The Edwards SAPIEN 3 Transcatheter Heart Valve

Transforming the Therapy of Aortic Valve Replacement

Dr. Andrew Taussig
March 5, 2017
High number of US patients with severe aortic stenosis remain largely undertreated

Prevalence of mod+ AS\(^1\): ~1.6m  
Prevalence of sev+ AS\(^1\): ~565k  
Treatment through SAVR or TAVR: ~88k  
TAVR cases: ~18k

Symptoms of aortic stenosis

- Shortness of breath
- Syncope or presyncope
- Angina
- Fatigue
- Difficulty when exercising
- Swollen ankles and feet
- Rapid or irregular heartbeat
- Palpitations (an uncomfortable awareness of heart beating rapidly or irregularly)

The symptoms of aortic disease are commonly misunderstood by patients as ‘normal’ signs of aging. Many patients initially appear asymptomatic, but on closer examination up to 37% exhibit symptoms.

4. Lester SJ et al. CHEST 1998;113(4):1109-1114.
Severe aortic stenosis is life threatening and treatment is critical\(^5\)

After the onset of symptoms, patients with **severe aortic stenosis** have a **survival rate as low as 50% at 2 years and 20% at 5 years** without aortic valve replacement.

Severe aortic stenosis has a worse prognosis than many metastatic cancers

5-year survival of breast cancer, lung cancer, prostate cancer, ovarian cancer and severe inoperable aortic stenosis

*Using constant hazard ratio. Data on file, Edwards Lifesciences LLC. Analysis courtesy of Murat Tuczu, MD, Cleveland Clinic
Timely intervention is critical for patients with symptoms

- In the absence of serious comorbid conditions indicated in the majority of symptomatic patients with severe aortic stenosis
- Consultation with or referral to a Heart Valve Center is reasonable when discussing treatment options for:
  - Asymptomatic patients with severe valvular heart disease
  - Patients with multiple comorbidities for whom valve intervention is considered
- Because of the risk of sudden death, replacing the aortic valve should be performed promptly after the onset of symptoms
- Age is not a contraindication to surgery

Identifying Potential Candidates for TAVR
TAVR Experience / Virtual Clinic Development...

- Developed with 5 Interventional Cardiologists and 2 CV Surgeons
- Every case involves one surgeon / cardiologist
- Hybrid room availability every Wednesday and QO Friday
- Mitral Clip cases done simultaneously in cath lab
**TAVR Experience... virtual clinic...**

**Typical Week...**

- Monday morning TAVR conference and case review
- Clinic cases reviewed virtually ... sent to other clinic same day...
- Wednesday ... TAVR Day!! and QO Friday....
- Meet Wednesday AM and Friday AM pre-TAVR cases...
The specialized Heart Team

Cohesive, multi-disciplinary approach embodies

- Optimal patient centric care
- Dedication across medical specialties
- Collaborative treatment decision

National coverage determination⁹

The patient (preoperatively and postoperatively) is under the care of a Heart Team

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Devising the treatment plan is a collaborative process

A Heart Team will conduct a comprehensive evaluation to determine whether the TAVR procedure is appropriate

- Review all patients who are not obvious surgical candidates, regardless of perceived risk
- Obtain information required to make a recommendation for the best plan of care
- All treatment options, including hospice care, are discussed with the patient and caregivers
- Ultimate treatment choice is a collaborative decision between the physicians, patients and patient’s family
TAVR patients may present with some of the following:  

Severe, symptomatic native aortic valve stenosis  

- History of stroke / CVA  
- Reduced EF  
- Prior CABG  
- History of Afib  
- Fatigue, slow gait  
- Prior open chest surgery  
- Peripheral vascular disease  
- Old age  
- History of syncope  
- Heavily calcified aorta  
- Prior chest radiation  
- History of CAD  
- History of COPD  
- History of renal insufficiency  
- Diabetes and hypertension  
- Frailty  

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The TAVR procedure can be performed through multiple access approaches

- Some patients may not have adequate vascular access to accommodate the sheath used during transfemoral procedures
- For these patients, alternative access approaches are available*

