Vascular Study Group of Greater New York (VSGGNY)

April 23, 2021
2 pm - 4:30 pm ET
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
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>CE Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00 pm</td>
<td>Welcome</td>
<td>No</td>
</tr>
</tbody>
</table>
| 2:05 pm| Regional Data Review  
Jeffrey Indes, MD, Regional Medical Leader, VSGGNY  
Learning Objectives:  
• 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       |
| 3:05 pm| Regional QI Proposal  
Jeffrey Indes, MD, Regional Medical Leader, VSGGNY  
Learning Objectives:  
• 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       |
<table>
<thead>
<tr>
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<th>CE Credit</th>
</tr>
</thead>
</table>
| 3:35 pm  | National VQI Update  
Cheryl Jackson, DNP, MS, RN, CNOR, CPHQ, Quality Director, PSO  
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       |
| 4:05 pm  | AQC Update – Angela Kokkosis, M.D.                                   | No        |
| 4:05 pm  | VQC Update – Glenn Jacobwitz, M.D.                                  | No        |
| 4:20 pm  | RAC Update – Jeffrey Indes, M.D.                                    | No        |
| 4:20 pm  | Governing Council Update – Jeffrey Indes, M.D.                      | No        |
| 4:20 pm  | Case Presentation  
1. Patricia Yau, MD, PGY-4, “Endovascular interventions for claudication do not meet minimum standards for the Society for Vascular Surgery efficacy guidelines”, Montefiore Medical Center / Albert Einstein College of Medicine | No        |
| 4:30 pm  | Open Discussion/Next Meeting/Meeting Evaluation                      | No        |
No presenter has a disclosure or conflict of interest to report.
Welcome and Introductions

<table>
<thead>
<tr>
<th>Albany Medical Center</th>
<th>North Shore University Hospital</th>
<th>Westchester Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnot Health</td>
<td>NYU Langone Medical Center</td>
<td>White Plains Hospital</td>
</tr>
<tr>
<td>Beth Israel Medical Center</td>
<td>NYU Winthrop Hospital</td>
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</tr>
<tr>
<td>Brooklyn Methodist Hospital</td>
<td>Orange Regional Medical Center</td>
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</tr>
<tr>
<td>Catholic Health Mercy Hospital of Buffalo</td>
<td>Queens</td>
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</tr>
<tr>
<td>Catholic Health Sister of Charity Hospital</td>
<td>Southside Hospital</td>
<td></td>
</tr>
<tr>
<td>Columbia University Irving Medical Center</td>
<td>St. Luke's Campus</td>
<td></td>
</tr>
<tr>
<td>Crouse Hospital</td>
<td>St. Luke's-Roosevelt Hospital Center</td>
<td></td>
</tr>
<tr>
<td>Glens Falls Hospital</td>
<td>St. Peter's Hospital</td>
<td></td>
</tr>
<tr>
<td>John T. Mather Memorial Hospital</td>
<td>Staten Island University Hospital - North Site</td>
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</tr>
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<td>Kaleida Health</td>
<td>Stony Brook University Medical Center</td>
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<td>Lenox Hill Hospital</td>
<td>United Health Services Hospitals, Inc.</td>
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<td>Long Island Jewish Medical Center</td>
<td>University Hospital</td>
<td></td>
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<tr>
<td>Maimonides Medical Center</td>
<td>University of Rochester Medical Center</td>
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</tr>
<tr>
<td>MidHudson Regional Hospital</td>
<td>Vassar Brothers Medical Center</td>
<td></td>
</tr>
<tr>
<td>Montefiore Medical Center</td>
<td>Weill Cornell University Medical Center</td>
<td></td>
</tr>
<tr>
<td>Mount Sinai Hospital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VQI Regional Quality Report

Spring 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 January 31, 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.
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 overall, aggregate percentage of cases with the noted outcome, as well as the 25th, 50th (median), and 75th percentiles, for centers in your region and VQI, respectively ([25th|50th|75th]). Your center’s results are highlighted blue if your center is in the “best” 25th percentile for VQI Overall, and coral if your center is in the “worst” 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 = “Best” 25th percentile  Coral = “Worst” 25th percentile

Note that procedure volume results are not highlighted
Dashboard Highlights

• New Colors [Legend: Blue = “Best” 25th percentile | Coral = “Worst” 25th percentile]

• New procedure groupings

• New Case Appendix with...
Dashboard Highlights

• Embedded drill-down and data feedback

VQI Case Appendix

Winter 2020

About the Appendix

The VQI Case Appendix provides embedded data feedback and drill-down for each dashboard report. Using the appendix, centers can easily identify and download cases that were reviewed or excluded from each report, as well as cases with each noted outcome.

The interactive tables below give your center’s cases (both reviewed and excluded) entered for the procedure timeframe of each report (as of 11/30/2020). Each row references a particular case and each case is referenced by a PRIMPROCID, a unique case identifier assigned to each procedure to protect patient identity. Additional data elements are included for each case to further facilitate quality improvement efforts, including procedure and patient characteristics, length-of-stay (LOS) data, discharge medication data, complication data, and other data elements related to dashboard report construction.

To download a .csv or .xlsx file containing your center’s data, click on either the “CSV” or “Excel” buttons located above each interactive table.
Dashboard Highlights

- **Embedded drill-down and data feedback**

<table>
<thead>
<tr>
<th>PRIMPROCID</th>
<th>In INFRA</th>
<th>In INFRA CLAUD</th>
<th>Indication Right</th>
<th>Indication Left</th>
<th>Side Treated</th>
<th>Postop LOS</th>
<th>Total LOS</th>
<th>Discharge Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td></td>
<td>Not Treated</td>
<td>Tissue Loss</td>
<td>L</td>
<td>4</td>
<td>7</td>
<td>Home</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td></td>
<td>Not Treated</td>
<td>Tissue Loss</td>
<td>L</td>
<td>2</td>
<td>3</td>
<td>Home</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td></td>
<td>Not Treated</td>
<td>Tissue Loss</td>
<td>L</td>
<td>8</td>
<td>8</td>
<td>Rehab Unit</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td></td>
<td>Not Treated</td>
<td>Tissue Loss</td>
<td>L</td>
<td>12</td>
<td>12</td>
<td>Rehab Unit</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td></td>
<td>Not Treated</td>
<td>Claudication</td>
<td>L</td>
<td>2</td>
<td>2</td>
<td>Home</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td></td>
<td>Not Treated</td>
<td>Claudication</td>
<td>L</td>
<td>2</td>
<td>2</td>
<td>Home</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td></td>
<td>Tissue Loss</td>
<td>Tissue Loss</td>
<td>R</td>
<td>13</td>
<td>13</td>
<td>Rehab Unit</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td></td>
<td>Tissue Loss</td>
<td>Not Treated</td>
<td>R</td>
<td>5</td>
<td>15</td>
<td>Rehab Unit</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td></td>
<td>Not Treated</td>
<td>Acute Ischemia</td>
<td>L</td>
<td>5</td>
<td>7</td>
<td>Home</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td></td>
<td>Rest Pain</td>
<td>Not Treated</td>
<td>R</td>
<td>2</td>
<td>2</td>
<td>Rehab Unit</td>
</tr>
</tbody>
</table>

- # of INFRA cases in procedure timeframe
- # of INFRA cases included in each INFRA dashboard
- # of INFRA cases not included in either INFRA dashboard (note: 5+9+66=80)
- Download .csv or .xlsx file of your data
- Binary indicators for dashboard inclusion (1=yes, 0 = no)
- Use scroll bar to see additional variables
- Change the # of rows for display (10,25,50,100,250, or 500)
- Search: Returns every row containing at least 1 cell satisfying the value entered in the search bar (not incredibly useful)
- Sort on any column by clicking the double arrows
- Click to page thru your cases

12
Dashboard

The dashboard provides a high-level summary 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” column give the overall, aggregate percentage of cases with the noted outcome, as well as the 25th, 50th (median), and 75th percentiles, for centers in your region and VQI, respectively (25th/50th/75th). Your center’s results are highlighted blue if your center is in the “best” 25th percentile for VQI Overall, and coral if your center is in the “worst” 25th percentile for VQI Overall.

