



Summary of Best Practices

(2009-2011 QI Projects: < 50% AVF, Reduction in Long-Term Catheter Rate and < 55% AV Fistula)

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 ○ Review and discuss stenosis monitoring data/trending. • Review patient's vascular access with the patient's specific Nephrologist. • Have a protocol or P&P in place for vascular access care incorporating but not limited to the elements below: <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/day planner for tracking vein mapping, surgical consults, surgeries, follow-ups, etc.

Mission Statement

To provide leadership and assistance to renal dialysis and transplant facilities in a manner that supports continuous improvement in patient care, outcomes, safety and satisfaction.

	<ul style="list-style-type: none"> • Utilization of tracking tools designed for patient level and facility level data. • Conduct weekly/monthly meetings to review/discuss all patients with CVC. • Social Worker assist with insurance issues so that problems are resolved in a timely manner. • All staff are involved and take an active role in following up with patients.
<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. • Patients with CVCs are referred for vessel mapping prior to surgical consult to ensure that the patient is a candidate for an AVF. • A “Request for Vessel Mapping” document (created by the facility) is included in the facility’s pre-admission checklist. • The inclusion of CPT codes and ICD-9 codes when requesting for authorization for referral and surgery from HMOs expedited the approval process. • Communication with the nephrologist regarding new patients that will be discharged from the hospital. Requesting nephrologist to contact the vascular surgeon for and AVF evaluation/surgical date prior to the patient’s discharge. • Communicate with the surgeon via email enables a quicker response time. (Should obtain permission from the surgeon to communicate in this method.) • Implementation of corporate AVF program and policies and procedures.
<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.
<p>Change Concept #5: <i>Full Range of appropriate surgical approaches to AVF evaluation and placement</i></p>	<ul style="list-style-type: none"> • Share surgical videos with surgeons or refer them to the Fistula First website for the video • Use vascular access centers if available or possible for: <ul style="list-style-type: none"> ○ vein mapping ○ de-clotting ○ fistulogram/angiogram
<p>Change Concept #6: <i>Secondary AVF placement in patients with</i></p>	<ul style="list-style-type: none"> • Conduct sleeves up assessment to identify AVF conversion patients

<p><i>AV grafts</i></p>	<ul style="list-style-type: none"> • Convert failing AVGs to secondary AVFs • Patients are given reminder letters/memos and reminder phone calls about their appointments to ensure they do not forget to go to their appointments with the surgeon.
<p>Change Concept #7: <i>AVF placement in patients with catheters where indicated</i></p>	<ul style="list-style-type: none"> • Implement a catheter reduction program. <ul style="list-style-type: none"> ○ Education ○ Mapping ○ Surgical evaluation ○ AVF placement ○ Maturation follow-up ○ Cannulation ○ Catheter removal • Patient acknowledgement when an AVF is used as the patient’s primary access (certificate, some type of celebration - balloons, announcement, etc). • Use best cannulators for first cannulation. • Patients are given reminder letters/memos and reminder phone calls about their appointments to ensure they do not forget to go to their appointments with the surgeon.
<p>Change Concept #8: <i>Cannulation training for AV fistulas</i></p>	<ul style="list-style-type: none"> • Utilize the Fistula First Cannulation video as a teaching tool for cannulation. • Implement the buttonhole technique as a cannulation option or alternative.
<p>Change Concept #9: <i>Monitoring & maintenance to ensure adequate access function</i></p>	<ul style="list-style-type: none"> • Use vascular access centers if available or possible for: <ul style="list-style-type: none"> ○ de-clotting ○ fistulogram/angiogram ○ stenosis monitoring • At least monthly or more frequently follow up with patients on their vascular access status (appointments, placement and maturation of access). • Conduct stenosis monitoring on a regular basis for early identification of possible access problems. • Have nephrologists talk to vascular access centers about vascular access care/interventions. • Review and discuss stenosis monitoring data/trending for each patient as necessary or quarterly. • Newly placed AVFs should be monitored/assessed to ensure maturation – look, listen and feel. • Newly placed AVFs are referred back to the surgeon for maturation evaluation prior to cannulation. • Nephrologists assess newly placed AVFs during rounds to ensure the access is maturing.
<p>Change Concept #10: <i>Education for care givers and patients</i></p>	<ul style="list-style-type: none"> • Utilization of available educational resources and tools developed by Fistula First • Engage nephrologists and surgeons in Fistula First (vascular access care and placement) • Patient education <ul style="list-style-type: none"> ○ vascular access care <ul style="list-style-type: none"> ▪ One-on-one with the patient and/or family or both together ▪ Posters posted for patients to see in the lobby or unit to initiate conversation regarding AVF access ▪ Resources available for patients to take home to

	<p>reinforce education</p> <ul style="list-style-type: none"> ▪ Discuss issues/problems with patient’s access ▪ encourage and engage nephrologists to educate patients and their families ▪ Encourage patients to ask questions ▪ Ensure that patient and/or families understand what is being said/taught <ul style="list-style-type: none"> ○ Share stories with patients or have other patients share their stories about vascular access and dialysis ○ Educate and re-educate patients periodically on vascular access options – specifically AVF (advantages and disadvantages) ○ Peer-to-peer education <ul style="list-style-type: none"> • Staff education <ul style="list-style-type: none"> ○ In-service to reinforce/re-educate vascular access care: <ul style="list-style-type: none"> ▪ Assessment & cannulation ▪ Facility P&Ps on vascular access care ▪ Maturation process • Social Workers play a key role in providing education, psychosocial and emotional support for patients. • All staff are involved and take an active role in educating patients. • Patients and families are involved in the AVF process.
<p>Change Concept #11: <i>Outcomes feedback to guide practice</i></p>	<ul style="list-style-type: none"> • Create reports to distribute or post at facility <ul style="list-style-type: none"> ○ Nephrologist report – AVF placement and usage rates as well as infection rates ○ Surgeon report – performance and/or functionality rates
<p>Change Concept #12: <i>Modifying hospital systems to detect CKD and promote AV fistula planning & placement</i></p>	<p>Utilization of hospital liaison. (This person was created by the dialysis corporation – it can also be implemented by a facility.) The hospital liaison ensures that patients are educated and informed about their disease process, treatment options and outpatient dialysis placement. They assist with initiating the fistula process.</p>
<p>Change Concept #13: <i>Support patient efforts to live the best possible quality of life through self-management</i></p>	<ul style="list-style-type: none"> • 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.