</tr>
<tr>
<td>Anticoagulation and Antiplatelet Treatment Plan Communication and Documentation</td>
<td>Aaron Barnes, MD</td>
</tr>
<tr>
<td>Poster/QI PROJECT:</td>
<td>Primary Author</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Froedtert Hospital Performance Improvement Project to Increase Antiplatelet and Statin Medications Prescribed at Discharge</td>
<td>Juliann Inkmann</td>
</tr>
<tr>
<td>VQI Checklist in the EMR: Impact on Statin and Antiplatelet Prescriptions at Discharge</td>
<td>Claire Motyl, BA</td>
</tr>
<tr>
<td>Using VQI and EMR chart alerts to increase compliance of statin and aspirin, a retrospective study</td>
<td>Jennifer Landis PA-C</td>
</tr>
<tr>
<td>Development of a Successful Process to Enhance the Transition between Data Managers</td>
<td>Donna Albergo, RN</td>
</tr>
<tr>
<td>Road to Recovery for Patients Undergoing Vascular Procedures at the Heart and Vascular Center</td>
<td>Sandy Fillion, MSN</td>
</tr>
<tr>
<td>Sustaining High Performance in Long Term Follow Up Care</td>
<td>Rouchelyn Fallorina, RN</td>
</tr>
<tr>
<td>Increasing data entry rates for VQI variables using SmartText: a pilot approach</td>
<td>Aravind Ponukumati</td>
</tr>
<tr>
<td>Implementation of a Long Term Follow Performance Improvement Project for the TEVAR and Complex EVAR Module</td>
<td>Zdenek Novak</td>
</tr>
<tr>
<td>Implementation of providing patients with surgical site care instructions and supply kits on day of discharge to decrease surgical site infections</td>
<td>Sue Nappo, RN</td>
</tr>
<tr>
<td>Impact of preoperative anemia in patients undergoing peripheral vascular intervention</td>
<td>Abdul Kader Natour, MD</td>
</tr>
</tbody>
</table>
Charter participants become part of focused group calls

- Interactive discussion sharing barriers and successes
- Sharing of charters
- Networking
- Checking in – where are you in the process
- Celebrating success

One on one calls, if requested
National QI project details

• Submit Project Charters and supporting documentation for presentations and posters to QI@SVSPSO.ORG or Bwymer@svspso.org

• Visit the VQI Members Only Website for sample charters, webinars, and presentations on VQI Quality Improvement Projects. www.vqi.org
Participation Awards
Participation Awards Program

- Participation Awards began in 2016 to encourage active participation in the registries program and recognize the importance of participation.

- Participating centers can earn up to three stars based on actions that lead to better patient care – more details available at https://www.vqi.org/quality-improvement/participation-awards/
MAJOR CHANGE

• Long Term Follow-Up 2018 cases
  – COVID-19 affect
  – Remove LFTU from the 2020 Participation Award – **BUT**...
  – Acknowledge centers that maintained, improved LTFU with a certificate
    • Centers in top 25% for 2018 LTFU rates
    • Statistically significant increase in LTFU rate from 2017 to 2018
Scoring 2020 (During COVID-19)

• Three categories scored, each on a 0-6 point scale:
  o LTFU – REMOVED. Separate recognition.
  o Meeting attendance (weighted 50%)
  o QI project involvement (weighted 40%)
  o Number of registry subscriptions (weighted 10%)

• The final score is calculated as follows:
  Total points = 5 x Attendance score + 4 x QIP score + 1 x Registry score
2021 Participation Award:

Effective immediately the Participation Committee unanimously voted to re-instate LTFU criteria in the 2021 Participation Awards.

