Meeting the Network's 60% Goal for AVF in Place Among Incident Patients

Best Demonstrated Practices

Northwest Renal Network
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Twenty percent of Network dialysis facilities meet the Network and CMS goal of having 60% of incident patients begin chronic dialysis with an AV Fistula in place. These facilities were recently surveyed, in order to find out what they were doing right, so the information could be shared, and other facilities could use it to improve their score on this Critical Performance Measure. While it's easy to assume that a dialysis facility would have no responsibility for actions that occur before a patient enters the facility, these facilities prove that when a facility *chooses to take* this responsibility, the results can be positive for both the facility and the patient. There will always be patients that show up unannounced. But that can become the exception, rather than the norm.

Corporate Programs and Protocols

Among the 20% of facilities that met the 60% goal, one out of six were independent or were operated by regional groups with only a few facilities, proving that any facility can meet this goal. But for the other five out of six facilities, their greatest tool was their own corporate programs, protocols, and classes. So the first *Best Practice* is to

> *Familiarize yourself and your staff with* ***your corporate programs and protocols*** *for locating CKD patients before they begin dialysis ("Early Referral"), for planning vascular access among pre-dialysis patients with eGFR below 44, and for placing permanent accesses, preferably fistulas, as early as possible ("Early Placement").*

Even among the 20% of facilities that met the goal, one out of five facilities owned by large organizations did not take advantage of their corporate programs and protocols. And among all Network facilities owned by large organizations with corporate programs and protocols for CKD and new ESRD patients, only one out of four met the goal.

For many facilities and many professionals, Early Referral requires stretch thinking. Medical Directors will need to re-orient the Nephrologists that refer patients to their facility, and Nephrologists will need to re-orient the Primary Care Physicians that refer CKD patients to them. The Fistula First Breakthrough Initiative (FFBI) has

already developed an extensive array of tools to further this, starting with their Change Concept #12, *Modify hospital systems to detect CKD and promote AV fistula planning and placement*, detailed at
http://www.fistulafirst.org/HealthcareProfessionals/FFBIChangeConcepts/ChangeConcept12.aspx.
We've attached a copy, but there are many related tools that are found only at the Fistula First website.

Medical Directors' Toolkit

FFBI has also prepared a Vascular Access Management Toolkit for Medical Directors, found at
http://www.fistulafirst.org/LinkClick.aspx?fileticket=o0P6dxNsxZU%3d&tabid=121.
We've also included a copy of this. An important part of it is the *Nephrology Clinician Agreement*, found at
http://www.fistulafirst.org/LinkClick.aspx?fileticket=zmnxsK2Qzys=&tabid=121.
The Medical Director has taken responsibility for following CMS's Conditions for Coverage, and in turn the Medical Director can use these tools to enlist the Nephrologists who refer patients in sharing that responsibility. That shared responsibility can include outreach to the PCPs and hospitals that care for CKD patients, to facilitate Early Referral.

Early Referral and Placement

Six of the Network's multi-facility organizations had facilities that met the 60% goal, and seven multi-facility organizations did not.

> *Those seven organizations may need to start from scratch to **create their own programs and protocols** for Early Referral, Early Placement, and Catheter Replacement.*

While that effort may sound challenging, it only needs to be done once, and it will improve the performance of these facilities far into the future. As often as healthcare professionals move around, chances are these organizations will already have someone in their employ who is familiar with the programs and protocols at organizations which already have them.

FFBI also has a prepared program for Early Placement, as well as subsequent placement where a catheter has persisted into prevalence, in its Change Concept #7, *AVF placement in patients with catheters where indicated*, which can be found at
http://www.fistulafirst.org/HealthcareProfessionals/FFBIChangeConcepts/ChangeConcept7.aspx.
We've attached a copy, but again, there are many auxiliary tools available from the FFBI website.

It's critically important that new fistulas mature properly. FFBI has prepared an *Algorithm for Monitoring the Newly Placed AV Fistula for Maturation*, at http://www.fistulafirst.org/LinkClick.aspx?fileticket=r36gGJJmmIw%3d&tabid=128, as part of Change Concept #9. A common reason for patient preference for catheters is prior experience with a failed permanent access. Choice of surgeon is paramount, and must be made on the basis of performance. FFBI Change Concept #4 deals with this important issue; see http://www.fistulafirst.org/HealthcareProfessionals/FFBIChangeConcepts/ChangeConcept4.aspx for sample correspondence and questionnaires that a Nephrologist might use to help choose and direct surgeons. If competent surgeons are not available locally, then stretch thinking may be required to include travel to a high-performing surgeon. If it's done right, it only needs to be done once. If competent surgeons are not available on an insurance plan, then it may be necessary to negotiate with the insurance company to be able to obtain successful fistulas.

Vascular Access Manager

Seventy percent of facilities that meet the 60% goal *have an appointed Vascular Access Manager* in their unit. Here's a sample job description for a Vascular Access Manager, volunteered by the Denver Network, www.esrdnet15.org/QI/jobdes.pdf. Many successful facilities assign this duty to the "entire care team," and it's good that everyone is aware of the parameters. But it's also good to have one person take primary responsibility for keeping track of patient accesses, so that it never "slips through the cracks." Dialysis facility staff are very busy people.

Effective Staff and Patient Education

Critical to the Early Referral and Early Placement process is *effective staff and patient education*. Who educates a patient on how to choose an access, and how the education is done, is a prime determinant in patient resistance to fistulas. In cases where a facility shows a high percentage of patients who refuse to use a fistula, it's likely that the folks who educate the patients need to be retrained. Many successful facilities use prevalent patients with fistulas as educators, and many use a team approach. You can find many tools to assist with patient education at http://www.nwrenalnetwork.org/P/PtEdMaterials.pdf , and many tools to assist with staff education at http://www.nwrenalnetwork.org/QI/QI.htm#ff and http://www.nwrenalnetwork.org/fist1st/fist1st.htm#staff.

Online Network Seminar

The Network's QI Director, Lynda Ball, MSN, RN, CNN, has prepared an online seminar on Early Referral and Early Placement. We recommend that you attend it, at http://www.nwrenalnetwork.org/QI/wrfs/F-WAAVF100711.wmv. Everyone has

barriers to quality care, but every patient deserves the best possible care. When a barrier seems insurmountable, it doesn't need to become an "excuse" for less-than-optimal care. When analysis falls short, let your curiosity work on your barriers while you're doing other things. Ask yourself, "I wonder how I'm going to overcome that barrier!" and then, take your mind off of it for a while. There's a good chance that insights will present themselves when you aren't expecting them.