

Fistula First Mentoring Project

- Please place this call on MUTE– not hold.
 - Some facilities' hold button have music playing and it will disrupt the conference.
- If you do not have a mute button, * 6 should allow you to mute your phone.
- To un-mute your phones during discussion or question sessions, * 6 will un-mute your line.

FOR THE COURTESY OF EVERYONE ON THIS CALL, PLEASE MUTE YOUR PHONES UNTIL REQUESTED TO UN-MUTE THEM. - *Thank you.*

The WebEx will start in a few minutes. Thank you for your patience.



*Southern California Renal Disease Council, Inc.
ESRD Network 18*

Fistula First Mentoring Project

**Shean Strong, QI Manager
Lisle Mukai, QI Coordinator**



Quality Assessment and Performance Improvement (QAPI) Project

WebEx Conference

Los Angeles, CA

September 29, 2011

Before we begin.....

- Place this call on MUTE– **not hold.**
- If you do not have a mute button, * 6 should allow you to mute your phone.
- Hold all your questions until the end of the presentation.
- Complete the evaluation at the end of this presentation.
- This presentation will be recorded and posted to the Network website.



Objectives of WebEx

- Present Network Fistula First data/information.
- Present the project to project facilities and mentoring facilities.
- Present goals and objectives for the project.
- Provide guidelines for the project.
- Present basic quality improvement processes.
- Share best practices learned from previous vascular access QAPI projects.