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

<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></td>
<td>Procedure Volume</td>
<td>[79</td>
<td>247</td>
<td>393]</td>
</tr>
<tr>
<td></td>
<td>Procedure Volume, All</td>
<td>[75</td>
<td>753</td>
<td>2941]</td>
</tr>
<tr>
<td>Multiple</td>
<td>Long-Term Follow-up</td>
<td>56.8% [27%</td>
<td>67%</td>
<td>74%]</td>
</tr>
<tr>
<td></td>
<td>Discharge Medications</td>
<td>81% [77%</td>
<td>80%</td>
<td>86%]</td>
</tr>
<tr>
<td>TFEM CAS ASYM</td>
<td>Stroke/Death</td>
<td>2.8% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td>TFEM CAS SYM</td>
<td>Stroke/Death</td>
<td>9.6% [0%</td>
<td>0%</td>
<td>1%]</td>
</tr>
<tr>
<td>TCAR ASYM</td>
<td>Stroke/Death</td>
<td>1% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td>TCAR SYM</td>
<td>Stroke/Death</td>
<td>0% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td>CEA ASYM</td>
<td>Stroke/Death</td>
<td>1.1% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td></td>
<td>Postop LOS&gt;1 Day</td>
<td>28.1% [18%</td>
<td>25%</td>
<td>33%]</td>
</tr>
<tr>
<td>CEA SYM</td>
<td>Stroke/Death</td>
<td>1.9% [0%</td>
<td>0%</td>
<td>0%]</td>
</tr>
<tr>
<td></td>
<td>Postop LOS&gt;1 Day</td>
<td>55.2% [33%</td>
<td>50%</td>
<td>65%]</td>
</tr>
<tr>
<td>EVAR</td>
<td>Postop LOS&gt;2 Days</td>
<td>20.8% [15%</td>
<td>22%</td>
<td>33%]</td>
</tr>
<tr>
<td></td>
<td>Sac Diameter Reporting</td>
<td>50.2% [20%</td>
<td>63%</td>
<td>70%]</td>
</tr>
<tr>
<td></td>
<td>SVS Sac Size Guideline</td>
<td>70.8% [61%</td>
<td>71%</td>
<td>79%]</td>
</tr>
<tr>
<td>TEVAR</td>
<td>Sac Diameter Reporting</td>
<td>57.8% [21%</td>
<td>48%</td>
<td>82%]</td>
</tr>
<tr>
<td>OAAA</td>
<td>In-Hospital Mortality</td>
<td>13.6% [0%</td>
<td>0%</td>
<td>20%]</td>
</tr>
<tr>
<td></td>
<td>SVS Cell-Saver Guideline</td>
<td>95% [100%</td>
<td>100%</td>
<td>100%]</td>
</tr>
<tr>
<td></td>
<td>SVS Iliac Inflow Guideline</td>
<td>100% [100%</td>
<td>100%</td>
<td>100%]</td>
</tr>
<tr>
<td>PVI CLAUD</td>
<td>ABI/Ao Pressure</td>
<td>59.2% [59%</td>
<td>68%</td>
<td>82%]</td>
</tr>
<tr>
<td>INFRA CLTI</td>
<td>Major Complications</td>
<td>3.6% [0%</td>
<td>2%</td>
<td>5%]</td>
</tr>
<tr>
<td>SUPRA CLTI</td>
<td>Major Complications</td>
<td>11.9% [0%</td>
<td>0%</td>
<td>12%]</td>
</tr>
<tr>
<td>LEAMP</td>
<td>Postop Complications</td>
<td>10.1% [7%</td>
<td>10%</td>
<td>14%]</td>
</tr>
<tr>
<td>HDA</td>
<td>Primary AVF vs. Graft</td>
<td>83.6% [72%</td>
<td>79%</td>
<td>89%]</td>
</tr>
<tr>
<td>IVCF</td>
<td>Filter Retrieval Reporting</td>
<td>52.3% [39%</td>
<td>48%</td>
<td>73%]</td>
</tr>
</tbody>
</table>

Legend: Blue = “Best” 25th percentile  Coral = “Worst” 25th percentile
Note that procedure volume results are not highlighted
## Procedure Volume

Procedures performed between January 1 and December 31, 2020

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

<table>
<thead>
<tr>
<th>Procedure</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></td>
<td>530</td>
<td>11221</td>
</tr>
<tr>
<td>CEA</td>
<td></td>
<td>793</td>
<td>15828</td>
</tr>
<tr>
<td>EVAR</td>
<td></td>
<td>386</td>
<td>6473</td>
</tr>
<tr>
<td>HDA</td>
<td></td>
<td>688</td>
<td>6405</td>
</tr>
<tr>
<td>INFRA</td>
<td></td>
<td>544</td>
<td>6797</td>
</tr>
<tr>
<td>IVCF</td>
<td></td>
<td>230</td>
<td>1515</td>
</tr>
<tr>
<td>LEAMP</td>
<td></td>
<td>308</td>
<td>3192</td>
</tr>
<tr>
<td>OAAA</td>
<td></td>
<td>23</td>
<td>1243</td>
</tr>
<tr>
<td>PVI</td>
<td></td>
<td>3028</td>
<td>37799</td>
</tr>
<tr>
<td>SUPRA</td>
<td></td>
<td>108</td>
<td>1892</td>
</tr>
<tr>
<td>TEVAR</td>
<td></td>
<td>151</td>
<td>2691</td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>NA (&lt;3 centers)</td>
<td></td>
<td>5938</td>
</tr>
<tr>
<td>Overall (Jan-Dec 2020)</td>
<td></td>
<td>8023</td>
<td>100994</td>
</tr>
<tr>
<td>Overall (Jan-Dec 2019)</td>
<td></td>
<td>11432</td>
<td>116809</td>
</tr>
</tbody>
</table>
**Procedure Volume by Center in Your Region (Jan-Dec 2020)**

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

**Procedure Volume Across VQI (Jan-Dec 2020)**

- **Others**
- **Nor. Cal.**
- **So. Cal.**
- **Canada**
- **Pacific NW**
- **MidSouth**
- **SoVONet**
- **Michigan**
- **Midwest**
- **Rocky Mtns.**
- **Mid-Atlantic**
- **Up. Midwest**
- **Carolines**
- **G. Lakes**
- **New England**
- **New York**
- **Virginia**
- **Southeast**

**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 December 31, 2020

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

<table>
<thead>
<tr>
<th>Procedure</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>2748</td>
<td>49828</td>
<td></td>
</tr>
<tr>
<td>CEA</td>
<td>6658</td>
<td>150058</td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td>3996</td>
<td>59655</td>
<td></td>
</tr>
<tr>
<td>HDA</td>
<td>6440</td>
<td>59322</td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
<td>4021</td>
<td>64165</td>
<td></td>
</tr>
<tr>
<td>IVCF</td>
<td>1817</td>
<td>15055</td>
<td></td>
</tr>
<tr>
<td>LEAMP</td>
<td>1761</td>
<td>19810</td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td>342</td>
<td>14321</td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td>21247</td>
<td>251233</td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td>1204</td>
<td>20722</td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td>1234</td>
<td>19158</td>
<td></td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>NA (&lt;3 centers)</td>
<td>42963</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>61128</td>
<td>766290</td>
<td></td>
</tr>
</tbody>
</table>
Procedure Volume by Center in Your Region (Through Dec 2020)

