< 55% AV Fistula Project

Conference Call

Wednesday, November 3, 2010
2-3pm

TOPIC	SUMMARY	ACTION
1. Roll Call	Roll call conducted.	Facilities are expected to participate in project conference calls.
2. Best Practice Sharing	The Clinic Manager of our best practice facility shared her facility's processes and activities with the project group. • Shared her facility's current AV fistula rate. • Stated that she has a very good Administrative Assistant (AA). Her AA follows up with the patients and surgeons office frequently and persistently. Her AA ensures that patient's appointments are made and the patients go to their appointments. If they do not go, she finds out why they did not. She follows up with the surgeons to ensure that appointments were scheduled and what the results are of those appointments (i.e. evaluations, date of surgery, etc.). • The Clinic Manager follows up with the AA twice a month to review patient statuses, reasons why patients did not make appointments, results of evaluations, etc. • Upon admission of a patient, the facility: o Educates the patients. ✓ Types of vascular accesses available. ✓ Pros/cons of each type of vascular access. Stresses optimal choice in vascular access – AVF.	Implement best practices learned as they apply to your facility.

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	✓ Stress infection problems with catheters. ✓ States mortality rates with catheters. ✓ Handouts included in their new patient packets. ✓ Show them other patients who have AV fistulas. o Requests nephrologist to order an evaluation. o AA staff sets up appointment for evaluation immediately before the patient can get comfortable with the catheter or infection develops. o AA follows up with patient and surgeons on status of evaluation and placement. o AVF usually placed within 30 days. • The best practice facility shared that they are working with their AV graft patients on converting to a secondary AV fistula when the patient's graft clots. The need to follow up with these patients more. They need to work on educating their staff. This will be their next project. • They shared that they are currently educating their nephrologists about getting their patients evaluated for AVF immediately prior to being admitted to the facility. This is an issue that is hard for them to overcome, but they are continuously working at it. • The facility will soon have HERO access patients at their facility. She explained what a HERO access was and stated that this is last resort access for catheter patients. The HERO is considered a graft. • In regards to education, the facility teaches the patients about all access types and about vascular access care for each type of access. They explain which access is most desirable and the reasons why it is. All staff (RNs, PCTs, and MDs) take an active role in educating the patients about vascular access. All patients are encouraged to ask questions.	
3. Open discussion:	The project facilities need to start improving their AVF usage. Meeting the minimum standard is a start but project facilities must continue improving. Achieving higher AVF usage is getting more difficult and project facilities need to start finding new and creative ways to improve. These conference calls will allow project facilities to share and discuss their issues and concerns they are experiencing with one another and brainstorm ideas for possible solutions. These calls will also allow for best practice sharing with each other so we can all improve. Overall, the purpose of improving vascular access outcomes is to improve the patient's quality of life. Network suggested that facilities' take what they may learn from this call and incorporate it in their QAPI plans as applicable. Facilities were reminded that Step 1 of their QAPI plan is due on Friday, November 5, 2010.	Implement best practices learned as they apply to your facility.

	Facility 1:
	• The facility works with 3 surgeons. The facility will be meeting with the nephrologists and surgeons regarding vascular access placement.
	• Group suggestions/discussion:
	  o Stop using surgeons that are not engaged in placing AV fistulas.
	  o Encourage patients to be proactive in their vascular access care – tell patients to ask their surgeons for AVF evaluation and placement.
	
	Facility 2:
	• Utilizes their corporate "Impact" program.
	• Review patient vascular status: Facility will review patients one-by-one to determine specific problems with the patient's vascular access or why the patient doesn't have a vascular access.
	• Group suggestion/discussion:
	  o Review each patient's primary access by going to the chair side one-by-one and noting their access. Some facilities don't realize that they haven't updated a patient's access on their log and the change was never reflected.
	