*Transapical and Transaortic approaches are only approved with the Edwards SAPIEN XT valve
A collaborative treatment decision

1. Patient with severe aortic stenosis identified by referring physician

2. Patient referred to valve clinic

3. Additional testing completed

4. Multidisciplinary review and treatment decision by Heart Team

5. Treatment recommendations reviewed with referring physician, patient and patient’s family

Devising a treatment plan is a collaborative process

Ultimate treatment choice is a collaborative decision between the physicians, patient and patient’s family.
TAVR: History of evidence
Alain Cribier: First human transcatheter valve replacement (2002)
History of Edwards’ transcatheter heart valve technology in the United States

- **2010**: Edwards SAPIEN valve
- **2011**: Edwards SAPIEN valve
- **2012**: SAPIEN valve approved for high-risk patients
- **2014**: SAPIEN XT valve approved for high or greater-risk patients
- **2015**: Edwards SAPIEN 3 valve
- **2016**: SAPIEN 3 and SAPIEN XT valves approved for intermediate or greater risk patients

Landmark PARTNER clinical trials begin
The Edwards SAPIEN valve

Superior to medical management in inoperable

Unprecedented clinical outcomes in high risk patients

Transforming the therapy of aortic valve replacement

Significantly improves survival*

SAPIEN valve inoperable

*The PARTNER trial inoperable cohort
Significant reduction in mortality for inoperable patients with patients with the SAPIEN valve

Of the 358 patients 94% of patients in the standard therapy group died within 5 years

21.8% absolute reduction in mortality at 5 years

Standard therapy includes medical management and BAV
Patients treated with standard therapy were rehospitalized twice as often as TAVR patients.

Rehospitalization inoperable cohort

Of the 358 patients, 87.3% of patients with standard therapy were rehospitalized for cardiac issues.

39.7% absolute reduction of rehospitalization at 5 years

Standard therapy includes medical management and BAV.
The Edwards SAPIEN 3 valve delivers

Superior to medical management for inoperable patients*

Unprecedented clinical outcomes in high risk patients

Transforming the therapy of aortic valve replacement

Transformational design, definitive data*

SAPIEN 3 valve high-risk
*The PARTNER II high-risk cohort
Low mortality at 30 days the PARTNER II trial: SAPIEN 3 valve high-risk

All-cause mortality of the 491 patients in the PARTNER II trial was 1.6% at 30 days

Cardiovascular mortality was 1.0%

The PARTNER II trial high-risk and inoperable TF SAPIEN 3 valve cohort 30 day results
Mortality rates continue to decline

- **PARTNER IB trial** (transfemoral): 6.3%
- **PARTNER IA trial** (overall): 5.2%
- **PARTNER IIB trial** (transfemoral): 4.5%
- **PARTNER IIB trial** (overall): 3.6%
- **PARTNER IIA trial** (overall): 3.4%
- **PARTNER II HR trial** (overall): 2.2%
- **PARTNER II S3i trial** (overall): 1.1%

**All-cause mortality (%)**

1. **SAPIEN valve**: 175
2. **SAPIEN XT valve**: 271
3. **SAPIEN 3 valve**: 583

Edwards Lifesciences
Low stroke at 30 days the PARTNER II trial: SAPIEN 3 valve in high-risk

Disabling stroke
(as treated patients)

Disabling stroke was **0.8% at 30 days**

The PARTNER II trial high-risk and inoperable TF SAPIEN 3 valve cohort 30 day results
Stroke rates continue to decline

Neurologist evaluations (pre and post)

- **PARTNER I B (TF)**: 7.3%
  - 179 SAPIEN valve

- **PARTNER II B (TF)**: 4.4%
  - 271 SAPIEN valve

- **PARTNER II B (TF)**: 4.3%
  - 282 SAPIEN XT valve

- **PARTNER II HR (TF)**: 1.4%
  - 491 SAPIEN 3 valve

Stroke rates continue to decline.
Conclusions

In high-risk and inoperable patients, the excellent 30-day outcomes with the SAPIEN 3 valve were also seen at 1 year

