

FISTULA FIRST UPDATES:

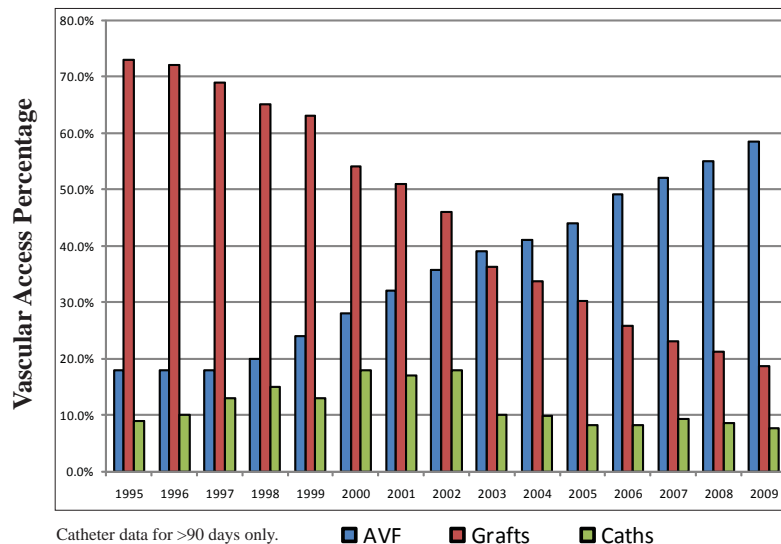
Currently, Network 18 has met and exceeded the Network's prevalent AVF goal of 57.8% and the stretch goal of 58% for the 2009-2010 year. Network 18's prevalent AVF rate as of January 2010 is 58.8%! We are 7.2 percentage points away from CMS's goal of 66% AVF usage. At the end of this month,

CMS will revise Network 18's AVF goal based on the March 2010 AVF rate. The Network will notify all facilities of the new AVF goal when it is established. Thank you everyone for your continued efforts in improving vascular access care given to our patients!

Below is a graph (Graph 1) that illustrates the Network's progress since 1995 in all vascular access types.

Graph 1

Network 18 Vascular Access Trend

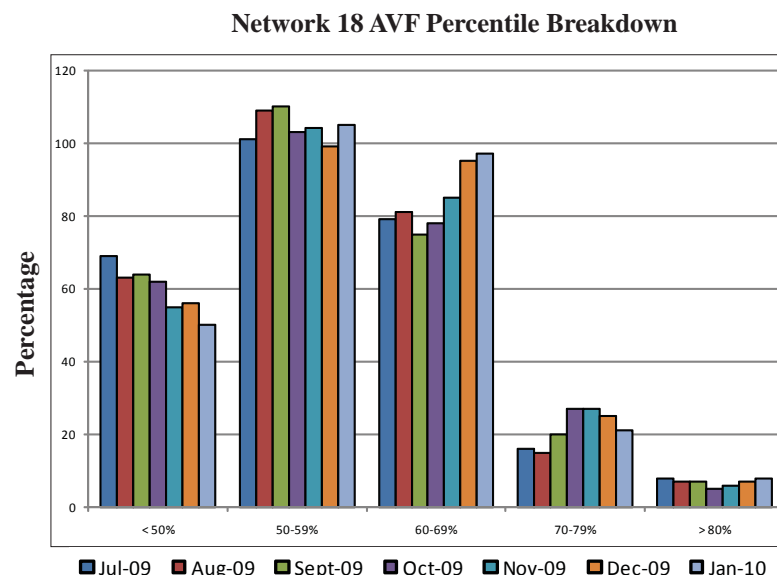


At the beginning of 2008, there were 120 facilities with AVF rates less than 50%. This year that number has decreased to 50 facilities (Graph 2). The Medical Review Board (MRB) will continue monitoring all facilities with AVF rates less than 50%. The Network will continue distributing facility-specific SIMS reports to these facilities on a monthly basis, so they can monitor their progress and use this report to find areas for improvement. We encourage these facilities to conduct Quality Assessment and Performance Improvement plans for vascular access. NW 18 strongly advises facilities to frequently review your plan and make necessary changes to attain improvement towards your goals and the Network goals.

minimum 50% AVF rate. Currently, there are 50 facilities (17.8%) who are within this category. 231 facilities (82.2%) have an AVF rate of 50% or greater. It isn't an impossibility to improve and maintain improvements. It is very difficult to find ways to improve and implement processes but we have been told by some successful facilities that it takes persistence and dedication by the whole team – all staff. We suggest that facilities share their successful processes, strategies and/or activities with other facilities, so that all Network facilities succeed in improving vascular access care. Facilities that fall below 50% AVF rate should take the initiative and call successful facilities listed within this newsletter or listed in the *Champion Vascular Access Facilities* flyer and find out how these facilities succeeded and maintained their improvements. A Network facility directory can be found on the Network 18 website at www.esrdnetwork18.org.