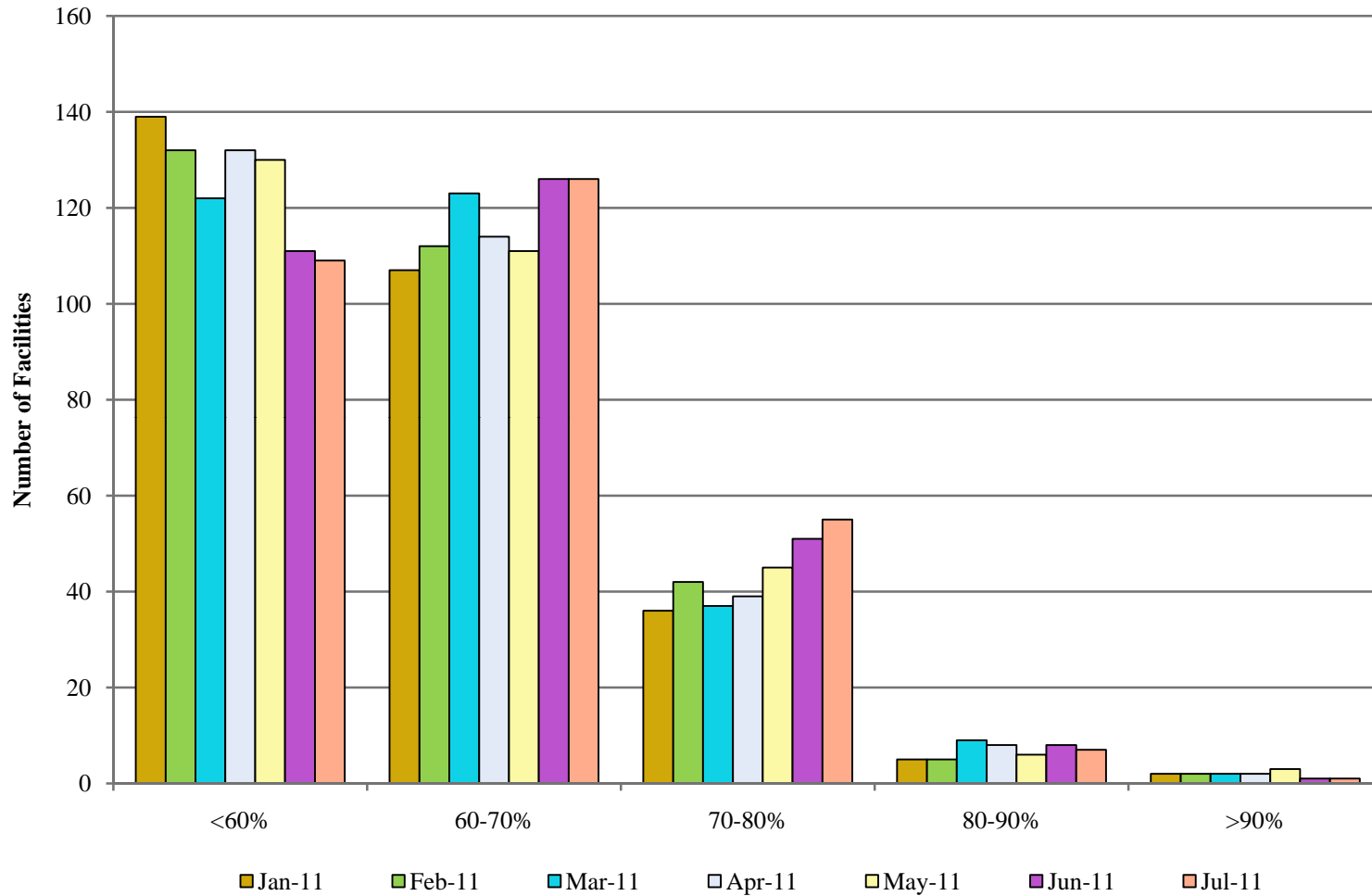


Network 18 AV Fistula Data

- Network 18 goal = 62.3% by March 2012
- Network 18 stretch goal = 63.0% by March 2012
- Network 18 & the Medical Review Board (MRB) will monitor all facilities with AVF rates < 60%.



