



## Increasing AVF Rates in Facilities with AVF Rates < 50% Conference Call

Wednesday, May 26, 2010  
2:00 – 2:30 pm

TOPIC	SUMMARY	ACTION
Roll Call:	Roll call was taken.	
Summary of Best Practices	<p>Network 18 reviewed all the best practices shared during the project’s monthly conference calls. The summary of best practices shared were a compilation of both the &lt; 50% AVF project and the Reduction in Long-Term Catheter project.</p> <p>Please see attached “Summary of Best Practices” documents – Attachment 1a</p>	Implement successful strategies or helpful suggestions as appropriate for your facility.
QI Process	<p>The QID (Quality Improvement Director) reviewed the elements and necessary considerations for conducting and completing the PDSA (Plan-Do-Study-Act) form used for this project’s QAPI plan.</p> <ul style="list-style-type: none"> <li>• <b>Section 1: Plan</b> The QID pointed out that upon review of all the facilities’ QAPI plans, many facilities did not have a well written problem statement. The problem statement states the relevance/value of what the problem is that you are trying to solve. The problem statement directs your plan.</li> <li>• <b>Section 2: Do</b> This section pertains to implementing a well developed plan. The facility should document any obstacles or problems encountered while implementing their plan. Data trending and monitoring would assist facilities in determining whether they were progressing toward the goal – thus data collection is an integral part of the</li> </ul>	<b>Complete your facility’s QAPI plan and submit it to the Network office by Monday, June 14, 2010. You can fax it to (323) 962-2891.</b>

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	<p>“Do” process.</p> <ul style="list-style-type: none"> <li>• <b>Section 3: Study</b> This section pertains to the final analysis of the data you’ve collected and comparing it to your goal(s) and expectation(s). You note the lessons learned and what the facility did to change or revise the plan upon realizing obstacles or problems they encountered to ensure that they met their goal.</li> <li>• <b>Section 4: Act</b> During this step you determine whether the plan you implemented was successful or not. <ul style="list-style-type: none"> <li>○ <b>Yes:</b> If your plan was successful then implement the plan to sustain improvements.</li> <li>○ <b>No:</b> Refine your plan. Further conduct a root-cause analysis to determine other causes for the problem if necessary. It is possible that sometimes you may have to change to a completely new plan.</li> </ul> </li> </ul> <p><b>Please complete sections 2-4 of your PDSA form and submit it to the Network office by the due date. You may fax your completed plan to (323) 962-2891.</b></p> <p><b>** <u>ALL FACILITIES’ QAPI PLAN ARE DUE TO THE NETWORK OFFICE ON MONDAY, JUNE 14, 2010.</u></b></p>	
<p>Moving Forward – Change Concept 12</p>	<p>Per Fistula First:</p> <ul style="list-style-type: none"> <li>• Early identification , early education, timely referral to nephrology, and coordination with discharge planning will provide patient and family support in making decisions related to renal replacement therapy and vascular access. Hospital stays provide an additional opportunity for early diagnosis of CKD. Early identification<sup>1</sup> of patients with kidney disease can slow the progression of the disease.</li> <li>• Implementation of Change Concept at the facility level <ul style="list-style-type: none"> <li>○ Nephrologist and/or Medical Directors can meet with local hospital(s) to discuss implementing lab result referrals. This would be a notation on lab results for refer to a nephrologist with eGFR 30-44 (CKD Stage 3), eGFR 15-29 (CKD Stage 4) and eGFR &lt; 15 (CKD Stage 5).</li> </ul> </li> </ul>	<p>Engage your nephrologists to communicate with facility affiliated hospitals and Primary Care Physicians in implementing the reporting of eGFR to identify CKD patients early so that care and education can be initiated, especially evaluation and placement of an AVF.</p>

	<ul style="list-style-type: none"> <li>▪ By having hospitals report these results and have an alert notification on the results, patients in early stages of CKD can be identified and proper care can be implemented to slow the progression to ESRD and/or prepare the patient for ESRD – vascular access being one of the priorities of care.</li> <li>▪ Nephrologists can also speak with their PCP (Primary Care Physician) colleagues about obtaining eGFRs on patients they suspect has a risk for CKD and if results reveal that they are in CKD to refer them to a nephrologist.</li> <li>▪ The Fistula First website has tools available for physicians to use to assist them in discussing this Change Concept with hospital administration. These tools include hospital tools ranging from hospital care plan, vein preservation and discharge planning tools.</li> </ul> <ul style="list-style-type: none"> <li>○ Facilities can ensure maturation of these newly created AVFs by implementing Change Concept #9: Monitoring and maintenance to ensure adequate access function             <ul style="list-style-type: none"> <li>▪ Post-surgical follow-up 4-6 weeks post placement (ensure access is maturing properly)</li> <li>▪ Assessment of access with every treatment</li> <li>▪ Patient education on vascular access care</li> <li>▪ Proper cannulation (cannulation by expert cannulators for first cannulation)</li> </ul> </li> </ul>	
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Recorded By: Lisle Mukai, QI Coordinator