A percentile breakdown of vascular access distribution is shown in Table 1. As mentioned above at the beginning of 2008, there were 120 facilities who fell below the

Graph 2



Where Do You Rank?

Please review your facility-specific SIMS - *Vascular Accesses Used in Prevalent Patients* report included in this mailing and see where you rank amongst all Fistula First facilities in Network 18 using Table 1 below. Also,

please review your reports for trends with your vascular access team. If your facility does not meet or exceed the Network's minimum goals for each vascular access type, please review your vascular access plan an/or program and reassess where you can make improvements.

Table 1

AV FISTULA (MINIMUM AVF GOAL= 50%)	<50%	50-59%	60-69%	70-79%	≥80%	GOAL
YOUR FACILITY (JANUARY 2010)						CMS: 66% NW: 57.8%
TOTAL # OF FACILITIES:	50	105	97	21	8	

CATHETER (>90 DAYS)	<10%	10-19%	20-29%	30-39%	≥40%	GOAL
YOUR FACILITY (JANUARY 2010)						CMS/NW: <10%
TOTAL # OF FACILITIES:	210	61	8	1	0	

AV GRAFT	<24%	24-34%	35-44%	45-54%	≥55%	GOAL
YOUR FACILITY (JANUARY 2010)						CMS/NW: <24%
TOTAL # OF FACILITIES:	204	64	11	2	0	

New: Change Concept #12 & Change Concept #13

A Change Concept is simply a general notion or approach that has been found to be useful in developing ideas for changes that lead to improvement. The change concepts developed by the Fistula First Initiative are all concepts that are recognized as effective in improving the AV fistula rates in prevalent hemodialysis patients.

The entire Fistula First Breakthrough Initiative Change Package and tools to support the Change Concepts can be viewed in full on the FFBI website <http://www.fistulafirst.org>. Eleven Change Concepts were developed and implemented in 2003, by an

interdisciplinary workgroup supported by a team from the Institute for Healthcare Improvement (IHI).

Change Concept #12 (See Attachment 2a)

Modify hospital systems to detect CKD and promote AV fistula planning and placement. Hospitals develop a comprehensive plan for early identification of patients with kidney disease to allow for interdepartmental coordination for protective measures programs to prevent nephrotoxicity or other causes of further kidney damage, to allow for vessel preservation, patient and family support, and vascular access planning and/or placement. Patients with eGFR <30 - 44 (CKD Stage 3B).

Change Concept #13 (See Attachment 2b)

Support patient efforts to live the best possible quality of life through self-management.

- Patient achieves optimum treatment outcomes and health status through collaborative knowledge-building related to CKD progression and treatment and through effective application of self-management interventions, such as self-monitoring and decision-making.
- Health care clinicians utilize techniques and strategies for the education of those who participate in vascular access education and management that are designed to encourage, enhance, and support patient self-management. This includes motivational interviewing, health coaching, and other patient empowerment strategies and techniques.

Dr. James Cimino – Cimino Fistula

The dialysis community bids farewell to a true pioneer. Dr. James Cimino died in February 2010. In 1966, Dr. Cimino and his partner Dr. Brescia revolutionized hemodialysis by creating the Cimino fistula. (A Cimino fistula is created by joining a large vein directly to an artery = arteriovenous fistula) The Cimino fistula is still being used today. It continues to be the most effective and long-lasting method used for long term vascular access - thus making it the “gold standard” of vascular accesses.

Dr. Cimino started his career as a phlebotomist at New York City’s Bellevue Hospital in the 1950s. He noticed that Korean War veterans had fistulas and that these were easy places to draw blood samples. He also realized that these fistulas did not seem to be harmful to the patients. He convinced Dr. Kenneth Appel, a surgeon, to create these fistulas in kidney failure patients. The procedure was so successful that the Scribner shunts (original vascular access that lasted a few days to weeks) were quickly replaced with Cimino fistulas. Although the dialysis community has lost the father of the AV fistula, we should not grieve his death but instead celebrate his life. Dr. Cimino through his caring provided an increased quality of life for dialysis patients that can never be measured. His knowledge made the world a better place. We honor Dr. Cimino with every fistula we place.

