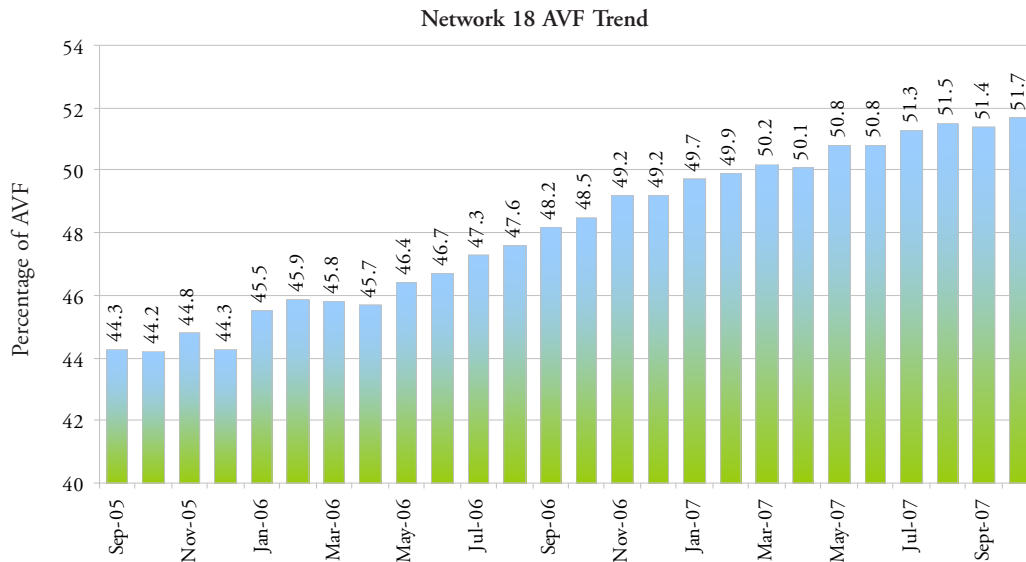


NETWORK 18 FISTULA FIRST UPDATES:

According to the latest Dashboard (October 2007), ESRD Network 18 has an AVF rate of 51.7! We would like to thank all facilities for the hard work and commitment they have shown in improving the quality of vascular access care given to all ESRD patients.



The Network continues to support all facilities through participation and collaboration with renal organizations throughout Southern California.

Fistula First Cannulation Videos

The Fistula First Cannulation videos were distributed to all Independent facilities in September 2007. LDO (FMC and DaVita) facilities can obtain their videos from their corporate offices. If you have not received your video, please contact the Network office for Independent facilities or your corporate office for LDO facilities.

Incident Patient Referral Project

The Network will be mailing out Nephrologist-specific incident patient reports in December for the time period of April – September 2007. We distribute these reports on a semi-annual basis to encourage

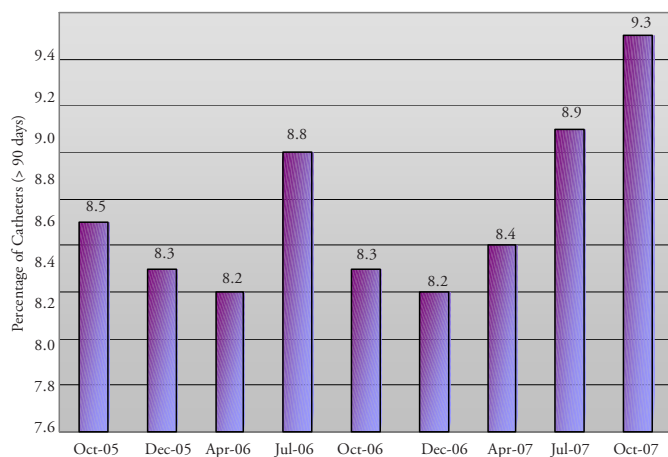
Nephrologists to become proactive in vascular access planning and placement with their CKD patients, promoting Change Concept #2- Timely Referral to Nephrologist and Change Concept #3- Early referral to surgeon for “AVF Only” evaluation and timely placement. Facilities can refer to this report when encouraging Nephrologists to refer patients for timely vascular access evaluation and placement.

Catheter Reduction Policy

Based on the SIMS Fistula First Summary Report (see graph below) the Network catheter rate > 90 days has been increasing within the last year. Although our rate of 9.3% meets the CMS goals of < 10%, we are very concerned about the increasing trend occurring this year. Please continue to make efforts in improving the quality of vascular access care given to our ESRD patient population. Even

with all our best efforts, the Network is aware and understands that many of our *incident* (new patients < 90 days) ESRD patients usually start dialysis treatment with a catheter in place. Because of this, we would like to ensure that all facilities have a Catheter Reduction Policy in place to address all catheters within the facility. Enclosed in this mailing is a sample “Catheter Reduction Policy” written in conjunction with the Network Medical Review Board and the renal community Quality Improvement experts. Please use this document as a guide to revise your facility’s policy or implement if your facility does not currently have a policy in place. This policy was based on the Fistula First Breakthrough Initiative’s Change Concept # 7. Also enclosed is the “Management of Patient with Central Venous Catheter”. This algorithm/flow chart can be used by dialysis facilities to transition patients from central venous catheters to arteriovenous fistulae. Please review these documents and share them with your staff and physicians. You can find these helpful tools on the Network 18 website: www.esrdnetwork18.org and the Fistula First website: www.fistulafirst.org.