Centers (centers with <10 cases not shown)

Procedure Volume Across VQI (Through Dec 2020)

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

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

Physician Specialties Across VQI (as of January 31, 2021, N=5617 Physicians)
Physician Specialties Across Your Region (as of January 31, 2021, N=268 Physicians)
Long-Term Follow-up

Procedures performed between January 1 and December 31, 2018

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></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS</td>
<td>490 (58%)</td>
<td>7782 (64%)</td>
<td></td>
</tr>
<tr>
<td>CEA</td>
<td>951 (54%)</td>
<td>18807 (71%)</td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td>540 (58%)</td>
<td>7327 (72%)</td>
<td></td>
</tr>
<tr>
<td>HDA</td>
<td>1054 (61%)</td>
<td>8010 (67%)</td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
<td>524 (57%)</td>
<td>7339 (72%)</td>
<td></td>
</tr>
<tr>
<td>IVCF</td>
<td>237 (73%)</td>
<td>2003 (77%)</td>
<td></td>
</tr>
<tr>
<td>LEAMP</td>
<td>289 (68%)</td>
<td>3309 (66%)</td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td>35 (80%)</td>
<td>1251 (75%)</td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td>2902 (52%)</td>
<td>34936 (70%)</td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td>168 (50%)</td>
<td>2359 (72%)</td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td>191 (71%)</td>
<td>2684 (69%)</td>
<td></td>
</tr>
<tr>
<td>Overall (Jan-Dec 2018)</td>
<td>7381 (57%)</td>
<td>95807 (70%)</td>
<td></td>
</tr>
<tr>
<td>Overall (Jan-Dec 2017)</td>
<td>6323 (67%)</td>
<td>86744 (73%)</td>
<td></td>
</tr>
</tbody>
</table>
**Long-Term Follow-Up by Center in Your Region (Jan-Dec 2018)**

- Blue bars: Other centers in your region
- Orange bar: Your center

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

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

---

**Long-Term Follow-Up by Region Across VQI (Jan-Dec 2018)**

- Blue bars: Regions
- Arrow indicates region’s rate differs significantly from the VQI rate.

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

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

Procedures performed between January 1 and December 31, 2020

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>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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EVAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INFRA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEAMP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OAAA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PVI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUPRA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEVAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Center Overall</td>
<td>5662</td>
<td>81%</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>Your Region Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VQI Overall</td>
<td>81735</td>
<td>85%</td>
<td>9%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The table shows the distribution of discharge medications among procedures performed at various centers. The percentages indicate that 81% of cases received a combination of antiplatelet and statin, 12% received only antiplatelet, 4% received only statin, and 3% received neither.
Discharge Antiplatelet+Statin by Center in Your Region (Jan-Dec 2020)

- Other centers in your region
- Your center

Centers (centers with <10 cases not shown)

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

Discharge Antiplatelet+Statin by Region Across VQI (Jan-Dec 2020)

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

* Indicates centers that do not belong to a regional group.

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

Procedures performed between January 1 and December 31, 2020

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>72</td>
<td>1338</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>2.8%</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>64</td>
<td>1224</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>3.1%</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>0.9%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.11</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.
**TFEM CAS SYMP: Stroke/Death**

Procedures performed between January 1 and December 31, 2020

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></td>
<td>94</td>
<td>1537</td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>9.6%</td>
<td>4.8%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>94</td>
<td>1434</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>9.6%</td>
<td>4.9%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>3.8%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.01</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.
Stroke or Death after TFEM CAS for Symptomatic Admissions in Your Region (Jan-Dec 2020)

- 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 TFEM CAS for Symptomatic Admissions by Region Across VQI (Jan-Dec 2020)

- 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 ASYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2020

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.

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>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>195</td>
<td>4068</td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>1%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>191</td>
<td>3864</td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>1.4%</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 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 (Jan-Dec 2020)

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 (Jan-Dec 2020)

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 January 1 and December 31, 2020

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.

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></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>49</td>
<td>2138</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>0%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>48</td>
<td>2039</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>0%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>2.2%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.63</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 Symptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
Stroke or Death after TCAR for Symptomatic Admissions in Your Region (Jan-Dec 2020)

- 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 Symptomatic Admissions by Region Across VQI (Jan-Dec 2020)

- 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 ASYMP: Stroke/Death

Procedures performed between January 1 and December 31, 2020

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>523</td>
<td>8867</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td>1.1%</td>
<td>0.9%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>480</td>
<td>8410</td>
<td></td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td>1.2%</td>
<td>0.9%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td>0.8%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.31</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 (Jan-Dec 2020)

- 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 (Jan-Dec 2020)

- 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 ASYMP: Postop LOS>1 Day

Procedures performed between January 1 and December 31, 2020

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. 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>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>523</td>
<td>8867</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among procedures meeting inclusion criteria</td>
<td><strong>28.1%</strong></td>
<td>22.7%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>480</td>
<td>8427</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among cases with complete data</td>
<td>27.1%</td>
<td>22.7%</td>
</tr>
<tr>
<td>Expected rate of LOS&gt;1 day among cases with complete data</td>
<td>23.9%</td>
<td>NA</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.11</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.
Postop LOS>1 Day after CEA for Asymptomatic Admissions by Year

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

Procedures performed between January 1 and December 31, 2020
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></td>
<td>154</td>
<td>4593</td>
</tr>
<tr>
<td>Observed rate of stroke or death among procedures meeting inclusion criteria</td>
<td></td>
<td></td>
<td>1.9%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>151</td>
<td></td>
<td>4416</td>
</tr>
<tr>
<td>Observed rate of stroke or death among cases with complete data</td>
<td></td>
<td></td>
<td>2%</td>
</tr>
<tr>
<td>Expected rate of stroke or death among cases with complete data</td>
<td></td>
<td></td>
<td>2.4%</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td></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 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 (Jan-Dec 2020)

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 Symptomatic Admissions by Region Across VQI (Jan-Dec 2020)

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 January 1 and December 31, 2020

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>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>154</td>
<td>4592</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among procedures meeting inclusion criteria</td>
<td>55.2%</td>
<td>42.4%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>151</td>
<td>4430</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;1 day among cases with complete data</td>
<td>55%</td>
<td>42.3%</td>
</tr>
<tr>
<td>Expected rate of LOS&gt;1 day among cases with complete data</td>
<td>47.8%</td>
<td>NA</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.09</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.**
Postop LOS > 1 Day after CEA for Symptomatic Admissions by Year

Rates shown are observed rates among cases meeting inclusion criteria.
EVAR: Postop LOS>2 Days

Procedures performed between January 1 and December 31, 2020

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></td>
<td>360</td>
<td>6032</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;2 days among procedures meeting inclusion criteria</td>
<td></td>
<td>20.3%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td></td>
<td>337</td>
<td>5450</td>
</tr>
<tr>
<td>Observed rate of LOS&gt;2 days among cases with complete data</td>
<td></td>
<td>20.8%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Expected rate of LOS&gt;2 days among cases with complete data</td>
<td></td>
<td>18.4%</td>
<td>NA</td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td></td>
<td>0.26</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.
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 (Jan-Dec 2020)

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 >2 Days after EVAR by Region Across VQI (Jan-Dec 2020)

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.
EVAR: Sac Diameter Reporting

Procedures performed between January 1 and December 31, 2018
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>514</td>
<td>6782</td>
<td></td>
</tr>
<tr>
<td>Percentage with sac diameter reported between 9 and 21 months post-procedure</td>
<td><strong>50.2%</strong></td>
<td></td>
<td>59.3%</td>
</tr>
</tbody>
</table>
EVAR Sac Diameter Reporting by Year