<table>
<thead>
<tr>
<th></th>
<th>1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall TF survival</td>
<td>87.7%</td>
</tr>
<tr>
<td>High-Risk TF survival</td>
<td>89.3%</td>
</tr>
<tr>
<td>Inoperable TF survival</td>
<td>84.3%</td>
</tr>
</tbody>
</table>

- Between 30 days and 1 year, the rates of both disabling stroke and significant paravalvular AR remained low and stable
- There was no association observed between the occurrence of mild PVL and mortality at 1 year
- Hemodynamic valve performance was sustained at 1 year
The Edwards SAPIEN 3 valve now approved for intermediate-risk patients

Superior to medical management for inoperable patients*

Unprecedented clinical outcomes in high risk Patients*

Transforming the therapy of aortic valve replacement

Better than surgery for intermediate-risk patients*

*The PARTNER II trial intermediate-risk cohort, VI population (n=2,005); the difference in the primary endpoint (composite of all-cause mortality, all stroke, and ≥ moderate aortic regurgitation at one year) event rate between TAVR with the SAPIEN 3 valve and surgery appeared to be clinically significant. The PARTNER II trial intermediate-risk cohort 30-day unadjusted clinical event rates for TAVR with the SAPIEN 3 valve, AT population (n=1,077).
The PARTNER II Trial: Intermediate-risk cohort

Intermediate-risk symptomatic severe aortic stenosis

PARTNER II S3i
( n = 1078 )

Assessment for optimal valve delivery access

Transfemoral (TF)
TF TAVR SAPIEN 3 valve

Transapical (TA)/Transaortic (TAo)
TA / TAo TAVR SAPIEN 3 valve

PARTNER IIA
( n = 2032 )

Assessment transfemoral access

Yes
Transfemoral (TF)
1:1 Randomization
TA TAVR SAPIEN XT valve vs Surgical AVR

No
Transapical (TA)/Transaortic (TAo)
1:1 Randomization
TA/TAo TAVR SAPIEN XT valve vs Surgical AVR

The most robust, rigorous study in more than 3,000 intermediate-risk patients
### Baseline patient characteristics

#### Other co-morbidities (AT)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>PARTNER II S3i trial SAPIEN 3 valve (n =1,077)</th>
<th>PARTNER IIA trial surgery (n =944)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years ± SD)</td>
<td>81.9 ± 6.6</td>
<td>81.6 ± 6.8</td>
</tr>
<tr>
<td>Median STS score (% [ IQR ] )</td>
<td>5.2 [4.3, 6.3]</td>
<td>5.4 [4.4, 6.7]</td>
</tr>
<tr>
<td>CAD (%)</td>
<td>69.6</td>
<td>66.5</td>
</tr>
<tr>
<td>Previous CABG (%)</td>
<td>27.9</td>
<td>25.7</td>
</tr>
<tr>
<td>Cerebrovascular disease (%)</td>
<td>9.0</td>
<td>10.3</td>
</tr>
<tr>
<td>PVD (%)</td>
<td>28.2</td>
<td>32.2</td>
</tr>
<tr>
<td>COPD (%)</td>
<td>30.0</td>
<td>30.2</td>
</tr>
<tr>
<td>Cr Level &gt; 2 mg/dL (%)</td>
<td>7.5</td>
<td>5.4</td>
</tr>
<tr>
<td>Atrial fibrillation (%)</td>
<td>36.0</td>
<td>34.9</td>
</tr>
<tr>
<td>Permanent pacemaker (%)</td>
<td>13.2</td>
<td>12.0</td>
</tr>
<tr>
<td>15 ft. walk test &gt; 7s (%)</td>
<td>41.3</td>
<td>45.7</td>
</tr>
</tbody>
</table>
## Baseline patient characteristics
### Other co-morbidities (AT)