The following is a list of the four domains for the 2021 Participation Awards criteria:

- Domain 1 – LTFU – 40% weighted
- Domain 2 – Regional Meeting attendance – 30% weighted
- Domain 3 – QI Project – 20% weighted
- Domain 4 – Registry subscriptions – 10% weighted

The final score is calculated as follows:

Total points = 4 x LTFU score + 3 x Attendance score + 2 x QI score + 1 x registry score
Arterial Quality Council:

Peter Rossi, MD
AQC Update:

• Development Priorities for end of 2021/ early 2022
  o Infra/Supra revisions goal to complete by end of 2021
  o OAAA revision goal to complete by end of Q2 2022

• New “Pathways” follow up reports
  o CAS, EVAR available
  o CEA, TEVAR, PVI, HDA available late 2021 - early 2022
  o All other registries to follow
AQC Update:

• **Clinical Appropriateness Performance Indicators (CAPI reports)**
  o Aligning with SVS Guidelines

• **Standard Operative Notes**
  o We have resumed talks with Epic and have restarted the initiative to create standard op notes, which will enable automated data abstract, based on the standardized notes. This functionality would be available to all Epic users.

• **Registry Specific Quality Improvement Initiatives**

• **Patient Reported Outcomes: My PAD PRO Pilot PVI**

• **Opioid variables: Infra-Inguinal – Available August**

• **Registry Education: recorded sessions!!**
  — All available on VQI.org  [https://www.vqi.org/resources/webinars-events/](https://www.vqi.org/resources/webinars-events/)
Vascular Medicine Consult Registry

The Society for Vascular Surgery Patient Safety Organization® (SVS PSO) and the Society for Vascular Medicine (SVM), in collaboration with the American Heart Association® (AHA), are excited to introduce the SVS Vascular Quality Initiative’s Vascular Medicine Consult (VMC) Registry.

This Registry will target the management of NEW Outpatient Consults who are being treated medically for:

- Atherosclerotic carotid artery occlusive disease
- Abdominal Aortic aneurysm
- Peripheral lower extremity arterial disease due to atherosclerosis or true aneurysm

The Vascular Medicine Consult Registry provides a unique opportunity to look at the natural history of a disease and what factors impact the progression. The emphasis of this Registry will be medication details and dosages, risk factor and lifestyle modifications such as exercise and diet, and non-operative treatments and counseling. The value of this Registry centers on the comparative effectiveness of surgery vs. medically managing these vascular diseases.

Learn more: The Vascular Quality Initiative | Vascular Medicine Consult Registry (New) (vqi.org)
Venous Quality Council:
Fahad Shuja, MD
Venous SVS PSO Organization

SVS PSO Venous Arm

**Governing Council**
- 4 SVS Representatives
- 2 AVF Representatives
- 18 Regional Group Representatives

**Research Advisory Council (Venous RAC)**
- Chair: Nicholas Osborne

**Venous Quality Council (VQC)**
- Chair: Marc Passman
- 3 AVF + 2 SVS Representatives
- 18 Regional Group Representatives

**Committees**
- **IVC Filter Committee**
  - Chair: Tony Gasparis

- **Varicose Vein Committee**
  - Chair: Nick Osborne

- **Venous Stent Committee**
  - Chair: William Marston
Three Year Goals for VQC:

- Dedicated podium time for VQI at AVF
- Update Varicose Vein and IVC quarterly interoperative dashboards
- Create Venous Stent dashboard
- Work on LTFU dashboards for all 3 venous procedures
- Continue work C2 disease and appropriateness of care
- Continue work with United Healthcare
- Create COPI (Center Opportunity for Process Improvement) reports
- Create CAPI (Clinical Appropriateness Performance Indicators) reports
Venous Stent Inclusion/Exclusion Criteria

Inclusion Criteria:
Percutaneous (closed) and/or cut-down (open) procedures to treat patients with symptomatic venous obstructions due to chronic thrombosis and/or some venous compression disorders. Vessels included: Inferior Vena Cava, Common iliac vein, External iliac vein, Common Femoral Vein, Deep Femoral Vein, Femoral Vein, Popliteal Vein.