Your Center  Your Region  VQI Overall
EVAR Sac Diameter Reporting in Your Region (Jan-Dec 2018)

- Other centers in your region
- Your center

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>University of Rochester Medical Center</td>
</tr>
<tr>
<td>2</td>
<td>North Shore University Hospital</td>
</tr>
<tr>
<td>3</td>
<td>Lenox Hill Hospital</td>
</tr>
<tr>
<td>4</td>
<td>NYU Langone Medical Center</td>
</tr>
<tr>
<td>5</td>
<td>Columbia University Irving Medical Center</td>
</tr>
<tr>
<td>6</td>
<td>Stony Brook University Medical Center</td>
</tr>
<tr>
<td>7</td>
<td>Maimonides Medical Center</td>
</tr>
<tr>
<td>8</td>
<td>Long Island Jewish Medical Center</td>
</tr>
<tr>
<td>9</td>
<td>Westchester Medical Center</td>
</tr>
<tr>
<td>10</td>
<td>Montefiore Medical Center</td>
</tr>
<tr>
<td>11</td>
<td>Kaleida Health</td>
</tr>
<tr>
<td>12</td>
<td>Catholic Health Mercy Hospital of Buffalo</td>
</tr>
<tr>
<td>13</td>
<td>Catholic Health Sister of Charity Hospital</td>
</tr>
<tr>
<td>14</td>
<td>Weill Cornell University Medical Center</td>
</tr>
<tr>
<td>15</td>
<td>Staten Island University Hospital - North Site</td>
</tr>
</tbody>
</table>

*** Indicates center’s rate differs significantly from the regional rate.
EVAR Sac Diameter Reporting by Region Across VQI (Jan-Dec 2018)

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

"**" Indicates region’s rate differs significantly from the VQI rate.
Moving The Needle

National Quality Initiative – EVAR Sac Diameter Report
• Wide Variation in Compliance – VQI Mean 58.6% (22-89%)
• Little improvement since inception in 2016

“It is the obligation of the operating surgeon to stress the need for lifelong surveillance and integrate discussions about LTFU into all stages of AAA EVAR care to ensure that their patients achieve optimal outcomes.” – Salvatore Scali, MD, Professor of Surgery, University of Florida.

Barriers to Reporting
• No LTFU; patient lost to evaluation
• Patient Factors
  ▪ No Need, “Feeling Well”
  ▪ Unaware of importance of LTFU and imaging
  ▪ Moved/phone disconnected
  ▪ Lost insurance
  ▪ Too far to travel/inconvenient parking
Moving The Needle

Other Barriers
• Dictated Patient Visit with “AAA sac unchanged” or “No endoleak or size increase”
• Imaging not available at time of visit
• Center not wanting to use Radiology report information

Discussion

Suggestions for improvement:
➢ Center unblinding at Regional meetings ➔ Peer competition
➢ Biannual Physician Report sent with PRIMPROCID information
➢ GC Update Report from each Regional Medical Director to maintain awareness
➢ “Best Practice” Webinar made available for low performing centers
➢ Make Sac Diameter size notation at every patient encounter
EVAR: SVS Sac Size Guideline

Procedures performed between January 1 and December 31, 2020

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

The table below gives the number of EVAR procedures meeting the inclusion criteria, and the percentage of those procedures meeting the SVS 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>319</td>
<td>5357</td>
</tr>
<tr>
<td>Percentage meeting SVS sac size guideline</td>
<td></td>
<td>70.8%</td>
<td>74.2%</td>
</tr>
</tbody>
</table>
TEVAR: Sac Diameter Reporting

Procedures performed between January 1 and December 31, 2018

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>109</td>
<td>1454</td>
<td></td>
</tr>
<tr>
<td>Percentage with sac diameter reported between 9 and 21 months post-procedure</td>
<td><strong>57.8%</strong></td>
<td>59.8%</td>
<td></td>
</tr>
</tbody>
</table>
TEVAR Sac Diameter Reporting by Year

- Your Center
- Your Region
- VQI Overall
TEVAR Sac Diameter Reporting in Your Region (Jan-Dec 2018)

Other centers in your region | Your center
---|---
100% | 100%
90% | 90%
80% | 80%
70% | 70%
60% | 60%
50% | 50%
40% | 40%
30% | 30%
20% | 20%
10% | 10%
0% | 0%

Centers (centers with <10 cases not shown)

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

TEVAR Sac Diameter Reporting by Region Across VQI (Jan-Dec 2018)

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

---

*** indicates region's rate differs significantly from the VQI rate.
OAAA: In-Hospital Mortality

Procedures performed between January 1 and December 31, 2020
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>22</td>
<td>1044</td>
<td></td>
</tr>
<tr>
<td>Observed rate of In-Hospital Mortality among procedures meeting inclusion criteria</td>
<td>13.6%</td>
<td>4.6%</td>
<td></td>
</tr>
<tr>
<td>Number of procedures with complete data*</td>
<td>22</td>
<td>977</td>
<td></td>
</tr>
<tr>
<td>Observed rate of In-Hospital Mortality among cases with complete data</td>
<td>13.6%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Expected rate of In-Hospital Mortality among cases with complete data</td>
<td>5.9%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>P-value for comparison of observed and expected rates</td>
<td>0.14</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.
OAAA: SVS Cell-Saver Guideline

Procedures performed between January 1 and December 31, 2020
Includes Open AAA (OAAA) procedures only. Excludes any patient with $\text{EBL} \leq 500$ 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></td>
<td>20</td>
<td>1063</td>
</tr>
<tr>
<td>Percentage meeting SVS cell-saver guideline</td>
<td></td>
<td>95%</td>
<td>92.5%</td>
</tr>
</tbody>
</table>
OAAA Cell-Saver Guideline in Your Region (Jan-Dec 2020)

Centers (centers with <10 cases not shown)

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

OAAA Cell-Saver Guideline by Region Across VQI (Jan-Dec 2020)

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

** Indicates region’s rate differs significantly from the VQI rate.
OAAA: SVS Iliac Inflow Guideline

Procedures performed between January 1 and December 31, 2020

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></td>
<td>21</td>
<td>1176</td>
</tr>
<tr>
<td>Percentage meeting SVS iliac inflow guideline</td>
<td>100%</td>
<td></td>
<td>98.1%</td>
</tr>
</tbody>
</table>
OAAA Iliac Inflow Guideline in Your Region (Jan-Dec 2020)

Centers (centers with <10 cases not shown)

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

OAAA Iliac Inflow Guideline by Region Across VQI (Jan-Dec 2020)

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

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

Procedures performed between January 1 and December 31, 2020

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>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>990</td>
<td>12455</td>
</tr>
<tr>
<td>Percentage with ABI/toe pressure assessment</td>
<td>59.2%</td>
<td>74.5%</td>
</tr>
</tbody>
</table>
ABI/Toe Pressure Assessment before PVI for Claudication by Year

- Your Center
- Your Region
- VQI Overall
INFRA CLTI: Major Complications

Procedures performed between January 1 and December 31, 2020

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>414</td>
<td>5212</td>
<td></td>
</tr>
<tr>
<td>Percentage with major complications</td>
<td><strong>3.6%</strong></td>
<td>4.6%</td>
<td></td>
</tr>
</tbody>
</table>
Major Complications after INFRA for CLTI in Your Region (Jan-Dec 2020)

- 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 (Jan-Dec 2020)

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

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

Procedures performed between January 1 and December 31, 2020

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></td>
<td>67</td>
<td>1177</td>
</tr>
<tr>
<td>Percentage with major complications</td>
<td></td>
<td><strong>11.9%</strong></td>
<td>7.4%</td>
</tr>
</tbody>
</table>
LEAMP: Postop Complications

Procedures performed between January 1 and December 31, 2020
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>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>307</td>
<td>3184</td>
</tr>
<tr>
<td>Percentage with postoperative complications</td>
<td>10.1%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>
**Postop Complications after LEAMP in Your Region (Jan-Dec 2020)**

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

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 (Jan-Dec 2020)**

- Rocky Mtn.
- Mid-America
- Virginia
- Southeast
- New York
- Up. Midwest
- VQI
- Carolinas
- New England

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

"*** indicates region’s rate differs significantly from the VQI rate.