<table>
<thead>
<tr>
<th>Characteristic (%)</th>
<th>PARTNER II S3i trial SAPIEN 3 valve (n =1,077)</th>
<th>PARTNER IIA trial surgery (n =944)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD</td>
<td>69.6</td>
<td>66.5</td>
<td>0.14</td>
</tr>
<tr>
<td>Previous CABG</td>
<td>27.9</td>
<td>25.7</td>
<td>0.27</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>9.0</td>
<td>10.3</td>
<td>0.36</td>
</tr>
<tr>
<td>PVD</td>
<td>28.2</td>
<td>32.2</td>
<td>0.05</td>
</tr>
<tr>
<td>COPD</td>
<td>30.0</td>
<td>30.2</td>
<td>0.92</td>
</tr>
<tr>
<td>Cr Level &gt; 2 mg/dL</td>
<td>7.5</td>
<td>5.4</td>
<td>0.06</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>36.0</td>
<td>34.9</td>
<td>0.61</td>
</tr>
<tr>
<td>Permanent pacemaker</td>
<td>13.2</td>
<td>12.0</td>
<td>0.42</td>
</tr>
<tr>
<td>15 ft walk test &gt; 7s</td>
<td>41.3</td>
<td>45.7</td>
<td>0.06</td>
</tr>
</tbody>
</table>
All-cause mortality*

Number at risk:
- Surgery: 944, 859, 836, 808, 795
- SAPIEN 3 TAVR: 1077, 1043, 1017, 991, 963

*The PARTNER II trial intermediate-risk cohort unadjusted clinical event rates.
Disabling Stroke*

*The PARTNER II trial intermediate-risk cohort unadjusted clinical event rates.
## Paravalvular regurgitation (VI)

<table>
<thead>
<tr>
<th></th>
<th>PARTNER II S3i trial</th>
<th>PARTNER IIA trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAPIEN 3 valve surgery</td>
<td>3.8 Moderate of severe</td>
<td>0.5 Moderate of severe</td>
</tr>
<tr>
<td></td>
<td>45.0</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>PARTNER II S3i trial</th>
<th>PARTNER IIA trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAPIEN 3 TAVR</td>
<td>1.5 Moderate of severe</td>
<td>0.3 Moderate of severe</td>
</tr>
<tr>
<td></td>
<td>39.8</td>
<td>95.9</td>
</tr>
</tbody>
</table>

- **Severe**
- **Moderate**
- **Mild**
- **None / trace**

### No. of Echos:

<table>
<thead>
<tr>
<th></th>
<th>30 Days</th>
<th>1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>755</td>
<td>610</td>
</tr>
<tr>
<td>SAPIEN 3 TAVR</td>
<td>992</td>
<td>875</td>
</tr>
</tbody>
</table>
## Unadjusted clinical events
### At 30 days and 1 year (AT)

<table>
<thead>
<tr>
<th>Events (%)</th>
<th>30 Days</th>
<th>1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PARTNER II S3i trial SAPIEN 3 valve (n =1,077)</td>
<td>PARTNER IIA trial surgery (n =944)</td>
</tr>
<tr>
<td><strong>Death</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All-cause</td>
<td>1.1</td>
<td>4.0</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>0.9</td>
<td>3.1</td>
</tr>
<tr>
<td><strong>Neurological events</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All stroke</td>
<td>2.7</td>
<td>6.1</td>
</tr>
<tr>
<td>Disabling stroke</td>
<td>1.0</td>
<td>4.4</td>
</tr>
</tbody>
</table>

**KM Estimates**
## Other unadjusted clinical events
### At 30 days and 1 year (AT)

<table>
<thead>
<tr>
<th>Events (%)</th>
<th>30 Days</th>
<th>1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-hospitalization</td>
<td>4.6</td>
<td>11.4</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Major vascular complication</td>
<td>6.1</td>
<td>---</td>
</tr>
<tr>
<td>Life-threatening / disabling bleeding</td>
<td>4.6</td>
<td>---</td>
</tr>
<tr>
<td>New atrial fibrillation</td>
<td>5.0</td>
<td>5.9</td>
</tr>
<tr>
<td>New permanent pacemaker</td>
<td>10.2</td>
<td>12.4</td>
</tr>
<tr>
<td>Re-intervention</td>
<td>0.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Endocarditis</td>
<td>0.2</td>
<td>0.8</td>
</tr>
</tbody>
</table>

