

The Joint Venous Consortium: Rationale and Proposed Goals

Maximizing the doctor/patient relationship through education and oversight.

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The endovenous revolution is running full speed ahead. New technologies have emerged and dramatically tipped the scales in favor of minimally invasive approaches versus previous surgical standards. The procedures are relatively straightforward and offer excellent outcomes, fast recoveries, and increased patient satisfaction. With this new paradigm has come an increase in the number of procedures performed, as well as a shift from hospital-based to office-based venous practices. Patients seem to universally favor endovenous techniques, with some even specifying their preferred approach by name.

However, with this revolution has come negative trends as well. First and foremost, we have lost control of formal training. The office environment can provide a more efficient and comfortable setting that patients and physicians both prefer, but left unregulated, it has allowed vein practices to operate with little if any oversight and quality assurance. Physicians from many specialty backgrounds are opening vein clinics—some appropriately, some perhaps not. They can read a textbook or attend a weekend course, open an office, market themselves as a vein specialist, and suddenly, there is another vein clinic. Further compounding the issue, the venous landscape has become commoditized in cyberspace to the point where all vein clinics can seem the same to the untrained eye. Patients search online for vein specialists in their region, and they are pointed toward offices with savvy search engine engagement such as pre-paid ad words and physicians described as “board certified in venous disease.”

Among the potential issues related to insufficient training and understanding of venous disease, many believe that some physicians are performing medically unnecessary procedures, such as endovenous ablations in patients who only

have spider veins. Several articles have recently been published in *VEIN Magazine* describing the scope of the problem being seen in the United States.^{1,2} In our estimation, there appears to be an increasing minority of doctors who are “gaming the system” (ie, suggesting that a procedure is medically necessary in order to justify insurance coverage and performing an excessive number of procedures on individual patients). This is all happening at the expense of the patient, ethical physicians, and the reimbursement system. The consequent conflict of interest has disrupted the doctor/patient relationship.

So how do we fix this problem? Catastrophic events should undoubtedly be addressed, and perhaps we also need to move toward a value-based system, one in which doctors are not incentivized solely by reimbursement. In so doing, we can work toward repairing the doctor/patient relationship while addressing abuse within the system by appropriately aligning the incentives.

Physicians from all specialty backgrounds dedicated to offering optimal therapy in appropriately selected patients with venous disease must work together to eliminate abuse and preserve the integrity and availability of these procedures. The authors feel that the formation of a Joint Venous Consortium (JVC) would be a positive step forward, as elucidated in the following sections.

A JOINT VENOUS CONSORTIUM

Members of the American Venous Forum (AVF) originally proposed the JVC at the Pacific Vascular Symposium in 2006 (see the *Goals of the Joint Venous Consortium* sidebar).³

A JVC composed of the larger venous stakeholders, including the American Venous Forum (AVF), the Society for Vascular Surgery (SVS), the American

College of Surgeons (ACS), the Society of Interventional Radiology (SIR), the American College of Phlebology (ACP), and the Society for Cardiovascular Angiography and Interventions (SCAI), could be the first step in developing a unified voice to represent venous disease specialists. ACS advocacy activities at the federal and state level currently represent the interests of practicing surgeons and their patients; the JVC could fulfill the same mission for venous disease.

Five Goals of the JVC

1. Code of professional conduct. By developing a code of conduct, all vein specialists, regardless of specialty origin, would have a primer to refer to. *VEIN Magazine* previously published an article listing the “Don’ts” of vein treatment.⁴ This code of conduct could elucidate the “Dos and Don’ts” as guidance.

2. Metrics guidelines. The JVC would be the conduit through which societal members could align themselves with third-party payers (government or private) to establish better medical necessity policies and procedures. If the JVC had access to claims data, we could audit and police ourselves internally. We need to link reimbursement to behavior; this is where the Intersocietal Accreditation Commission falls short. The SVS’s Vascular Quality Initiative is a robust system with a claims-based auditing process. Currently, they only audit Medicare claims, but perhaps the JVC could help do the same with commercial carriers in the future.

As an example, the JVC could give guidance to payers as to the average number of vein treatments per leg and the average number of procedures that should be performed per patient in order to ethically run a vein practice; outliers could then be examined. The insurers have the data on how many claims individual doctors submit. This approach would be advantageous to insurers and vein specialists because these data are a check on those practitioners who operate outside the norm.