---

*In collaboration with NCDR*
HDA: Primary AVF vs. Graft

Procedures performed between January 1 and December 31, 2020
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>586</td>
<td>5069</td>
<td></td>
</tr>
<tr>
<td>Percentage with primary AVF</td>
<td><strong>83.6%</strong></td>
<td><strong>81.7%</strong></td>
<td></td>
</tr>
</tbody>
</table>
Primary AVF Access by Year

- Your Center
- Your Region
- VQI Overall

2017, 2018, 2019, 2020
Primary AVF Access in Your Region (Jan-Dec 2020)

Other centers in your region | Your center

Centers (centers with <10 cases not shown)

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

Primary AVF Access by Region Across VQI (Jan-Dec 2020)

Canada* | New England* | Midwest* | Rocky Mnts.* | New York | Virginia | G. Lakes | VQI | Mid-America | Mid-Atlantic* | Carolinas* | Southeast* | Up. Midwest*

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

**** Indicates region’s rate differs significantly from the VQI rate.
### IVCF: Filter Retrieval Reporting

Procedures performed between January 1 and December 31, 2018

Includes Inferior Vena Cava Filter (IVCF) procedures only. Excludes filters with permanent planned duration, patients who have died since discharge, or patients where no follow-up was possible.

The table below gives the number of procedures meeting the inclusion criteria, and the percentage of those procedures in which the filter was reported as retrieved (or retrieval was attempted) at any time post-procedure. Because follow-up is critical for assessing filter retrieval, cases meeting the inclusion criteria are broken down into those with follow-up records (at least 1 follow-up record) and those without follow-up records.

<table>
<thead>
<tr>
<th></th>
<th>Your Center</th>
<th>Your Region</th>
<th>VQI Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of IVCF procedures meeting inclusion criteria</td>
<td>151</td>
<td>1224</td>
<td></td>
</tr>
<tr>
<td>Number without follow-up records</td>
<td>21</td>
<td>145</td>
<td></td>
</tr>
<tr>
<td>Number with follow-up records</td>
<td>130</td>
<td>1079</td>
<td></td>
</tr>
<tr>
<td>Percentage with Filter Retrieval, or Attempt at Retrieval</td>
<td><strong>52.3%</strong></td>
<td>59.7%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because No Follow-up Records Created</td>
<td>13.9%</td>
<td>11.8%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Not Clinically Indicated</td>
<td>22.5%</td>
<td>18.8%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Patient Declined</td>
<td>2.6%</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Lost to Follow-Up</td>
<td>1.3%</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Deemed Too Late for Removal</td>
<td>2%</td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because Planned Later Removal</td>
<td>7.3%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Percentage not retrieved because No Reason Given</td>
<td>2.6%</td>
<td>1.1%</td>
<td></td>
</tr>
</tbody>
</table>
The charts show the IVC Filter Retrieval Reporting in Your Region (Jan-Dec 2018) and the IVC Filter Retrieval Reporting by Region Across VQI (Jan-Dec 2018). The bars represent different regions, and the annotations indicate that specific rates differ significantly from the regional average. The data is presented in a clear and organized manner, making it easy to understand at a glance.
Regional Improvement Projects

• Jeffrey Indes, MD
• Angela Kokkosis, MD
• Glenn Jacobwitz, MD
Case Presentation

Bath J, Lawrence PF, Neal D, Zhao Y, Smith JB, Beck AW, Conte M, Schermerhorn M, Woo K

VSGGNY 4/23/21

Patricia Yau MD, PGY-4
Montefiore Medical Center / Albert Einstein College of Medicine
National VQI Update: Cheryl Jackson
Quality Director, SVS PSO
Number of Participating Centers

Location of VQI Participating Centers

784 VQI Centers
783 centers in North America
1 center in Singapore
VQI Regional Quality Groups

18 Regional Quality Groups
# VQI Procedure Volume

**Total Procedures Captured**

(as of 3/1/2021) 800,030

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral Vascular Intervention</td>
<td>264,170</td>
</tr>
<tr>
<td>Carotid Endarterectomy</td>
<td>153,662</td>
</tr>
<tr>
<td>Infra-Inguinal Bypass</td>
<td>66,858</td>
</tr>
<tr>
<td>Endovascular AAA Repair</td>
<td>62,262</td>
</tr>
<tr>
<td>Hemodialysis Access</td>
<td>62,252</td>
</tr>
<tr>
<td>Carotid Artery Stent</td>
<td>52,728</td>
</tr>
<tr>
<td>Varicose Vein</td>
<td>44,970</td>
</tr>
<tr>
<td>Supra-Inguinal Bypass</td>
<td>21,629</td>
</tr>
<tr>
<td>Lower Extremity Amputations</td>
<td>20,547</td>
</tr>
<tr>
<td>Thoracic and Complex EVAR</td>
<td>20,624</td>
</tr>
<tr>
<td>IVC Filter</td>
<td>15,486</td>
</tr>
<tr>
<td>Open AAA Repair</td>
<td>14,762</td>
</tr>
<tr>
<td>Vascular Medicine Consult</td>
<td>55</td>
</tr>
<tr>
<td>Venous Stent</td>
<td>25</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
Trainee engagement:

- Plans –
  - Invite students and trainees to regional and national meetings
  - Engage students and trainees in quality improvement projects
  - Participate in presentations and publications
  - VQI intern program (in development)
Trainee engagement:

- What are your ideas?
VQI Members call for volunteers early 2021:

- 19 Applicants
- VQI Representatives
  - Dr. Leila Mureebe – Chair
  - Dr. Carla Moreiro – Vice-Chair
  - Dr. Samantha Minc
  - Dr. Patricia Fernandez
  - Dr. Mina Boutros
  - Dr. Rafael Malgor
Update on PSO Diversity Committee

• Awaiting appointments from
  ➢ SVS DEI Committee
  ➢ AVF
  ➢ ACC

• Broad representation
  ➢ Years in practice
  ➢ Region
  ➢ Gender
  ➢ Race
FDA Safety Notifications

- As a Patient Safety Organization, we feel compelled to share Safety Notifications with VQI Members
- FDA will contact the SVS PSO with Safety Notifications it wants us to communicate
- Safety Notifications will appear in both the PSO and SVS newsletters
- All Safety Notifications are posted to the VQI and SVS Websites

https://www.vqi.org/resources/fda-communication/
The 2021 VQI Annual Meeting has been moved to August!

Important Dates and Times for the 2021 VQI Annual Meeting at VAM

August 17, 2021 12PM – 6:30PM* Pacific Time
August 18, 2021 8AM – 5PM Pacific Time

*Poster Presentation and Networking Reception – Tuesday, August 17th at 5:00PM to 6:30PM

We are hopeful that we will be able to have an in-person meeting at the San Diego Convention Center. In the event we are unable to meet live, we will transition to on-line presentation.
Partners and Endorsing Organizations

SVS | VQI

In collaboration with NCDR®

SVU

American Venous Forum

American Heart Association®

Society for Vascular Medicine

Access Excellence

VASCULAR ACCESS SOCIETY OF THE AMERICAS
ACC and SVS began 2021 with a united vascular registry - creating a single resource focused on improving care and outcomes of patients with vascular disease.