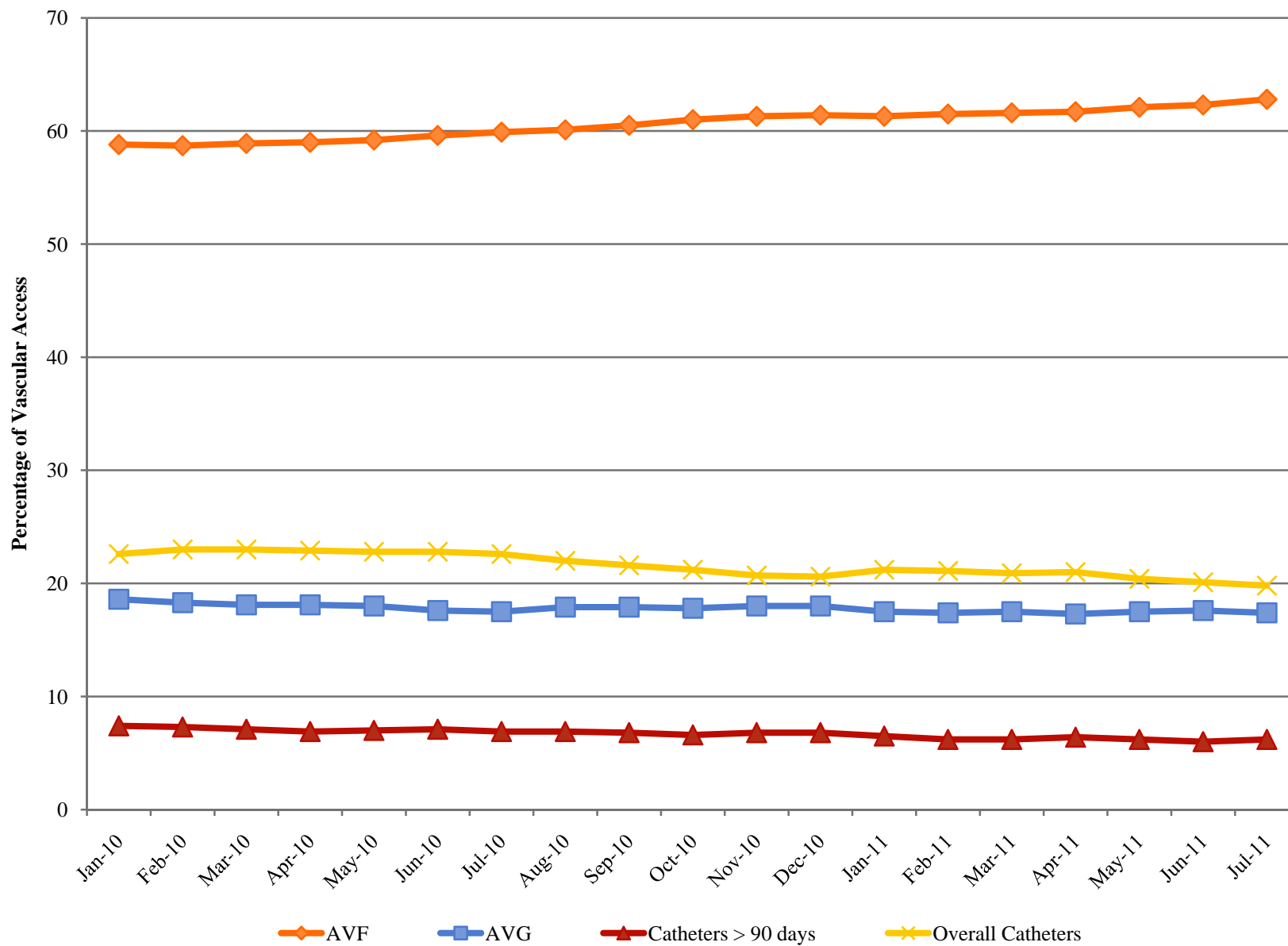
Network 18 AVF Percentile Breakdown



63.4% of facilities with AVF rate > 60%
36.3% of facilities with AVF rate < 60%



Network 18 Vascular Access Trend



Proposed Payment Year 2014 ESRD QIP: Vascular Access Type

- The vascular access type would consist of 2 subcomponent measures, which would receive a separate performance rate:
 - % of hemodialysis patients using AVF during last treatment of the month.
 - % of hemodialysis patients with intravenous catheter for 90 days prior to last dialysis session.
- Scores would be averaged to derive the vascular access rate.
- CMS website - CMS ESRD QIP information:
 - http://www.cms.gov/esrdqualityimproveinit/01_overview.asp?



Fistula First Mentoring Project



Background and Description of the Project

- Developed to assist facilities that have AVF rates < 50%.
- Ease of communication between facilities regarding issues dealt with at the facility level.
- Facility to facility communication may be much easier and less stressful allowing for collaboration between facilities.
- Mentoring facilities can be an alternative source of resource.
 - Knowledge & experienced gained to achieve high AVF outcomes.



Inclusion Criteria

- Project facilities inclusion criteria:
 - Facility AVF rate $\leq 50\%$ and have not made or maintained at least a 1.0 percentage point improvement within the last year (May 2010 – May 2011 data).
 - Patient census ≥ 50 patients.
 - Facility opened ≥ 6 months.

- Mentoring facilities selection criteria:
 - AVF rate $\geq 63\%$ based on May 2011 data.
 - Facility was within the area/county of a project facility.

- 10 project facilities and 10 mentoring facilities were selected for the project.



Expectation of the Project

- Project facilities improve AVF outcomes by achieving at a minimum their established facility-specific AVF goal by developing a QAPI plan that will allow for continued improvements.
- Mentoring facilities assist and guide project facilities with their vascular access process and/or program through sharing of knowledge (best practices), experience and association with other renal resources (surgeons, radiologists, vascular access centers, etc).
- Achievement of the project facilities' aggregate AVF goal of 50.9%.



Project Facilities' Responsibilities

- Conduct a root cause analysis (RCA) with their Interdisciplinary Team.
- Develop a Quality Assessment and Performance Improvement (QAPI) plan with their Interdisciplinary Team.
- Implement their QAPI plan and revise it as necessary.
- Utilize the tools and resources provided as appropriate.



Project Facilities' Responsibilities *(continued)*

- Maintain communication with assigned mentor facility.
- Participate in project conference calls, WebEx's and activities.
 - Conference calls will be held every-other-month.
- Submit all requested documents in a timely manner.



Mentor Facilities' Responsibilities

- Provide assistance and guidance to the project facility to help them improve their AVF rate.

- Be a resource for your project facility.
 - Sharing of experiences and lessons learned on how to develop a successful vascular access program.
 - Availability to discuss issues/concerns and brainstorm possible solutions.
 - Introducing and/or referring project facilities to good surgeons, radiologists, vascular access centers, etc.
 - Teaching and/or sharing tips on how to educate patients, staff, and other medical personnel (surgeons, PCPs, radiologists).
 - Teaching and/or sharing tips on communication skills.



Mentor Facilities' Responsibilities (continued)

- Share best practices.
 - Interventions, activities and/or strategies.
 - Processes and/or Policies & Procedures.
 - Useful tools and resources (including educational resources for patients, staff and other medical personnel – surgeons, PCPs, radiologists).
 - Dealing with difficult issues (patient refusal, patient compliance with appointments, insurance issues, lack of surgeons, etc).
- Maintain communications with project facility.
- Participate in conference calls and WebEx's.
 - Held every-other-month



Network Responsibilities

- Facilitate the project.