Network 18 Catheter Quarterly Trend (> 90 days)

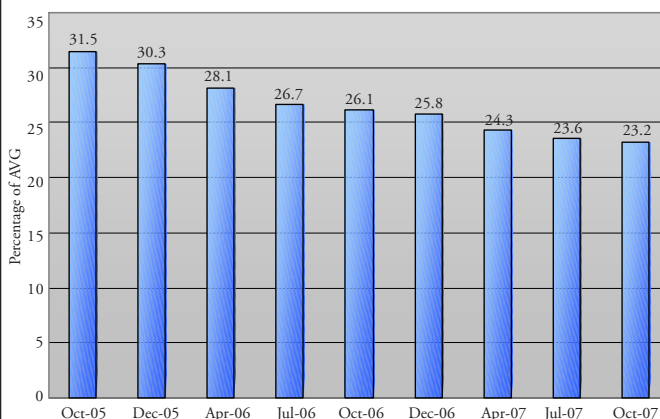


AV Grafts

According to the SIMS Fistula First Summary Report, Network 18’s average AVG rate is 23.2%. Although the trend is slowly decreasing (see graph

below), we would like to remind everyone of Change Concept #6, “Secondary AV Fistulae in Patients With AV Grafts”. This is an effective strategy for increasing AVF prevalence in AVG patients through planning and construction of an AVF in existing graft patients prior to graft failure. This change concept considers a secondary AVF plan to be discussed with the patient, family, staff, nephrologist, and surgeon in anticipation of AVF construction on the earliest evidence of graft failure. It is recommended that the timing for AVF conversion be no later than the first signs of graft failure by monitoring and surveillance – in no case later than following the first intervention for stenosis or thrombosis. Any delay in conversion beyond this point is likely to result in loss of the window of opportunity for this AVF option, since further graft interventions, especially if done as an emergency, are likely to damage or utilize the outflow vein, or the graft will eventually be abandoned (usually after a failed intervention), resulting in a catheter and a new graft in a different location. (*Adapted from Change Concept #6*) We would like to also remind all facilities to please conduct stenosis monitoring and surveillance on all AVF and AVG accesses as part of your daily quality care processes.

Network AVG Quarterly Trend



Stenosis Monitoring & Surveillance

Preliminary Clinical Performance Measures (CPM) results for stenosis monitoring reveal that Network 18 has improved from 72% in the 2006 CPM to 77%

this year. The CMS/Network 18 goal for this clinical indicator is 100% monitoring. Per the 2006 K/DOQI Guidelines,

“The basic tenet for vascular access monitoring and surveillance is that stenoses develop over variable intervals in the great majority of vascular accesses and, if detected and corrected, under-dialysis can be minimized or avoided (dialysis dose protection) and the rate of thrombosis can be reduced.”

To ensure that all AVF/AVG accesses are properly assessed, monitored, and surveillance performed, the Network presented a power point presentation on “Vascular Access Assessment & Stenosis Monitoring” which can be found on the Network 18 website under Quality Improvement Educational Resources and Presentations. We have included with this mailing the “VAMP© Vascular Access Monitoring & Surveillance Flow Chart” developed by Dr. Lawrence Spergel, MD, FACS for the Fistula First Breakthrough Initiative as a helpful tool. This algorithm/flow chart outlines monitoring mechanisms for vascular access function, normal and abnormal findings, and recommendations for interventions. We have also included a “Monthly Vascular Access Monitoring & Surveillance Referral/Intervention Tracking Log” for your internal use if you do not currently have one. Please review all documents and share them with your staff. These documents can also be found on the Network 18 website: www.esrdnetwork18.org and the Fistula First website: www.fistulafirst.org.

Fistula First Vascular Access Monthly Log CDs
FOR INDEPENDENT FACILITIES: The Network will be mailing out the updated Fistula First Data Collection CDs in January 2008. The CD will be pre-populated with the facility patient census as of December 31, 2007. Please ensure that your patient census is reported correctly and on time to the data department via the facility PAR

and 2728 Medical Evidence Form so that the information on the CD will be correct and current.

The Large Dialysis Organizations will continue to submit their Fistula First data electronically via their corporate office.

“CHAMPIONS CORNER”

Top facilities with the highest AVF rates in Network 18 as of October 2007 are:

- ❖ Fresenius Medical Care – South Orange County = 88.6%
- ❖ Independent – Kidney Center of Thousand Oaks, Inc. = 79.5%
- ❖ DaVita – Westminster South Dialysis = 72.6%
- ❖ Renal Advantage, Inc. – Fletcher Parkway-El Cajon = 73.1%

Network 18’s Vascular Access rates as of October 2007:

- ❖ AVF = 51.7%
- ❖ AVG = 23.2%
- ❖ Catheter > 90 days = 9.3%
- ❖ Catheter < 90 days = 15.8%

Should you need assistance with your facility’s vascular access program or have questions or concerns, please call Lana Kacherova or Lisle Mukai at the Network 18 office.

Success in improving your facility’s AVF rates is a team effort. We welcome your input and feedback - it helps all facilities in Network 18!

Lana Kacherova or Lisle Mukai may be reached at the Network 18 office at (323) 962-2020 or e-mail them at skacherova@nw18.esrd.net or lmukai@nw18.esrd.net.