ACC PVI registry participants who have not yet joined the SVS VQI, may contact the SVS VQI account team by emailing vqi@m2s.com, or by calling 603-298-6717, to begin enrollment.
Ongoing Collaboration

• ACC NCDR will have representation on all VQI Councils and Committees
COVID-19 Update

• COVID-19 Variable insertion into registries (Sept. 2020)
• Two JVS Publications (JVS & JVSVL) on registry volumes
• AHRQ PSO Presentation on VQI Response
• International Registry submission for June issue Seminars in Vascular Surgery
• Initial Outcomes Review of COVID-19 effect in registries
• Collaboration with Vascular Surgery COVID-19 Collaborative (VASCC) on LTFU in participating centers
PAD Patient Reported Outcomes (PROs)

My Peripheral Arterial Disease: a VQI Pilot of Patient Reported Outcomes for PAD

- The Society for Vascular Surgery Vascular Quality Initiative is seeking practices to participate in My PAD, a pilot program for the collection of patient reported outcomes (PRO) on patients undergoing endovascular treatment for peripheral arterial disease (PAD).

- The 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 a long overdue need to learn and measure the patient’s perspective.

- **Must be in the PVI registry and have greater than 70% follow up! Not too late to join the Pilot!!**
PAD Patient Reported Outcomes (PROs)

**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 smart phone
- Educational materials for direct from patient data entry
- PRO feedback to participating physicians
Reporting Highlights and Questions:

• New On-line Follow-up reports
  – EVAR Released - Jan 2021
  – CEA/CAS/PVI/TEVAR – To Be Released in 2021

• New Dashboard and Regional Report Drilldown

• Suggestions for “other” reports
CME/CE CREDIT FOR REGIONAL MEETINGS

SPRING 2021
## Successful Rollout

<table>
<thead>
<tr>
<th>Type of credit</th>
<th>Total of those who took survey and claimed Contact Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBON (Iowa Board of Nursing)</td>
<td>83</td>
</tr>
<tr>
<td>AMA (MD/DO)</td>
<td>75</td>
</tr>
<tr>
<td>CE (Others)</td>
<td>25</td>
</tr>
<tr>
<td>All</td>
<td>183</td>
</tr>
</tbody>
</table>

**Approx. time to complete eval**

| Approx. time to complete eval           | 6 min                                                    |

31.4% of meeting attendees participated in the survey to receive 2.0 credit hours

183/582
Please describe any 'pearls' or takeaway messages:

- Identifying our areas of concern by comparison to others in our region and nationally is helpful toward setting priorities.
- Other facilities are experiencing the same difficulties I am with data abstraction.
- Excellent Meeting.
- Good collaboration and networking with peers.
- How important it is for my facility, not just the doctors, to have this information from the registry.
- By sharing the report with benchmarks, our organization will identify quality improvements we can work on to improve patient outcomes.
- Will look into doing more patient education.
Barriers
• Lack of administrative support, Patient compliance issues
• Lack of resources/equipment
• MDs to give specific measurement in their notes
• Abstractions leave little time for QI projects
• COVID, patients traveling and receiving follow up elsewhere

How will you address these barriers?
• Look in to obtaining additional administrative organization and support
• Review operational definitions and email m2support for clarification
• Educate others at my location. Continue patient education and follow-up.
• Keep as organized as possible and enter patient information ASAP
• Work with IT to create template for follow-up office visits (to include key data points)
• Show cost savings of implementation
• Better communication with PCP
Des Moines University is the continuing education provider for this activity.

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!

The attendance roster will be cross-referenced with those applying for CME/CE. Sign in correctly.

If you do not complete and submit the online forms within 7 days, continuing education credit cannot be awarded.
Meeting Attendance Credit

**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 ljjohnson@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_6r5DnilxkeN5wEK

You only have 7 days to complete forms for CME/CE Credit.

NO EMAIL WILL BE SENT AS A REMINDER OR WITH THE CME/CE LINK
Quality Improvement Update

Spring 2021
Quality Improvement Resources:

- 2021 Quarterly Webinars
  - May 5, 2021
  - September 2021
  - November/December 2021
- The VQI News
  - Provides updates on regulatory issues, technical updates, and crossover news from the SVS and SVN
- VQI Quality Improvement Newsletter
  - Focusing on QI processes, tools, and definitions
- VQI.org Members only pages
Update on Charters 2020 and 2021

• Fifty-eight (58) charters submitted in 2020!
  – LTFU – 14
  – D/C Medications – 17
  – Clinical – 3
  – *Documentation – 24

• *Multi-regional AAA size compliance project – 19 charter participants. 33 overall participants.

• 2021 – Twenty charters already!

• Focused phone calls are well attended – now on a quarterly schedule (Jan, April, July, Oct).
Putting VQI Data into Action
See what your colleagues are doing with QI

- Abstracts were submitted and acceptance notifications were sent out on March 1st
- Planning on an in-person meeting in San Diego
- If needed, we will once again convert the meeting into an all-virtual format
- Incorporating some aspects of virtual online learning
- Posters that were accepted for 2020 were automatically accepted into the 2021 poster session without the need to resubmit
Charters

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

• Visit the VQI Members Only Website for sample charters, webinars, and presentations on VQI Quality Improvement Projects. www.vqi.org
2020 Participation Award Changes
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
Participation Awards Program

- 2020 Participation Award results to be announced soon.
- 3 Star recipients are presented at the in-person Annual VQI meeting
- 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/](https://www.vqi.org/quality-improvement/participation-awards/)
Participation Award Results - VSGGNY

Stony Brook University Medical Center
University of Rochester Medical Center
Weill Cornell University Medical Center
Catholic Health Sister of Charity Hospital
Montefiore Medical Center
NYU Langone Medical Center

Catholic Health Mercy Hospital of Buffalo
Kaleida Health
Columbia University Irving Medical Center
St. Peter’s Hospital
Lenox Hill Hospital

Congratulations!
Regional Nominations

• **Regional Associate Medical Director Nominees:**
  – Dr. Michael Stoner - University of Rochester Medical Center

• **Arterial RAC Nominees:**
  – Dr. Jing Li – Stony Brook University Medical Center
  – Dr. Richard Schutzer – Columbia University Irving Medical Center

**Next steps:**
  – All nominees who accepted the respective roles within the time limit were included in the ballot to the regional Executive Council (EC). The vote closes May 5, 2021.
  – All nominees will be notified of the EC’s voting results.
Arterial Quality Council:
Angela Kokkosis, MD
AQC Update:

Chair: Randy DeMartino, MD (Mayo)
Vice Chair: Jessica Simons, MD (UMASS)
Kelly Byrnes & Marguerite Marlow,
Vascular Ultrasound representatives
ACC to make 2 appointments mid 2021
AQC Update:

<table>
<thead>
<tr>
<th>Preliminary Development priorities for 2021:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Infra/Supra - Jess Simons</td>
</tr>
<tr>
<td>2. OAAA - Rumi Faizer</td>
</tr>
<tr>
<td>3. Amputation - Ahmed Abou-Zamzam</td>
</tr>
</tbody>
</table>

Always looking for Volunteers to Join Registry Committees! Contact Carrie Bosela C.Bosela@svspso.org if interested!!
AQC Update:

- Clinical Appropriateness Performance Indicators (CAPI reports)
  - Aligning with SVS Guidelines
- Registry Specific Quality Improvement Initiatives
- PAD PRO’s
- COVID Interest Group and Response (CIGAR)
  - VASCC Collaboration
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 i. 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:
Glenn Jacobwitz, 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