- Provide available tools and resources.
 - Project toolkit
 - Network 18 website: www.esrdnetwork18.org

- Facilitate WebEx's and conference calls.



Network Responsibilities *(continued)*

- Monitor project facilities' progress.
- Distribute feedback reports to project facilities.
- Provide technical assistance as necessary or requested.



Project Goal

- Facility-specific Goal:
 - Each facility will be given a facility-specific goal for the project to achieve.
 - Goal will be determined using CMS's 20% quality deficit reduction formula based on 66%.
 - The goal was noted on the facility's PDSA (Plan-Do-Study-Act) form which was included in the project facilities' Project Toolkit.

- Aggregate Project Facility Goal:
 - To increase the aggregate AVF rate by 3.7 percentage points from 47.2% to 50.9% by March 2012.



Guidelines for the Project

- Project facilities and mentoring facilities must participate in all project conference calls, WebEx's and activities.
- The project facility should have a vascular access team (if they do not already have one).
- The project facility and mentoring facility must establish a regular line of communication.



Guidelines for the Project (continued)

- The project facility with the assistance and guidance of the mentoring facility should:
 - Conduct a root-cause analysis (RCA), to determine cause of poor AVF rate, stagnant AVF rate, or declining AVF rate.
 - Develop a QAPI plan to address the issues identified from the project facility's RCA.



Guidelines for the Project

(continued)

- The mentoring facility shares their best practices with the project facility.
 - Sharing interventions, processes, and activities that have been successful.
 - Sharing tools and resources (including education resources for patients and staff) that are useful for the vascular access team.



Guidelines for the Project *(continued)*

Sharing of best practice (continued)

- Sharing insights on good surgeons, use of vascular access centers, use of interventional radiologists, stenosis monitoring methods, how to communicate with surgeons and/or other care partners, etc.
- Availability to brainstorm solutions to issues/problems the project facility is experiencing. Or provide ideas and strategies to assist the project facility improve outcomes.



Guidelines for the Project

(continued)

- Sharing teaching techniques regarding patients, staff, or other medical personnel (i.e. surgeons, other physicians and interventional radiologists, etc).

- Project facilities must be diligent in:
 - Implementing their plan and revising it as necessary
 - Establishing communication and developing a relationship with their assigned mentoring facility
 - Developing and establishing relationships with other care partners (surgeons, vascular access centers, other dialysis facilities, hospitals, etc.).



Quality Improvement Process



Quality Improvement Process

Quality improvement is a continuous cycle of planning, implementing strategies, evaluating the effectiveness of these strategies and reflection to see what further improvements can be made.

*Royal Children's Hospital Melbourne –
Clinical Quality & Safety*



Root Cause Analysis (RCA)

Root Cause Analysis:

- Root cause analysis can use a variety of techniques to uncover root causes, including cause mapping, change analysis, the [Ishikawa fishbone diagram](#), [5 Whys](#), and others.
- All are designed to analyze the elements affecting a particular outcome to determine the root causes.



