

# Venous Center Accreditation

A pathway to improved quality of care.

BY JOHN BLEBEA, MD, MBA

If one includes the entire spectrum of venous disease, from telangiectasias and reticular veins to open leg ulcerations, there are approximately 25 million people in the United States who are affected.<sup>1</sup> More than 500,000 patients have active venous ulcers, with approximately 1% of all adults estimated to develop a leg ulcer at some point in their lives (Figure 1).<sup>2</sup> This level of disease prevalence is associated with a significant economic burden on the health care system, which is thought to be between \$1.5 to \$3 billion annually for ulcer care alone.<sup>3</sup> Particularly with the advent of less-invasive percutaneous methods for the treatment of venous insufficiency, the number of procedures performed has skyrocketed and has become a focus of concern for both payers and the public.<sup>4</sup>

## SOCIETAL NEED

A major part of this concern is a perception by government agencies and insurers that there is overuse and inappropriate care. Minimally invasive techniques allow outpatient treatment in an office setting where, unlike hospitals or surgery procedure centers, there is no external oversight. Currently, there is no objective review of indications or outcomes after these procedures, and no special licensing is required to vouch for the safety and quality of the procedures performed in the office setting. In addition, these venous procedures are performed by a diverse variety of physicians with different specialty backgrounds, many of whom did not receive venous training during residency. Even in specialties that included a venous interventional experience, such training is not standardized, and practitioners bring a wide range of knowledge, skill, and experience when it comes to venous procedures. Under these circumstances, how can the public be assured of physician quality and clinical care?

Individual physician quality has historically been defined by licensure and/or certification. Physician licensing

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usually represents the minimum legal qualifications needed to practice medicine in a particular state, and none is specific to venous disease in the United States. Certification, on the other hand, is a voluntary process attained by the physician after meeting certain educational and experience standards and, frequently, passing a written and/or oral examination. It is usually acquired soon after completing residency or fellowship training and may not require independent clinical experience or documentation of patient outcomes. It is specialty defined, and requirements can vary tremendously from one specialty to another.

In most circumstances, and certainly in the venous arena, certification alone does not ensure the quality of care provided by practitioners after they begin practice. The process has also not historically been a method to evaluate the ongoing clinical quality of care subsequently provided by practitioners. Recent efforts imposing requirements for ongoing maintenance of certification for physicians are commendable in their goals but are being met with resistance, have not been proven to improve the quality of care, and are not likely to be focused on venous disease in the foreseeable future. For society, insurers, and government payers, there is a present need to ensure quality of care and appropriate cost control now rather than in the future of venous care.

## ACCREDITATION

Rather than focusing on the individual physician, an alternative method of encouraging and evaluating the quality of medical care has been through the process of accreditation. Accreditation recognizes that quality of health care is not solely dependent upon the training and expertise of the physician but also that of the complete health care environment. Except for truly minor procedures, patient outcomes are significantly influenced by a wide array of other health care providers, from nurses and medical/surgical assistants to other physician specialists, such as anesthesiologists for surgical procedures and infectious disease specialists. In addition, institutional processes, such as housekeeping to maintain a clean environment, sterility in instrument preparation, radiation safety monitoring, efficient return of laboratory results, and appropriate patient scheduling and instruction, are also important determinants of the quality of care.

Recognizing the complexities of patient care, surgeons have long understood the institutional need for examining multiple parameters in ensuring quality patient care and initiated the process of hospital accreditation as early as 1917, when the American College of Surgeons defined a Minimum Standard for Hospitals and began on-site inspections.<sup>5</sup> This evolved into a partnership with the American College of Physicians, American Hospital Association, American Medical Association, and the Canadian Medical Association to create the Joint Commission on Accreditation of Hospitals (JCAH) in 1951 as an independent, not-for-profit organization with a primary purpose to provide voluntary hospital accreditation. With the passage of Social Security in 1965 and an included provision that hospitals accredited by JCAH were deemed to be in compliance for hospital participation in the Medicare and Medicaid programs, JCAH accreditation became a de facto requirement for all hospitals. Since that time, the organization has expanded beyond hospital accreditation to include more than

20,500 health care organizations and programs in the United States.<sup>6</sup> Their accreditation includes primary care, ambulatory surgery centers, and office-based surgery centers.<sup>7</sup> In the outpatient category, in addition to the JCAH, the Accreditation Association for Ambulatory Health Care was founded in 1979 with a focus on outpatient facilities and now accredits more than 6,300 organizations.<sup>8</sup> Similarly, the American Association for Accreditation of Ambulatory Surgery Facilities was established in 1980 to develop accreditation specifically for ambulatory surgery facilities and has now accredited more than 2,000 such centers.<sup>9</sup>

The model for accreditation of health care entities, which focuses on processes, quality of patient care, and measurement of outcomes, is therefore a well-established prototype. However, none of these organizations have venous care as their focus. In addition, for small office-based centers, which may be composed of only a single physician, these large organizations may be too demanding in their bureaucratic and paperwork requirements to be appealing. As an alternative, professional society-based accreditation programs have also developed for more focused areas of accreditation, with less of an administrative burden and usually less cost. The American College of Radiology has accreditation programs in nine areas of imaging,<sup>10</sup> whereas the American College of Cardiology has six programs in diagnostic and interventional cardiac and vascular procedures.<sup>11</sup> Other organizations have specifically been established to provide accreditation in particular areas, such as chest pain and heart failure.<sup>12</sup> It has been only recently, however, that accreditation specific for venous centers has become available.