- Acute obstruction of the Vein;
- Chronic thrombotic obstruction= Chronic Stenosis/Obstruction of the Vein;
- Non-thrombotic stenosis/compression such as May Thurner (iliac vein compression syndrome)

Exclusion Criteria:
- Venous Stent of the Internal Iliac (hypogastric), Great Saphenous Vein, Superior vena cava, Renal Veins, Subclavian vein, Jugular vein, Innominate vein and any upper extremity veins
- Vein Diameters that are not treatable per stent sizing recommendations
- Venous Inflow or Outflow issues precluding stent placement
Arterial Research Advisory Council:
Joseph Hart, MD
New RAC Education!!

Dr. Leila Mureebe,
SVS PSO Associate Medical Director

– Creating videos on how to submit a RAC Proposal for “success”
– Creating useful tools and tips to train new investigators
1. Review list of projects: 
https://www.vqi.org/data-analysis/rac-approved-project-search/

2. Submit proposal online: 
http://abstracts123.com/svs1/meetinglogin

3. Deadlines for submissions: 
The Vascular Quality Initiative | National Arterial and Venous RAC Schedules (vqi.org)
VISION: Vascular Implant Surveillance and Interventional Outcomes Network.

- It is a partnership between the Society for Vascular Surgery Patient Safety Organization’s Vascular Quality Initiative (SVS PSO) and Medical Device Epidemiology Network (MDEpiNet). The goal is to improve the quality, safety and effectiveness of vascular care.

- VISION developed algorithms, which allows certain VQI registry patients to be matched to Medicare claims data. Claims linkage allows very complete follow up on CMS patients (greater than 65 years of age, dialysis, etc).

- VISION’s primary goal is to facilitate low-cost, high-value and real-world evidence research through the creation of a national repository of linked clinical-claims analytic data sets. The secondary objectives are to measure the safety and effectiveness of vascular devices.
VISION: SRS Reports!

• The Vascular Quality Initiative is pleased to provide participating members with center-specific Survival, Reintervention, and Surveillance Reports (SRS)

• SRS reports are produced by the VQI as part of the Vascular Implant Surveillance and Interventional Outcomes Network (VISION) Project, a partnership between the VQI and the Medical Device Epidemiology Network (MDEpiNet). The reports are based on VQI-Medicare linked data. Each report shows each center’s long-term performance when compared to the VQI for Medicare patients undergoing the following procedures:
  ▪ endovascular abdominal aortic aneurysm repairs (EVAR)
  ▪ elective abdominal aortic aneurysm repair (EVAR + Open AAA)
  ▪ carotid endarterectomy for asymptomatic stenosis
  ▪ carotid artery stent procedures (TCAR and transfemoral procedures) for asymptomatic stenosis

• FAQs on the methods and definitions used to generate these reports can be found on the VQI Website (VQI.org). The goal of the SRS reports is to help VQI members assess their performance on these important metrics compared to the rest of the VQI and to improve the quality of vascular care at their center.
April 2021 meeting updates:

- COVID collaboration with VASCC
- Improved reporting (PSO reports/MedStreaming)
- US News and World Report Collaboration
- Data Integration (EPIC/Cerner)
- Relationships (Societies/FDA/CMS/Industry)
- SVS PSO Diversity Committee
Medstreaming + M2S are now Fivos

About Our Name

Fivos is an alternate name for the ancient Greek deity, Apollo: God of light, truth, medicine and healing. Celebrates our roots in imaging, our focus on healing, and our commitment to defragmenting insights across healthcare.

Visit: https://fivoshealth.com/ for more information
• Spring 2022 Regional Meeting
  – Location
  – Hybrid
  – Doodle Poll

Thank you!
REMEMBER TO PSO:

• **P**UT your FULL NAME in RingCentral to get credit for attendance and CME/CE credit (no exceptions will be made)

• **S**END an email to ljohnson@svspso.org with names of group members that are sharing 1 device

**O**FFICIALLY apply for CME/CE credit by clicking this link:
https://dmu.co1.qualtrics.com/jfe/form/SV_4GuwK2nLMqdttPw

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