Root Cause Analysis (RCA) *(continued)*

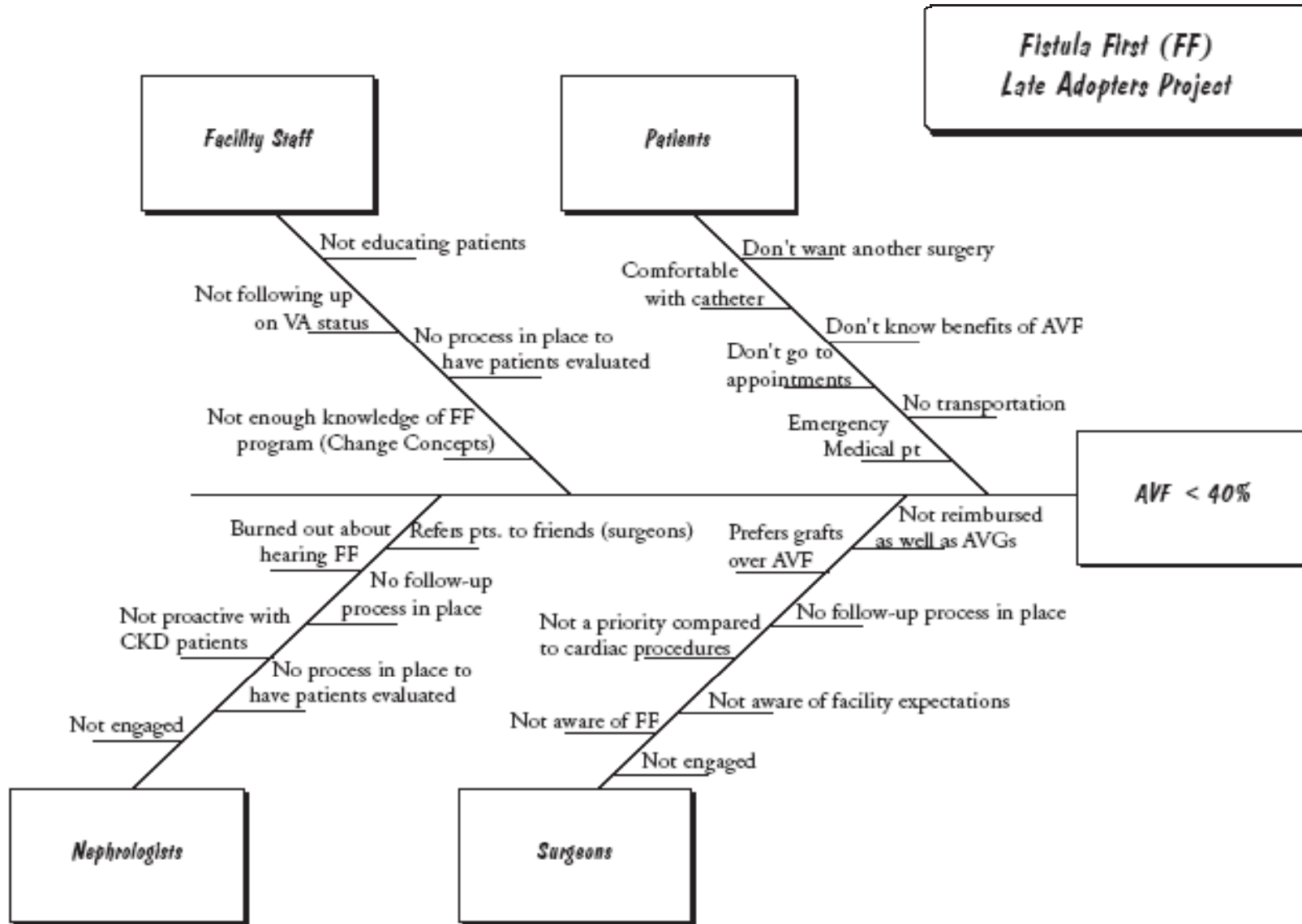
Fishbone Diagram

(aka: Cause and Effect Diagram)

- Will help to visually display the many potential causes for a specific problem or effect.
- Can be used by individuals or teams - most effective by a group.
- The team assists by making suggestions of possible causes until no more causes can be suggested.
- Once the entire fishbone is complete, a team discussion takes place to decide what are the most likely root cause(s) of the problem.