Date: 05-27-2010



## Summary of Best Practices

(2009-2010 QI Projects: < 50% AVF and Reduction in Long-Term Catheter Rate)

Change Concept	Facility Best Practice
<p><b>Change Concept #1:</b> <i>Routine CQI review of vascular access</i></p>	<ul style="list-style-type: none"> <li>• Communication between staff, patients, and doctors (daily when issues arise, during QI meetings, periodically to follow up on patient's status post access event, etc.)</li> <li>• VAC/manager conduct rounds periodically to visually see what is going on at the floor               <ul style="list-style-type: none"> <li>○ Staff properly providing vascular access care                   <ul style="list-style-type: none"> <li>▪ following P&amp;P</li> <li>▪ monitoring access properly</li> <li>▪ assessing access correctly</li> <li>▪ cannulating access properly</li> </ul> </li> <li>○ Patients following access care instructions                   <ul style="list-style-type: none"> <li>▪ washing accesses</li> <li>▪ holding sites properly post treatment</li> <li>▪ reporting problems with access</li> </ul> </li> <li>○ Assessing access sites and functionality of accesses</li> </ul> </li> <li>• Discuss vascular access during monthly QI meetings               <ul style="list-style-type: none"> <li>○ Discuss/review internal vascular access trending results</li> <li>○ Share NW reports with staff and during QI meetings – compare facility results to NW average &amp; goal and CMS goal</li> <li>○ Discuss clotting &amp; infection rates</li> <li>○ Discuss access problems/events and solutions</li> <li>○ Review incident patients and conversion patient's vascular access status</li> </ul> </li> <li>• Have a protocol or P&amp;P in place for vascular access care incorporating:               <ul style="list-style-type: none"> <li>○ Education</li> <li>○ Referral for evaluation</li> <li>○ Assessment for conversion (AVG to AVF)</li> <li>○ Access placement</li> <li>○ Assessing for maturity</li> <li>○ Follow up care</li> <li>○ Cannulation</li> <li>○ Monitoring of functionality</li> <li>○ Catheter removal</li> </ul> </li> <li>• Utilize a calendar book for tracking vein mapping, surgical consults, surgeries, follow-ups, etc.</li> </ul>
<p><b>Change Concept #2:</b> <i>Timely referral to nephrologist</i></p>	
<p><b>Change Concept #3:</b></p>	<ul style="list-style-type: none"> <li>• Have nephrologists talk to surgeons and vascular access centers</li> </ul>