**PARTNER II S3i trial SAPIEN 3 valve (n =1,077)**

**PARTNER IIA trial surgery (n =944)**

**PARTNER II S3i trial SAPIEN 3 valve (n =1,077)**

**PARTNER IIA trial surgery (n =944)**

*KM Estimates*
## Unadjusted procedural factors (AT)

<table>
<thead>
<tr>
<th></th>
<th>PARTNER II S3i trial SAPIEN 3 valve (n =1,077)</th>
<th>PARTNER IIA trial surgery (n =944)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean total hospitalization LOS (days)</strong></td>
<td>5.6</td>
<td>11.9</td>
</tr>
<tr>
<td><strong>Mean ICU stay (days)</strong></td>
<td>2.7</td>
<td>5.6</td>
</tr>
</tbody>
</table>
Clinical outcomes improve as therapy evolves

**Low mortality and stroke rates**  
Patient selection, procedural techniques, device evolution

- Edwards eSheath introducer set
- RetroFlex 3 delivery system
- NovaFlex+ delivery system
- Edwards Commander delivery system

**Improved vascular access**  
Lower profile devices expands treatment possibilities

- RetroFlex 3 introducer sheath
- Edwards eSheath introducer set
- Edwards eSheath introducer set*

**Increased treatment range**  
Larger and smaller valves

- SAPIEN valve 23 mm and 26 mm
- SAPIEN XT valve 23 mm, 26 mm, 29 mm
- SAPIEN 3 valve 20 mm, 23 mm, 26 mm, 29 mm

*Only used with 20 mm, 23 mm, 26 mm valve sizes
SAPIEN 3 valve

1. **Outer sealing skirt**
   - Designed to minimize paravalvular (PV) leak

2. **Frame design**
   - Enhanced frame geometry for low delivery profile
   - Cobalt-chromium

3. **Bovine pericardial tissue**
Edwards SAPIEN 3 valve: Designed for precise deployment and positioning
The Edwards SAPIEN 3 transcatheter heart valve is transforming the therapy of aortic valve replacement

Better than surgery for intermediate-risk patients*

<table>
<thead>
<tr>
<th>1.1% All-cause mortality†</th>
<th>1.0% Disabling stroke†</th>
</tr>
</thead>
</table>

75% Lower than surgery†

*The PARTNER II trial intermediate-risk cohort, VI population (n=2,005); the difference in the primary endpoint (composite of all-cause mortality, all stroke, and ≥ moderate aortic regurgitation at one year) event rate between TAVR with the SAPIEN 3 valve and surgery appeared to be clinically significant.
† The PARTNER II Trial intermediate-risk cohort 30-day unadjusted clinical event rates for TAVR with the SAPIEN 3 valve, AT population (n=1077).
Data Overview

Volume data through Quarter 4, 2016

Outcomes data through Quarter 3, 2016
TAVR Program Volume

Florida Hospital Orlando
TAVR Volume 2012-2016

Year
2012
2013
2014
2015
2016

Procedure Volume
0
50
100
150
200

12
69
96
159
212
Mortality Rate

QUARTER 4 2015 – Quarter 3 2016

ACC-TV Definition: Your hospitals in-hospital observed (unadjusted), all-cause mortality rate for all patients.

FH Orlando- 0.5% N/D= 1/186

5.2 3.1 1.6 0.0

10th Percentile 50th Percentile 90th Percentile

Mortality Rate - In Hospital Observed

Quarter 4 2015=0/33
Quarter 1 2016=1/47
Quarter 2 2016=0/45
Quarter 3 2016=0/61
**Stroke**

**ACC-TV Definition:** The proportion of patients your hospital proportion of patients with TAVR with any Stroke post procedure. This includes hemorrhagic, ischemic, or stroke of undetermined type.

**QUARTER 4 2015 – Quarter 3 2016**

- **FH Orlando:** 1.6%
- **N/D = 3/186**

- **Quarters:**
  - Quarter 4 2015 = 0/33
  - Quarter 1 2016 = 0/47
  - Quarter 2 2016 = 1/45
  - Quarter 3 2016 = 2/61
Significant Cardiac Event

**ACC-TV'T Definition:** The Proportion of patients with TAVR with a significant, procedure related, cardiac event post-procedure and prior to discharge. This includes coronary compression or obstruction, annular dissection, aortic dissection or cardiac perforation.