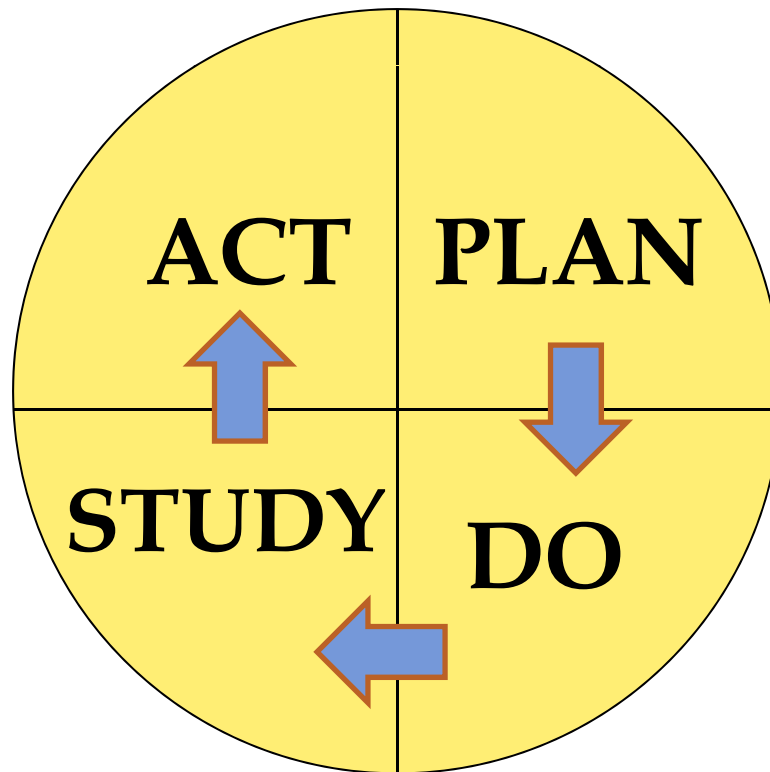


Fishbone Diagram



Plan-Do-Study-Act (PDSA):

PDSA is the format the Network uses for developing a QAPI plan.



Plan-Do-Study-Act (PDSA) (continued)

- PDSA approaches promote action by getting clinicians to reflect and brainstorm strategies that they hope will lead to improvement.
- It also promotes evaluation of these changes once the strategies have been implemented.



Plan-Do-Study-Act (PDSA) *(continued)*

PDSA is a cycle of improvement that involves asking three key questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?



Quality Assessment and Performance Improvement (QAPI) Plan

Cycle (Dates of the project):

<p>Adopted from IHI Website, June 2007</p>	<p>Project:</p> <p>TEAM: Facility Name & Provider # (List all members)</p> <p>BACKGROUND: (Summary of facility’s identified problem and description of what the facility has been doing to improve the problem in the past – root cause analysis (RCA) will assist with finding out where the problem(s) are.)</p>
<p>Step 1. PLAN: Plan/develop the test.</p>	<p>Problem Statement: (Statement outlining the root cause)</p> <p>AIM Statement: (Statement designed to guide you to your goal.)</p> <p>What is the goal? (Include a numeric goal to achieve.)</p> <p>Develop a plan to achieve the goal? (List steps of the plan – this will allow you to identify the step that may need modifying/revising if necessary.) Add more paper if necessary.</p> <p>What data sources are needed for the test? (What data sources will you be using to monitor your progress?)</p> <p>What measures are used to analyze if you are achieving the goal? Baseline: _____</p> <p>Measure: (Numerical formula – i.e. numerator/denominator = %)</p> <p>Monitoring frequency:</p>

<p>Step 2. <u>DO:</u> Try out the test on a</p>	<p>Implement the plan. <u>Document problems and unexpected observations.</u></p>
<p>Step 3. <u>STUDY:</u></p>	<p>Analyze the results and compare the results with your goal.</p>
<p>Step 4. <u>ACT:</u> Determine if the test was successful or the plan needs to be revised.</p>	<p>If the test was successful, how will you implement the plan on a wider scale?</p> <p>If it was not successful, what needs to be changed based on what you have learned? Should you continue to search for other root causes?</p>

Plan-Do-Study-Act (PDSA) *(continued)*

Plan:

- Develop a Problem Statement
- Develop an AIM Statement
- Set goals to achieve (numerical goals and a target date)



Plan-Do-Study-Act (PDSA) *(continued)*

Plan (continued):

- Develop your plan on how you will improve your identified problem.
- List data sources you will use to monitor your progress for the project.
- Plan on how you will collect your data.



Plan-Do-Study-Act (PDSA) *(continued)*

Plan (continued):

Write out the measure you will be using to analyze if you are achieving your goal. (numerical formula)

EXAMPLE:

of patients using AVF as primary access = AVF rate (%)
Total # of patients at the facility



Plan-Do-Study-Act (PDSA) (continued)

Plan (continued):

- Note your baseline for comparison towards your goal
- Note the frequency in which you will conduct measurement of your progress



Plan-Do-Study-Act (PDSA) (continued)

Do:

- Implement your plan.
- Document problems and unexpected observations of your plan.

Study:

- Analyze the results and compare it to the goal.
- This analysis should be conducted with the interdisciplinary team.
- Revise plan if necessary to achieve goal.



Plan-Do-Study-Act (PDSA) *(continued)*

Act:

- Is your plan successful?
- How will you ensure continued improvement?
- If it wasn't successful, what needs to be changed based on what you have learned?
- Should you continue to search for other root causes?