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<p><i>Early referral to surgeon for “AVF Only” evaluation and timely placement</i></p>	<ul style="list-style-type: none"> <li>• about AVF placement and vascular access care/interventions</li> <li>• Establish a relationship with the surgeon’s office and/or the surgeon</li> <li>• Schedule appointments during the beginning of the month because that’s when the distribution of welfare and Social Security checks occur</li> <li>• Refer pending Medi-Cal patients to county hospitals for vein mapping and placement</li> </ul>
<p><b>Change Concept #4:</b> <i>Surgeon selection based on best outcomes, willingness, and ability to provide access services</i></p>	<ul style="list-style-type: none"> <li>• Referral to surgeons willing to place AVF access if possible, not surgeons who prefer AVG placement</li> <li>• For facilities located in rural areas, recruit surgeons from other areas to come to your area to provide vascular access care (consultation, evaluation and follow ups). Arrange a regular schedule with a surgeon to come out to your facility or a designated location. (Seek referrals from other surgeons.)</li> <li>• Facility gives the patient the option to select the surgeon they want</li> </ul>
<p><b>Change Concept #5:</b> <i>Full Range of appropriate surgical approaches to AVF evaluation and placement</i></p>	<ul style="list-style-type: none"> <li>• Share surgical videos with surgeons or refer them to the Fistula First website for the video</li> <li>• Use vascular access centers if available or possible for: <ul style="list-style-type: none"> <li>○ vein mapping</li> <li>○ de-clotting</li> <li>○ fistulogram/angiogram</li> </ul> </li> </ul>
<p><b>Change Concept #6:</b> <i>Secondary AVF placement in patients with AV grafts</i></p>	<ul style="list-style-type: none"> <li>• Conduct sleeves up assessment to identify AVF conversion patients</li> <li>• Convert failing AVGs to secondary AVFs</li> </ul>
<p><b>Change Concept #7:</b> <i>AVF placement in patients with catheters where indicated</i></p>	<ul style="list-style-type: none"> <li>• Implement a catheter reduction program <ul style="list-style-type: none"> <li>○ Education</li> <li>○ Mapping</li> <li>○ Surgical evaluation</li> <li>○ AVF placement</li> <li>○ Maturation follow-up</li> <li>○ Cannulation</li> <li>○ Catheter removal</li> </ul> </li> <li>• Patient acknowledgement when an AVF is used as the patient’s primary access (certificate, some type of celebration - balloons, announcement, etc)</li> <li>• Use best cannulators for first cannulation</li> </ul>
<p><b>Change Concept #8:</b> <i>Cannulation training for AV fistulas</i></p>	<ul style="list-style-type: none"> <li>• Utilize the Fistula First Cannulation video as a teaching tool for cannulation</li> <li>• Implement the buttonhole technique as a cannulation option or alternative</li> </ul>
<p><b>Change Concept #9:</b> <i>Monitoring &amp; maintenance to ensure adequate access function</i></p>	<ul style="list-style-type: none"> <li>• Use vascular access centers if available or possible for: <ul style="list-style-type: none"> <li>○ de-clotting</li> <li>○ fistulogram/angiogram</li> <li>○ stenosis monitoring</li> </ul> </li> <li>• At least monthly or more frequently follow up with patients on their vascular access status (appointments, placement and maturation of access)</li> <li>• Conduct stenosis monitoring on a regular basis for early identification of possible access problems</li> <li>• Have nephrologists talk to vascular access centers about vascular access care/interventions</li> </ul>

<p><b>Change Concept #10:</b> <i>Education for care givers and patients</i></p>	<ul style="list-style-type: none"> <li>• Utilization of available educational resources and tools developed by Fistula First</li> <li>• Engage nephrologists and surgeons in Fistula First (vascular access care and placement)</li> <li>• Patient education             <ul style="list-style-type: none"> <li>○ vascular access care                 <ul style="list-style-type: none"> <li>▪ One-on-one with the patient and/or family or both together</li> <li>▪ Posters posted for patients to see in the lobby or unit to initiate conversation regarding AVF access</li> <li>▪ Resources available for patients to take home to reinforce education</li> <li>▪ Discuss issues/problems with patient’s access</li> <li>▪ encourage and engage nephrologists to educate patients and their families</li> <li>▪ Encourage patients to ask questions</li> <li>▪ Ensure that patient and/or families understand what is being said/taught                     <ul style="list-style-type: none"> <li>○ Share stories with patients or have other patients share their stories about vascular access and dialysis</li> <li>○ Educate and re-educate patients periodically on vascular access options – specifically AVF (advantages and disadvantages)</li> <li>○ Peer-to-peer education</li> </ul> </li> </ul> </li> </ul> </li> <li>• Staff education             <ul style="list-style-type: none"> <li>○ In-service to reinforce/re-educate vascular access care:                 <ul style="list-style-type: none"> <li>▪ Assessment &amp; cannulation</li> <li>▪ Facility P&amp;Ps on vascular access care</li> <li>▪ Maturation process</li> </ul> </li> </ul> </li> </ul>
<p><b>Change Concept #11:</b> <i>Outcomes feedback to guide practice</i></p>	<ul style="list-style-type: none"> <li>• Create reports to distribute or post at facility             <ul style="list-style-type: none"> <li>○ Nephrologist report – AVF placement and usage rates as well as infection rates</li> <li>○ Surgeon report – performance and/or functionality rates</li> </ul> </li> </ul>
<p><b>Change Concept #12:</b> <i>Modifying hospital systems to detect CKD and promote AV fistula planning &amp; placement</i></p>	
<p><b>Change Concept #13:</b> <i>Support patient efforts to live the best possible quality of life through self-management</i></p>	<ul style="list-style-type: none"> <li>• Encourage patients to advocate for themselves – ask about AVFs, call insurance companies if insurance approval is an issue, make/go to evaluation and surgical appointments, etc.</li> </ul>