**QUARTER 4 2015 – Quarter 3 2016**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>N/D</th>
<th>FH Orlando</th>
<th>10th Percentile</th>
<th>50th Percentile</th>
<th>90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 4 2015</td>
<td>0/33</td>
<td>0.0%</td>
<td>3.9</td>
<td>2.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Quarter 1 2016</td>
<td>0/47</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 2 2016</td>
<td>0/45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 3 2016</td>
<td>0/61</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/D= 0/186</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quarter 4 2015=0/33  
Quarter 1 2016= 0/47  
Quarter 2 2016=0/45  
Quarter 3 2016=0/61
Aortic Regurgitation (moderate to severe)

QUARTER 4 2015 – Quarter 3 2016

ACC-TV T Definition: Patients with TAVR with moderate to severe aortic regurgitation post procedure.

- FH Orlando- 1.1%
- N/D=2/185
- Quarter 4 2015=0/33
- Quarter 1 2016= 0/47
- Quarter 2 2016= 2/45
- Quarter 3 2016=0/60
Acute Kidney Injury - Stage 3

ACC-TVT Definition: The proportion of patients with acute kidney injury - stage 3 as determined by the Acute Kidney Injury Network (AKIN) RIFLE Criteria

NUMERATOR - difference between pre and post Creatinine >=300% or pre procedure Creatinine >=4mg/dl and the difference between pre and post Creatinine is >=0.5 or the New Requirement for Dialysis

(Exclusion - patients currently on Dialysis prior to procedure)

FH Orlando - 4.3%
N/D = 8/186

QUARTER 4 2015 – Quarter 3 2016

Quarter 4 2015 = 0/33
Quarter 1 2016 = 1/47
Quarter 2 2016 = 5/45
Quarter 3 2016 = 2/61
**Bleeding - Disabling**

**ACC-TV Definition:** The proportion of patients with TAVR with a disabling or life threatening bleeding event defined as having one of the following:

1. A bleeding event of Access Site, Hematoma, Retroperitoneal bleed, GI bleed, GU bleed, Transapical related event, Transaortic related event or Hemorrhagic stroke **AND** at least one of the following:
   a. Difference between pre and lowest post procedure hemoglobin is >=5dl **OR**
   b. RBC/whole blood transfusion units >= 4units

2. Unplanned vascular surgery or intervention **AND** difference between pre and post procedure hemoglobin >=5g/dl **OR**

3. Discharge status is deceased and Primary cause of death is Vascular

**QUARTER 4 2015 – Quarter 3 2016**

- **FH Orlando** - 2.7%
- N/D= 5/186

- Quarter 4 2015=1/33
- Quarter 1 2016= 3/47
- Quarter 2 2016= 1/45
- Quarter 3 2016=0/61
Median LOS Comparison

**TAVR ICU Median LOS**
Quarter 4 2015 - Quarter 3 2016

- FHO ICU Median ICU Hours: 35.2
- TVT National Median ICU Hours: 26

**TAVR Overall Median LOS**
Quarter 4 2015 - Quarter 3 2016

- FHO Median LOS Days: 6
- TVT National Median LOS Days: 3
Median LOS Comparison

TAVR Post-Procedural Median LOS
Quarter 4 2015 - Quarter 3 2016

- FHO Median Post-Procedural LOS = 4
- TVT National Median Post-Procedural LOS = 3

FHO TAVR Post-Procedural LOS Trend by Quarter
Quarter 4 2015 - Quarter 3 2016

- Q4 2015: 5
- Q1 2016: 4
- Q2 2016: 4
- Q3 2016: 3

From STS/ACC TVT Registry - An initiative of the STS National Database and the ACC's NCOR
Creating a “virtual” clinic...

- Requires a strong / active / committed coordinator..
- Requires a “team mentality” with flexibility / trust...
- Communication is key!!!

Thank you...