Plan-Do-Study-Act (PDSA) *(continued)*

Act (continued):

- You can go back to any step and revise as necessary.
- Note your progress on your form so that you have a record of the strategies/activities you've attempted and results of those attempts as well as the revisions you have made to improve your plan.



Plan-Do-Study-Act (PDSA) (continued)

- The PDSA cycle is a continuous cycle. It allows you to frequently assess your plan and make revisions as necessary to achieve your goal.
- Your plan should be reviewed at least monthly and/or when you realize that your strategy or activity is not working.



Tools and Resources

The following tools and resources are included in your project facility toolkit and available on the Network's website at www.esrdnetwork18.org.



VASCULAR ACCESS ROOT CAUSE ANALYSIS TOOL

If your facility has decreased in the percentage of AVFs or has not improved – please consider the questions below. **This is a tool designed to assist your facility in conducting a root cause analysis by determining possible reasons for declining AVF rates or non-improvement in AVF rates.**

AREAS/ELEMENTS TO CONSIDER:	YES	NO	IF "NO" - REASON(S)	RATIONALE
MANAGEMENT				
Does your facility have stable management?				Stable management is a necessity to ensure that all functions of the facility run smoothly. (Conditions for Coverage [CfC]: 494.180)
Does your facility have a Vascular Access Coordinator /Vascular Access Manager?				Management changes can potentially affect a facility's performance if processes, procedures, and protocols are not implemented during this transitional time period.
If your facility has recently experienced a management change, was the facility's vascular access program and its importance communicated to the new manager?				During management changes some things may be overlooked, not made a priority or not communicated. Ensure that the incoming manager is aware of the facility's responsibility to adhering to the Network's goals and activities for AVF usage and other clinical indicators.
Does your facility's vascular access program have written protocols, policies & procedures or a work process that is implemented by the staff, acting manager, etc.?				Having written processes, protocols, or policies & procedures would be beneficial during the times of management conversion. This would allow any staff member or acting manager, acting VAC, etc to continue implementing your vascular access program. This would ensure that your facility continues maintain and/or improve your vascular access outcomes.
Does your facility have sufficient staffing to allow managers or designated staff (i.e. Vascular Access Managers, QI Coordinators, etc.) to perform their duties?				CfC 494.180 require the governing body to provide resources (time, staff or funding) for QAPI audits, staff education, refurbishing, etc. as needed to support correction of identified problems.
Is there more than one individual who can access vascular access documents such as monthly access reports, event logs, referral/status logs, etc. at the facility?				Vascular access data stored in a computer should be accessible to more than one individual. This prevents inaccessibility to information relevant to the vascular access program because of management change. This is particularly important for Independent facilities who submit vascular access monthly reports to the Network.

Summary of Best Practices

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

Change Concept	Facility Best Practice
<p>Change Concept #1: <i>Routine CQI review of vascular access</i></p>	<ul style="list-style-type: none"> • 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.) • VAC/manager conduct rounds periodically to visually see what is going on at the floor <ul style="list-style-type: none"> ○ Staff properly providing vascular access care <ul style="list-style-type: none"> ▪ following P&P ▪ monitoring access properly ▪ assessing access correctly ▪ cannulating access properly ○ Patients following access care instructions <ul style="list-style-type: none"> ▪ washing accesses ▪ holding sites properly post treatment ▪ reporting problems with access ○ Assessing access sites and functionality of accesses • Discuss vascular access during monthly QI meetings <ul style="list-style-type: none"> ○ Discuss/review internal vascular access trending results ○ Share NW reports with staff and during QI meetings – compare facility results to NW average & goal and CMS goal ○ Discuss clotting & infection rates ○ Discuss access problems/events and solutions ○ Review incident patients and conversion patient's vascular access status • Have a protocol or P&P in place for vascular access care incorporating: <ul style="list-style-type: none"> ○ Education ○ Referral for evaluation ○ Assessment for conversion (AVG to AVF) ○ Access placement ○ Assessing for maturity ○ Follow up care ○ Cannulation ○ Monitoring of functionality ○ Catheter removal • Utilize a calendar book for tracking vein mapping, surgical consults, surgeries, follow-ups, etc.
<p>Change Concept #2: <i>Timely referral to nephrologist</i></p>	
<p>Change Concept #3: <i>Early referral to surgeon for "AVF Only" evaluation and timely placement</i></p>	<ul style="list-style-type: none"> • Have nephrologists talk to surgeons and vascular access centers about AVF placement and vascular access care/interventions • Establish a relationship with the surgeon's office and/or the surgeon • Schedule appointments during the beginning of the month because that's when the distribution of welfare and Social Security checks occur • Refer pending Medi-Cal patients to county hospitals for vein mapping and placement
<p>Change Concept #4: <i>Surgeon selection based on best outcomes, willingness, and ability to provide access services</i></p>	<ul style="list-style-type: none"> • Referral to surgeons willing to place AVF access if possible, not surgeons who prefer AVG placement • 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.) • Facility gives the patient the option to select the surgeon they want