**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
Join Today!!!

• **VQI@M2S.com**

• Lots of research potential
  – Submit ideas to Venous RAC

[The Vascular Quality Initiative | National Arterial and Venous RAC Schedules (vqi.org)]
Research Advisory Council:
Jeffrey Indes, MD
1. Review list of projects approved to avoid duplication

https://www.vqi.org/data-analysis/rac-approved-project-search/

2. Submit proposal online:

http://abstracts123.com/svs1/meetinglogin


• Agenda topics for Governing Council Meeting on April 12, 2021

• Dr. Mureebe discussed the formation of the SVS PSO’s new Diversity, Equity and Inclusion Committee

• Drs. Lemmon and Jorgensen presented the GC a proposal on a new PSO Trainee Scholarship Program

• Dr. Weaver provided an update on progress against strategic priorities, including an update on our collaboration with ACC
M2S Updates

Spring 2021

Regional Group Meetings
VQI Technology Updates
Revised warning COVID-19 message for Follow-up Mandatory Variable

- Released on **7/29/2020**

- The VQI added a temporary message about the impact of COVID-19 on LTFU completion rate calculations. The following message will display when submitting a LTFU that is missing any mandatory variable:
  - "IMPORTANT: The PSO understands that routine follow up visits may not be possible due to COVID-19 state mandates. Special considerations will be part of our LTFU calculation for 2020, please collect all of the required fields that are possible during this time."

- As a reminder, the VQI allows phone and telehealth appointments to be used for LTFU when Face-to-Face visits are not feasible.
“Was Help Text Helpful?” feature in help text box

- Released on **7/29/2020**
- This new feature is to provide feedback regarding the current help text. For each help text field, users will have the option to indicate if the help text provided was useful or not. This information will help the VQI to identify data fields that may be unclear to members.
- The “Was this helpful?” vote up/down button will display in the bottom right corner of the help text box:
Technology Released in Q4 2020

- Across-registry revision to add Covid-19 variables and optional Patient Email
  - Released on **8/29/2020** (SUPRA, INFRA, HDA, VVR, VSR & PVI)
  - Released on **9/23/2020** (AMP, IVC, CAS, EVAR & TEVAR)
  - Added 4 procedure variables and 1 30-day and LTF follow-up variable to VQI registries to collect information about COVID-19.
  - Added an optional Patient Email variable in the procedure form to support the upcoming PRO project.
  - The procedure fields are added to the existing Procedure form tab and follow-up field to the existing 30-day and long-term Follow-up tabs. All fields are consistent across registries, and are added for all sites enrolled in the registry.
**Technology Released in Q4 2020**

- TEVAR Revision to align with SVS/STS guidelines
  - Released on **9/30/2020**
  - Modified fields on the TEVAR form in order to become aligned with updated SVS/STS guidelines described in the article “Society for Vascular Surgery (SVS) and Society of Thoracic Surgeons (STS) reporting standards for type B aortic dissections”.
  - The overall intent of the SVS/STS is to generate more cohesive classification guidelines for both societies to follow in order to extract more granular information which would result in better reporting and research on type b aortic dissections.
  - The definition prior to this change was Type A = Zones 0-1 and Type B = Zones 2-5. The new definition is Type A = Zone 0 and Type B = Zone 1 and beyond as shown in the image to the right.
TEVAR Revision to align with SVS/STS guidelines (Cont’d)

- Procedure Form
  - Relation to Prior Dissection: The existing “Relation to Prior Dissection” field received updated help text that identifies the new dissection zones and includes a new image within the help text pop-up.
  - Entry Flow: A new “Entry Flow” field was added above False Lumen Rx.
  - Intestinal Ischemia and Unintentional Septal Rupture: Intestinal Ischemia and Unintentional Septal Rupture received additions to help text.

- Follow-up Form
  - Entry Flow: The new “Entry Flow” field added to the Procedure was also added to the Follow-up, dependent on the Pathology field (TEVAR_PATH) being Dissection (2).
  - Current Endoleak?: The dependency for this field changed to display when Pathology is Aneurysm in addition to Pathology being Dissection or Aneurysm from dissection.
  - Intestinal Ischemia: Similar to the Procedure, this field received additional help text.
Technology Released in Q4 2020

• Varicose Vein Registry (VVR) & Venous Stent Registry (VSR) revision for New CEAP Clinical Classification
  – Released on **11/11/2020**
  – CEAP classification used for classifying venous disorders has been updated to align with the current understanding of chronic venous disease (CVD).
• New selections of C2r, C4c, and C6r were added to the current list of CEAP classifications.

<table>
<thead>
<tr>
<th>C class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0</td>
<td>No visible or palpable signs of venous disease</td>
</tr>
<tr>
<td>C1</td>
<td>Telangiectasias or reticular veins</td>
</tr>
<tr>
<td>C2</td>
<td>Varicose veins</td>
</tr>
<tr>
<td>C2r</td>
<td>Recurrent varicose veins</td>
</tr>
<tr>
<td>C3</td>
<td>Edema</td>
</tr>
<tr>
<td>C4</td>
<td>Changes in skin and subcutaneous tissue secondary to CVD</td>
</tr>
<tr>
<td>C4a</td>
<td>Pigmentation or eczema</td>
</tr>
<tr>
<td>C4a2</td>
<td>Lipodermatosclerosis or atrophie blanche</td>
</tr>
<tr>
<td>C4c</td>
<td>Corona phlebectatica</td>
</tr>
<tr>
<td>C5</td>
<td>Healed</td>
</tr>
<tr>
<td>C52</td>
<td>Active venous ulcer</td>
</tr>
<tr>
<td>C5x</td>
<td>Recurrent active venous ulcer</td>
</tr>
</tbody>
</table>
Technology Released in Q4 2020

- Vascular Medicine Consult (VMC) registry revision to add new drug category and update CAD
  - Released on **11/19/2020**
  - Added a new drug category called Hemorheologic Agent (categorical field) that contains Cilostazol, Pentoxifylline and Other as Hemorheologic Types. These fields were added to Demographics, Treatment and Follow-up tabs. Dosing and Dosing Other as well as Frequency and Frequency Other will be collected for both Cilostazol and Pentoxifylline.
  - The following existing Cilostazol fields are retired from the form:
    - PRETX_CILOSTAZOL
    - TX_CILOSTAZOL
    - LTF_CILOSTAZOL
  - Added a select option, CAD asymptomatic, to the Procedure field “CAD Symptoms”.

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Projects in Progress

- VQI Patient Reported Outcome (PRO) collection for PVI
- Add opioid variables to INFRA
- Long-term follow-up reports
- HDA 2021 medium revision
- VMC 2021 small revision
- INFRA 2021 major revision
- SUPRA 2021 major revision
- OPEN 2021 major revision
Registry Projects
These projects are conducted within the SVS PSO and only non-identifiable data (removal of patient, center and physician information) will be provided to Medtronic/BARD/Cook/Gore or the FDA. Only standard of care practice is being evaluated. For such PSO activities, patient informed consent and Institutional Review Board review are not required.

Sites must follow their institutional guidelines.
TEVAR Dissection Surveillance Project is Open for Enrollment

- The SVS PSO is excited to announce the reopening of the TEVAR Dissection Surveillance Project to evaluate the Cook Zenith Dissection Endovascular System. FDA approval was granted for this device after safety and effectiveness were demonstrated in pre-market studies of complicated dissection with the proviso that the efficacy of TEVAR treatment of descending aortic dissection would be more fully analyzed through post-market surveillance, as was done through VQI for the W. L. Gore and Medtronic devices after their approval.