	Facility 3:
	• The facility developed a portfolio for each patient with their vascular access information. This portfolio is accessible to all staff members.
	• The Access Manager oversees the vascular access care of all patients and maintains the portfolios.
	• Facility utilizes the OC Vascular Access Center.
	• The facility developed and utilizes an algorithm for reducing catheters.
	• Group suggestion/discussion:
	  o Algorithms are very useful and have proven to work. They are a step-by-step way of approaching vascular access care. A facility should develop one from the point of a patient's admission to evaluation, placement, and usage of the AV fistula.
	
	Facility 4:
	• Facility has difficulty with insurance issues, scheduling problems, and finding a good surgeon.
	• Facility is successful in getting their nephrologists to order evaluations.	

- Facility needs to do a better job of following up with patients and surgeons.
- Group suggestion/discussion:
  - Harbor UCLA (county hospital) has a "Non-Urgent Request For Outpatient Referral Services" form for facilities to submit a request for an AVF evaluation and placement. This form has been utilized for by other facilities for their Medi-Cal patients. Harbor UCLA will only consider patients within their service area. It was suggested that all facilities check with their local county hospital and find out if this service is available in their area.
  - A facility shared that they do not think that county USC has a form, but they will call and find out.

Facility 5:

- Facility has a new Clinic Manager that has started a good patient tracking system.
- Their facility has a good staff that educates their patients.
- The facility's nephrologists are all on board with promoting AVF.
- The facility has developed a relationship with their MD's office.
- The facility is working on involving their Discharge Planner to schedule evaluations prior to discharge of the patient.

Facility 6:

- Facility is starting to email and/or text surgeons about their patients. This allows for a quicker response time rather than leaving messages and playing "phone tag" with the surgeon. The facility did advise to get the surgeon's approval to communicate in this manner first.

Facility 7:

- Facility shared that they have an elderly patient with many co-morbidities.
- Suggestion/discussion:
  - Ensure that the patient has been evaluated for an AV fistula and that documentation is in the patient's chart.
  - Not all patients are candidates for AV fistula placement – must have documentation in the chart why they are not a candidate.
  - Network briefly reviewed the DHS/Network communication process. Per the Network, DHS will usually call the Network for clinical data for a facility they will

survey. So the surveyor already has an idea on what area they will focus on prior to going out to the facility. If the facility has a high catheter rate, the surveyor will review that data at the facility and look in patient's charts to see why the patient has a catheter. It was stressed to ensure documentation is in the patient's chart.

Network commented that education is the key in getting patients to agree on getting AV fistula evaluations and placement. Understanding all aspects of vascular access care (types of accesses available – pros/cons, how to care for each type of access, mortality rates and quality of life) will allow the patient to make a very informed decision and become engaged in their care. Education is also the key in getting nephrologists and surgeons engaged in promoting AV fistula access. The Network suggested that facilities utilize their Social Workers in teaching the staff on how to teach patients so that everyone can be involved in educating the patients.

4. Group Progress:

Network 18 Vascular Access Rates - August 2010:

Type of Access	Rate	Goal
AV Fistula	60.1%	CMS = 66% NW 18 = 60.3% (by March 31, 2011)
Long Term Catheter (LTC)	6.9%	< 10%
AV Graft	17.9%	< 24%

< 55% AV Fistula Project Facilities AVF rate:

Month	Rate	Comment
June 2010	50.3%	Baseline for the project group.
July 2010	50.3%	No improvement made.
August 2010	50.0%	Decreased by 0.3 percentage points.

As of August 2010:

Access Type	% of Facilities	# of Facilities	Comments
AVF > 55%	70.1%	199	Out of 288 Fistula First facilities

Compare your facility's vascular access outcomes to that of the Network and the other project facilities. Implement plans to improve your facility's AVF usage.

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<tr><td>AVF < 55%</td><td>29.9%</td><td>85</td><td>Including < 55% AV Fistula project facilities</td></tr>
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<td>Next Call:</td>
<td>Wednesday, January 5, 2011 @ 2-3pm</td>
<td>Participate in bi-monthly conference calls.</td>
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Recorded By: *Lisle Mukai, QI Coordinator*________________ Date: *November 09, 2010*__