Project Tools & Resources

Tools/Documents:

- Guidelines for Network 18's Fistula First Mentoring Project.
- Vascular Access Root Cause Analysis Tool.
- Fishbone diagram instructions (Root cause analysis tool).
- Fishbone diagram template (Root Cause Analysis tool).



Project Tools & Resources *(continued)*

Tools/Documents (continued):

- Quality Assessment and Performance Improvement (QAPI) Plan (PDSA format).
- WebEx Conference Call Information.
- Summary of Best Practices.
- List of Resources for the project.



Project Tools & Resources *(continued)*

Tools/Documents (continued):

- WebEx Power Point Presentation.
- WebEx Conference Call recording.
- Conference call minutes .



Project Tools & Resources

(continued)

Resources:

○ Professional Resources:

- Secondary A-V Fistulae in Patients with A-V Grafts.
- Video Link: Patient Assessment Video – Secondary AVF Fistula Conversion.
- FFBI (Fistula First Breakthrough Initiative) draft letter to Primary Care Physician from the Nephrologist.
- FFBI sample letter to the surgeon.



Project Tools & Resources (continued)

Resources:

○ Professional Resources:

- Vascular Access Surgery Change in Physician Reimbursement 2009.
- Fistula First Payer Packet.
- Fistula First: Your Access to Success video order form.



Project Tools & Resources *(continued)*

○ **Patient Resources:**

- FFBI Patient Education Resource List.
- Understanding Your Hemodialysis Access Options.
- Navigating the Vascular “Seas” – Self-Exam of Access Simplified.
- FAQ for Patients & Families .



Project Summary

○ Objective:

- Assist facilities with AVF rates < 50% improve outcomes with the assistance and guidance of mentoring facilities through sharing of knowledge & experience.

○ Goal:

- Achievement of facility-specific AVF goal by March 2012 =
Noted on PDSA form.
- Achievement of group aggregate AVF goal – 50.9% by March 2012.



Project Summary

○ Timelines:

- Project cycle: September 2011 – April 2012.
- RCA & PDSA (Step 1) due: **Friday, October 24, 2011.**
- Conference calls will be scheduled on the 1st Wednesdays of every-other-month unless otherwise notified.
 - **Wednesday, November 2, 2011 @ 2-3pm will be our first call.**
 - Reminder notices and agendas will be faxed prior to the call.
- Evaluation of project tools & resources: December 2011
 - The Network will distribute evaluation forms via fax.



Project Summary *(continued)*

Timelines (continued):

- Achievement of facility-specific goal and project facilities' aggregate goal by March 31, 2012.
- Final PDSA (Step 2 – 4) due: April 2012
 - The Network will inform you when this is due.



Network Communication

- To communicate more efficiently with project and mentor facilities about this project and to be more eco-friendly, we are creating a listserv of all the facilities in this project.

- In the past, we have had e-mail delivery problems because of the facility's firewalls, **please ensure you are able to receive e-mails from me about the project.**
 - Add the Network email address to your contacts.
 - Consult with your IT Department to assist you.
 - Please check your “junk mail” /”spam” mail for they may have been sent there.



*Southern California Renal Disease Council, Inc.
ESRD Network 18*

*Shean Strong, MBA
Quality Improvement Manager
sstrong@nw18.esrd.net*

*Lisle Mukai, RN
Quality Improvement Coordinator
lmukai@nw18.esrd.net*



**6255 Sunset Boulevard, Suite 2211 • Los Angeles • California • 90028
(323) 962-2020 • (323) 962-2891/Fax • www.esrdnetwork18.org**