**Figure 1.** A venous ulcer in a patient with severe chronic venous insufficiency.

## INTERSOCIETAL ACCREDITATION COMMISSION—VEIN CENTERS

The Intersocietal Accreditation Commission (IAC) is a nonprofit organization supported by 36 sponsoring professional organizations with a specific mission of improving

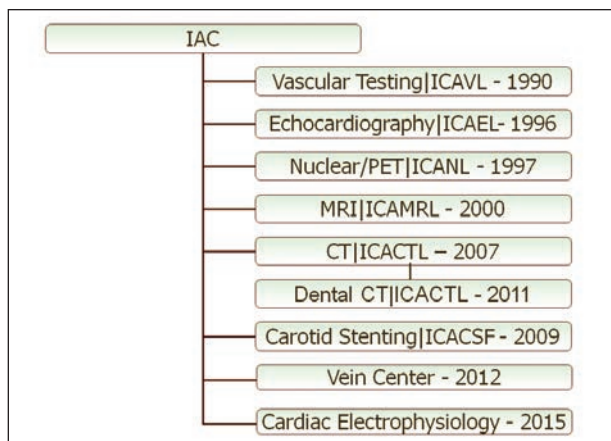


Figure 2. A listing of IAC accreditation divisions.

health care through accreditation.<sup>13</sup> Its origins date back to 1990, when it was established as the Intersocietal Commission for the Accreditation of Vascular Laboratories by nine professional societies involved in vascular diagnostics.<sup>14</sup> Since that time, it has grown to include eight specialty areas of certification (Figure 2). There are presently more than 15,000 IAC-accredited sites across the United States and Canada. Although initially the focus was on imaging modalities, more recently, it has expanded to include interventional procedures, as illustrated by the carotid stenting division. The vein center accreditation process was initiated in 2012 to meet the need for a venous-focused program that would not be overly administratively burdensome to small practices. In addition, it was important that defining the standards and requirements for accreditation be done



Figure 3. The IAC-VC seal of accreditation for vein centers.

by physicians rather than a bureaucratic organization far removed from medical care. Finally, it was deemed critical that professional representation be attained from the specialty organizations dealing with venous disease and consensus be reached on standards and processes. As a result, the sponsoring organizations and board of directors represent a broad diversity of specialties and clinical expertise (see the *IAC Sponsoring Organizations and Board of Directors* sidebar).

The purpose of the Intersocietal Accreditation Commission–Vein Centers (IAC-VC) (Figure 3) was to

## IAC SPONSORING ORGANIZATIONS AND BOARD OF DIRECTORS

### American Academy of Dermatology\*

Robert Weiss, MD

### American College of Phlebology\*

Stephen Daugherty, MD

Steven E. Zimmet, MD

### American College of Surgeons\*

John Blebea, MD, MBA

### American Society for Dermatologic Surgery

Mitchel P. Goldman, MD

### American Venous Forum\*

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### Society for Clinical Vascular Surgery\*

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### Society for Vascular Surgery\*

Marc Passman, MD

Deepak Nair, MD

### Society for Vascular Ultrasound\*

Diana L. Neuhardt, RVT

### Society of Interventional Radiology\*

Mark Garcia, MD

Neil Khilnani, MD

\*Founding society members.

TABLE 1. REQUIREMENTS FOR MEDICAL DIRECTOR AND STAFF PHYSICIANS

	Medical Director	Staff Physician
Board certification	ABMS, AOA, or RCPS	ABMS, AOA, or RCPS
Clinical experience	2 years after training	Ongoing
Venous procedures	200 cases over 3 years in two categories	100 cases over 3 years in one category
Ultrasound skills	100 diagnostic or therapeutic	30 diagnostic or therapeutic
CME	30 category I credit hours	30 category I credit hours
Abbreviations: ABMS, American Board of Medical Specialties; AOA, American Osteopathic Association; CME, continuing medical education; RCPS, Royal College of Physicians and Surgeons of Canada.		

establish minimal requirements for facilities to provide high-quality venous care, not criteria for centers of excellence. The areas to be covered were superficial venous, deep venous, and lymphatic disease, although, as of now, only standards for superficial disease and accreditation have been established. After a process of almost 2 years of regular teleconferences and in-person meetings (and some heated debates!), the standards and criteria were accepted by the board of directors and were made available to the public on November 2, 2013. Since that time, a total of 51 centers have been granted accreditation, and an additional 88 are being processed (either under review or pending revisions) as of August 1, 2015. Reflecting a societal and professional need, venous center accreditation growth has been the fastest of any division in IAC's history.