“CHAMPION FACILITIES”

Enclosed in this mailing please find the “**Champion Vascular Access Facilities**”. These facilities are acknowledged for achieving CMS’ goal for prevalent AVFs. **These facilities have a prevalent AVF Rate of 66% or greater!** We would also like to thank these facilities for their continuous effort in improving vascular access care given to their patients.

Top facilities per corporation: (January 2010)

- DaVita – *Magnolia West at Home*
- DaVita – *Monterey Park Dialysis Center*
- Fresenius Medical Care (FMC) – *San Fernando*
- Independent – *Kidney Institute of the Desert*
- Innovative Dialysis – *Montebello Dialysis Center, LLC*
- Kidney Center, Inc. – *Kidney Center of Simi Valley*
- Renal Advantage, Inc. – *RAI – Compton-Los Angeles*

BEST PRACTICE - SUCCESS STORIES

During a monthly conference call for one of the Network-driven QAPI projects, the Vascular Access Coordinator (VAC) of a Best Practice facility shared that she attributes her facility’s improvements to implementing her company’s catheter reduction program and persistent education of patients. This facility is located in a rural area and sometimes must send their patients out of town for procedures. The VAC uses a calendar book for tracking patient status in the AVF process - tracking mapping, surgical consults, surgeries, etc. She works closely with the PCTs and RNs meeting with them weekly to review patient’s progress and status. She has established relationships with the surgeon’s office. She calls the surgeon’s office frequently – she stated that this is very time consuming but it keeps the surgeon’s office aware of the facility’s needs and expectations and the facility is able to get the necessary appointments and documents they need. The VAC also works closely with the Social Worker on insurance issues. She stated that she works with the family members to advocate for the patient. She encourages them to go to the welfare office and make the Case Worker at the welfare office aware and understand the patient’s needs. She encourages the

family to be persistent. She also added that the patient must also be accountable and responsible for keeping up with their insurance. They too must be persistent when following up with their case worker.

During her sharing session, the VAC elaborated on the process she implements to achieve her outcomes.

1. Education

- The VAC initiates patient education. Teaching patients about the pros and cons of each vascular access type. Stressing infection for catheter patients.
- She educates patients one-on-one.
- Encourages patients to ask questions or voice concerns.
- Before she leaves the patient, she ensures that the patient has understood the information given to them.
- She informs the patient that she is always available to them and can contact her at anytime.
- The staff reinforces what was taught to the patient.
- The VAC stated that her staff is very motivated to teach and are persistent in doing so.
- **Education, Persistence and Encouragement are key** when teaching patients.

2. Mapping

- Some of the vein mapping is done at the hospital. The facility should ask for results/documentation of procedure.
- Her facility works with 3 vascular access surgeons with whom she communicates with often.
- She works with the patient and their families – especially with transportation.
 - She usually schedules the patient's appointments at the beginning of the month when Social Security checks and welfare checks are distributed – this allows the patient to budget the transportation cost into their month's expenses.

3. Surgical Evaluation

- Surgical evaluations are usually scheduled one week after the surgical consult.
- The access is usually placed after the 1st of the month – (transportation issue).
- Post placement education is conducted with the patient and their family.
- Frequent follow up with the patient.
- On-going teaching is conducted with the

patient.

- Ask for copies of post-op procedures from the surgeon's office.
4. Maturation Follow-Up
 - Send patients for 4 week follow-up.
 5. Cannulation
 - After 6 weeks, the VAC asks the surgeon if it is OK to cannulate the access.
 - Cannulation done in a step process
 - 1-and-1 (AVF and catheter)
 - 2 needle cannulation
 - Increase needle size
 6. Catheter Removal
 - After communication with the staff about the progress/status of the patient's AVF (usually around 4 weeks) they send the patient for catheter removal. The VAC stated that by that time the patient wants their catheter removed anyway.
 - After removal of the catheter, the facility celebrates and announces to the facility over the intercom that patient "John Doe" now has an AV fistula! The patient is given balloons and a certificate to mark the occasion. She states that the patients are excited about the recognition. All of the other patients also congratulate the patient.

We frequently solicit success stories from facilities and other Networks. As the basis for Quality Improvement, replication of successful practices to achieve desired outcomes is the premise for all quality improvement projects. Please share your successes with our renal community by submitting your story to Shean Strong or Lisle Mukai at any time.

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!

For information regarding quality improvement tools and resources please visit the Network 18 website at www.esrdnetwork18.org.

Should you need assistance with your facility's vascular access program or have questions or concerns, please call Shean Strong or Lisle Mukai at the Network 18 office (323) 962-2020 or e-mail them at sstrong@nw18.esrd.net or lmukai@nw18.esrd.net.