MEDCAC : Lower Extremity Chronic Venous Disease – Data Collection

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AMERICAN VENOUS FORUM

Disclosures

- Consultant BTG – Minor, less than $10,000
- Consultant BSN Jobst – Minor, less than $10,000

Expectations for Implementation of Standard of Care in Medicare Beneficiaries

- Implicit in the assurance of reimbursement for health care delivered to Medicare beneficiaries, is assurance that treatment will be delivered according to established standards of care

- Standard of care is generally established by
  - Published guidelines, where high-quality data (Level 1) is available
  - Aggregate practice patterns for similar disease entities, where high-quality data (Level 1) is not available, or guidelines have not been written

Guideline-driven care

- The Society for Vascular Surgery and the American Venous Forum have jointly (and often-times separately) published multiple guidelines, several of which have been quoted by prior speakers

- Imperfect, but telling data suggests that not all the guidelines are being utilized or implemented uniformly across the country

American Venous Registry (AVR)

- The AVR was the country's first attempt to collect real-world information on treatment practices across the US
- Instituted in 2009, it collected information on >8,000 vein ablation procedures performed for a diagnosis of varicose veins (VV)
- Important conclusions from the VV Module of AVR:
  - Mandated a standardized way of diagnosing and classifying VV
  - >15% of patients underwent vein ablation for a disease severity of C1 or C2 (i.e. very early stage) varicose veins
  - >30% of patients had not been treated with compression stockings for 4 weeks prior to undergoing vein ablation
  - >15% of patients were not treated with compression subsequent to vein ablation

American Venous Registry (AVR) to Vascular Quality Initiative (VQI)

- In the absence of a mandate, the AVR has not penetrated across all the sites practicing vein procedures
- In 2014, the AVR joined hands with VQI to establish the Venous arm of VQI
- It is hoped that the combined infrastructure and membership of SVS and AVF should increase participation
- Advantages and goals of the VV module of the VQI:
  - Standardized, guideline-driven approach to diagnosis (e.g. duplex ultrasound) and classification (e.g. CEAP classification)
  - Standardized, guideline-driven decision-making on treatment options (e.g. compression versus vein ablation)
  - Standardized approach to follow-up and assessment of outcomes (e.g. VCSS score and quality of life)
  - Establish outcome norms for regional and national standards
  - Identify differences in outcome based on treatment approaches (comparative effectiveness)
  - Collection of practice patterns where level 1 data is not available

VQI- Venous Stenting module

- We hope to introduce a venous stenting module shortly
- No level 1 data; therefore focus is on collection of practice patterns to establish diagnosis, treatment and outcome norms
- Advantages and goals will be similar to those of the VV Module; standardized collection of information on:
  - Diagnosis (e.g. duplex ultrasound and IVUS)
  - Estimation of disease severity (e.g. CEAP and VCSS)
  - Treatment (e.g. compression versus stenting)
  - Outcomes (VCSS and quality of life)

How do we encourage data-collection?

- Hundreds of practice locations where venous disease is treated in the US
- Approximately 50 centers currently collecting information in the VQI registry
- Linking reimbursement to collection of data in established registries
- Linking reimbursement to participation in randomized trials
- Models:
  - Reimbursement for carotid artery stenting in patients with asymptomatic carotid stenosis is possible only if data is entered into the CMS-approved CREST2-Registry (C2R) or in the randomized trial (CREST-2)
  - Reimbursement for Transcatheter Aortic Valve Replacement (TAVR) is possible only if data is entered into the CMS-approved TVT Registry or in a randomized trial