3. Venous curriculum/training. There are members of the AVF, SVS, ACP, and SIR who have started organizing a venous curriculum for training purposes. One glaring problem is the entry of physicians from nonprocedural specialty training backgrounds into a field characterized as procedural in nature. Venous procedures can be divided into those that involve the superficial venous system and those that involve the deep venous system. The unregulated office environment allows for a low barrier to entry for physicians without any procedural training who are often encouraged by those who provide economic incentives (eg, industry reps, mobile ultrasound

GOALS OF THE JOINT VENOUS CONSORTIUM³

- Increase awareness of venous disorders among physicians and the public
- Foster relationships with industry, government, and national/international societies
- Achieve influence through critical mass and clinical/scientific excellence
- Act as a project/grant clearinghouse
- Create evidence-based practice guidelines

labs, vein franchises, etc). These nonprocedurally trained physicians, with a little help, can perform “simple” procedures and then bill CPT codes and get reimbursed. The complications associated with superficial vein treatments are relatively low and benign. Many times, these go unreported, but the precedent is concerning not just for superficial, but deep disease.

It is critical to correct lax standards now as we proceed further into the “deep endovenous revolution.” A lack of training in this space will lead to serious patient injuries such as major axial vein perforation, thrombosis, and misplaced stents, vena cava filters, and embolization coils. These deep vein complications are already being seen with increased frequency.

The JVC could help program directors with resident/fellow training. In addition, guidelines could be put in place to help guide nonprocedure specialty training programs to increase awareness of the need to incorporate venous disease training.

4. Industry guidelines. The JVC would include industry by incorporating suggestions/guidelines as to their role regarding venous education and the identification of vein specialists who are outliers. This is a sensitive issue because industry usually makes their profits by selling more devices to more people. If a certain vein specialist utilizes a catheter/device/treatment more than the average and/or using it inappropriately, there would need to be some mechanisms in place, perhaps developed by the JVC and in cooperation with industry input, to identify outliers. It is important not to penalize whistle blowers.

5. Consequences. This is another difficult issue to tackle. Once identified, what actions can be taken toward the outliers of care? One possibility is that a stepwise system could be put in place that initially evaluates these physicians via an internal audit conducted by members of the JVC. If deviations are identified, an educational approach could first be taken. This allows the physician to voluntarily obtain further education suggested by the JVC to hope-

fully reorient him or her to proper patient care. Buy-in by payers and industry would be crucial. After the education step, if further analysis reveals continuing fringe care, a more aggressive approach could ensue. The particulars would be elucidated by the members of the JVC.

LEARNING FROM THE ROLE OF THE ACS

The dictum, "Do what's right for the patient," is the bedrock of the ACS. It is the cornerstone and cardinal principle of the original oath of 1913 and the Fellowship Pledge that all new fellows make today. The ACS was the first professional organization to take on the responsibility of setting standards for education and training of medical graduates and to educate the public and profession as to who is qualified to practice surgery. Article II of the bylaws states:

"The object of the College shall be to elevate the standard of surgery, to establish a standard of competency and character for practitioners of surgery, to provide a method of granting fellowships in the organization, and to educate the public and the profession to understand that the practice of surgery calls for special training, and that the surgeon elected to fellowship in this College has had such training and is properly qualified to practice surgery."⁵

In 1938, the criteria for training and a manual for hospitals that sought approval for their training programs were established. The standards are focused on the hospital and the resident and prescribe regular inspection of the hospitals. The College established the first Residency Review Committee, as it is now known, in the United States.

The importance of the standards for hospitals and surgical training cannot be emphasized enough. These programs, instituted by an organization of volunteers, fundamentally and profoundly changed how medicine was practiced and how physicians were trained in the United States. Patients were no longer operated on in their homes, and surgeon training was standardized. The College has continued to be dedicated to inspiring quality, maintaining the highest standards, and ensuring better outcomes. Medical knowledge and technology are continuously and rapidly expanding. The College has kept pace by developing educational and training resources to prepare surgeons to enter practice and for practicing surgeons to adapt. There have been many quality and educational programs (they are inextricably linked) carried out by the College since its founding.

Just as the ACS encompasses multiple specialties under one major institution, the JVC can incorporate multiple specialties with the universal goal of ethical patient care. Our specialty includes diverse backgrounds, but everyone treating venous disease should adhere to the same ethical standards.

CONCLUSION

The proposed format and mission of a JVC as described by the authors give a common voice to all physicians, industry, and payers involved in vein care. There is power in numbers and in cooperation. A strong JVC could effect changes and oversight of our self-proclaimed specialty so that unethical and fringe vein care would be identified and dealt with for the good of our patients as well as our specialty, thus ensuring the ACS mantra, "Do what's right for the patient." We believe the time is right for the major players to come under one aegis, the JVC.

Interested parties are invited to contact the authors. ■

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