The complete requirements for accreditation are available and can be downloaded from the IAC-VC website.<sup>15</sup> However, some highlights are worthy of emphasis. As the accreditation is that of a center, rather than an individual physician, there are certain center requirements that must be met for superficial venous accreditation. These include a minimum of at least 75 venous procedures during the preceding year. Of these procedures, at least 25 must have been performed in two of the four areas of superficial disease treatment: saphenous vein ablation (either surgical, chemical, or endovenous), phlebectomy, sclerotherapy, or nonoperative management of C5/C6 chronic venous insufficiency (compression therapy). Perhaps the more challenging requirements are those for the medical director and staff physicians (Table 1).

Although active board certification by one of the recognized bodies in the United States or Canada is preferred, a lapsed certification can be overcome by three letters of recommendation from physicians who practice in the community and are familiar with the applicant's venous practice. For those who have graduated within 5 years from an Accreditation Council of Graduate Medical Education residency or fellowship, in which

venous disease, interventional treatment, and ultrasound training were included in the core curriculum, the clinical case requirements are reduced to only 100 cases over the previous 3 years. For staff physicians, 2 years of clinical experience after training is not required, and their case numbers are only half of those for the medical director, along with a reduced number of venous ultrasounds performed. For everyone, there is a requirement for 30 hours of venous-specific continuing medical education to have taken place during the last 3 years.

In addition to the requirements for the medical director and staff, there are also expectations of the clinical practice at the center. These include a "time out" to be performed and documented before each procedure, preoperative marking of the site of surgery, labeling of all on-table solutions, a stocked crash cart with emergency medications, either basic or advanced life support certification for all physicians and nurses, and a protocol for the diagnosis and treatment of acute deep vein thrombosis. There is not, however, imposed micromanagement of care by the accreditation requirements. There is no mandate that a specific type of ablation technique be used (eg, radiofrequency vs laser ablation vs foam) in particular circumstances, the kind of sclerosant or its concentration, nor the type of anesthesia or sedation method to be employed. Unless specific guidelines or quality standards have been substantiated in the literature, medical practice mandates are not imposed on those wishing to become accredited.

## BENEFITS OF ACCREDITATION

There are a multitude of potential benefits to venous center accreditation.<sup>16</sup> Seeking accreditation in and of itself demonstrates a commitment to quality by a facility and its members because they are willing to examine what they do, how they do it, and have others compare their results to external standards. Accreditation requirements provide an outline of infrastructure needs, practice guidelines, and realistic quality care goals. The



## Accreditation may improve the process of care provided by health care organizations in terms of services and efficiency.

accreditation process is important because it forces the allotment of resources by multiple individuals at different levels of experience and responsibility to collaborate in a critical self-evaluation and review of internal processes in order to help identify and correct potential deficiencies and create improved internal policies and procedures. Direct involvement by all of the stakeholders not only provides a better understanding of what the center has actually been achieving until that point, but also leads to buy-in during the period of implementation that leads to actual process improvement. Because accreditation invites an external and independent agency to verify that facilities meet objective established standards, demonstrate quality patient care, and provide a mechanism for continuous process improvement, it should lead to improved patient outcomes. The process also induces institutional support for further improvements.

Although these benefits appear almost self-evident, it is in fact very difficult to establish a direct causal relationship between accreditation and improved patient outcomes. Accreditation may improve the process of care provided by health care organizations in terms of services and efficiency.<sup>16,17</sup> However, actual patient outcome improvement in office-based surgical procedures has not been definitively established.<sup>18</sup> Organizations such as IAC<sup>19</sup> and the Outpatient Endovascular and Interventional Society<sup>20</sup> are attempting to obtain such data. Until this is documented, however, we should not make the accreditation process too expensive or onerous.

Unfortunately, regulators at Blue Cross Blue Shield of Massachusetts have already forced the issue. In January of this year, even though not a single physician in the state had yet become accredited, it mandated that all providers who wish to perform endovenous ablation obtain IAC vein center accreditation by September 1, 2015.<sup>21</sup> More such administrative diktats may be coming in the near future from other insurers.

## CONCLUSION

Accreditation for venous centers is now available and should be attained by those who have an active

venous practice. Such accreditation will help patients decide whom they should seek for care and allow government agencies and insurers to more easily ascertain who is competent to perform certain procedures. For physicians, the accreditation application requirements will improve their clinical processes and, ultimately, the quality of care they provide to patients. Except for the moderate associated costs, there is no downside to accreditation. ■

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