- Patients will have 30 day, and annual visits for 5 years.
- Total reimbursement of $4,000 per patient for a patient followed annually for 5 years
• 12 of the 180 required patients enrolled (11 potential cases in process)
  – Retrospective enrollment allowed- All eligible cases from December 31, 2018 (protocol FDA approval date)
• 23 of 40 sites enrolled (10 more in contracting)
  – This project is conducted within the SVS PSO and only non-identifiable data (removal of patient, center and physician information) will be provided to Cook or the FDA. Only standard of care practice is being evaluated. For such PSO activities, patient informed consent and Institutional Review Board review are not required.

For more information, please contact: tevarproject@m2s.com
Initiated in October 2014, the TEVAR Dissection Surveillance Project Arm evaluates the W.L. Gore and Medtronic devices for treatment of Type B thoracic dissections.

Meeting FDA requirement
  - 194 chronic and 200 acute patients with device technical success

Currently in 5-year follow-up phase
PATHWAYS Support
PATHWAYS Support Projects

Claims Validation
The 2019 Claims Validation process was launched in July 2020.
• 50% of Centers have completed validation or are in progress.
• Please reach out to PATHWAYS Support if you were notified and haven’t started and are unclear with the process.
• PATHWAYS Support is here to help you!
Plans to launch 2020 Claims Validation are currently underway...Stay tuned!

PATHWAYS Educational Webinars
• Reporting & Analytics webinar series (2 sessions) were held in November & December.
  • Visit the Resources tab in PATHWAYS to access the presentations and recordings.
• EVAR FU Aggregate Report – Excited to expand this report to additional registries in the future!
PATHWAYS Support

PATHWAYS Communication

We have heard feedback that due to firewall and spam filter configurations at your centers, you may not be receiving mass emails from M2S. We are excited to help our users keep up to date with new release announcements.

- A new “Release Notes” button has been added to the “Support” tab in the upper left corner to provide you with historical release announcements to help you search for updates.
Meeting Evaluation/Roundtable

- What did you like about this meeting?
- What can we do better?
- Next meeting location?
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

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You only have **7 days** to complete forms for CME/CE Credit.

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Regional Data Managers Meeting

April 23, 2021
5 Minute break!!!
Modified Rankin Stroke Scale

March 2021
• Six-point disability scale
• Most widely used outcome measure in stroke clinical trials
• mRS comprises grades of stroke severity and was intended as a descriptive categorization of functional recovery.
  – Validity: Has been confirmed in multiple studies. Studies show correlation between lesion volumes and mRS. Interrater reliability ranges from moderate to nearly perfect due to the assessment is subjective.
  – Strengths: Short and easy to score.
  – Weaknesses: Some subjectivity in the scoring can affect the score.
# mRS Scale

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No symptoms</td>
</tr>
<tr>
<td>1</td>
<td>No significant disability. Able to carry out all usual activities, despite some symptoms.</td>
</tr>
<tr>
<td>2</td>
<td>Slight disability. Able to look after own affairs without assistance, but unable to carry out all previous activities.</td>
</tr>
<tr>
<td>3</td>
<td>Moderate disability. Requires some help, but able to walk unassisted.</td>
</tr>
<tr>
<td>4</td>
<td>Moderate severe disability. Unable to attend to own bodily needs without assistance, and unable to walk unassisted.</td>
</tr>
<tr>
<td>5</td>
<td>Severe disability. Requires constant nursing care and attention, bedridden, incontinent.</td>
</tr>
<tr>
<td>6</td>
<td>Dead</td>
</tr>
</tbody>
</table>
FDA Safety Notifications

• As a Patient Safety Organization, we feel compelled to share Safety Notifications with VQI Members
• FDA will contact the SVS PSO with Safety Notifications it wants us to communicate
• Safety Notifications will appear in both the PSO and SVS newsletters
• All Safety Notifications are posted to the VQI and SVS Websites

https://www.vqi.org/resources/fda-communication
My Peripheral Arterial Disease: a VQI Pilot of Patient Reported Outcomes for PAD

- The Society for Vascular Surgery Vascular Quality Initiative is seeking practices to participate in My PAD, a pilot program for the collection of patient reported outcomes (PRO) on patients undergoing endovascular treatment for peripheral arterial disease (PAD).
- The 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 a long overdue need to learn and measure the patient’s perspective.
- Must be in the PVI registry and have greater than 70% follow up! Pilot sites launch March 2021. Not too late to join the Pilot!!
PAD Patient Reported Outcomes (PROs)

**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 smart phone
- Educational materials for direct from patient data entry
- PRO feedback to participating physicians
The 2021 VQI Annual Meeting has been moved to August!

Important Dates and Times for the 2021 VQI Annual Meeting at VAM

August 17, 2021 12PM – 6:30PM* Pacific Time
August 18, 2021  8AM – 5PM Pacific Time

*Poster Presentation and Networking Reception – Tuesday, August 17th at 5:00PM to 6:30PM

We are hopeful that we will be able to have an in-person meeting at the San Diego Convention Center. In the event we are unable to meet live, we will transition to on-line presentation.
EVAR Sac Diameter Reporting by Region Across VQI (Jan-Dec 2018)

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

"**" Indicates region's rate differs significantly from the VQI rate.
Moving The Needle

National Quality Initiative – EVAR Sac Diameter Report
• Wide Variation in Compliance – VQI Mean 58.6% (22-89%)
• Little improvement since inception in 2016

“It is the obligation of the operating surgeon to stress the need for lifelong surveillance and integrate discussions about LTFU into all stages of AAA EVAR care to ensure that their patients achieve optimal outcomes.” – Salvatore Scali, MD, Professor of Surgery, University of Florida.

Barriers to Reporting
• No LTFU; patient lost to evaluation
• Patient Factors
  ▪ No Need, “Feeling Well”
  ▪ Unaware of importance of LTFU and imaging
  ▪ Moved/phone disconnected
  ▪ Lost insurance
  ▪ Too far to travel/inconvenient parking
Moving The Needle

Other Barriers

• Dictated Patient Visit with “AAA sac unchanged” or “No endoleak or size increase”
• Imaging not available at time of visit
• Center not wanting to use Radiology report information

Discussion

Suggestions for improvement:

➢ Center unblinding at Regional meetings ➔ Peer competition
➢ Biannual Physician Report sent with PRIMPROCID information
➢ GC Update Report from each Regional Medical Director to maintain awareness
➢ “Best Practice” Webinar made available for low performing centers
➢ Make Sac Diameter size notation at every patient encounter
CME/CE CREDIT FOR REGIONAL MEETINGS

SPRING 2021
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:

- **PUT** your FULL NAME in RingCentral to get credit for attendance and CME/CE credit (no exceptions will be made)
- **SEND** an email to ljohnson@svspso.org with names of group members that are sharing 1 device
- **OFFICALLY** apply for CME/CE credit by clicking this link: [https://dmu.co1.qualtrics.com/jfe/form/SV_3TKF7oemcG2Ex3E](https://dmu.co1.qualtrics.com/jfe/form/SV_3TKF7oemcG2Ex3E)

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
Putting VQI Data into Action
See what your colleagues are doing with QI

- Abstracts were submitted and acceptance notifications were sent out on March 1st
- Planning on an in-person meeting in San Diego
- If needed, we will once again convert the meeting into an all-virtual format
- Posters that were accepted for 2020 were automatically accepted into the 2021 poster session without the need to resubmit
Update on Charters 2020 and 2021

- Fifty-eight (58) charters submitted in 2020!
  - LTFU – 14
  - D/C Medications – 17
  - Clinical – 3
  - *Documentation – 24
- *Multi-regional AAA size compliance project – 19 charter participants. 33 overall participants.
- 2021 – Twenty charters already!
- Focused phone calls are well attended – now on a quarterly schedule (Jan, April, July, Oct).
Conclusion

• Roundtable
• Next meeting