

Northwest Renal Network
Quality Improvement Work Plan Overview
 July 2008 to June 2009
 MRB and CMS Approved Projects for QI Work Plan

GOAL	ACTIVITY
AVF-in-Use Rate for Prevalent Patients – Technical Education Workshop	
Increase rate of fistulas-in-use among prevalent patients at nineteen selected facilities.	<p>Nephrologist / surgeon / Network QI Director education program. Target audience of nephrologists, surgeons, vascular access coordinators, interventionalists, and patient care staff.</p> <p>Results: increase in AVF rate of 2% at the end of the project. Thirteen of the eighteen facilities that had some representation at the workshop demonstrated improvement between 1 to 10%.</p>
Buttonhole Complications	
Reduce complication rates among facilities utilizing the buttonhole technique between June 2008 and December 2008.	<p>Interventions included:</p> <ul style="list-style-type: none"> • Mailing of resource materials to all facilities using the buttonhole technique. • Infections: The QI Director developed new education materials and a program on preventing infections with the buttonhole technique. • Infiltrations and excessive bleeding: The QI Director developed new educational materials and programs to focus in on infiltrations and excessive bleeding. <p>Facilities that indicated complications with the technique were asked for action plans on how they would reduce complications.</p> <p>Results: percentage of facilities reporting buttonhole complications reduced from 54% to 29%.</p>
2008 AVF Peer-Comparison Mailing	
Increase fistula usage rates and decrease long-term catheter rates by October 2008.	<p>Summaries of December 2007 Fistula First data was sent to all Network facility Nurse Managers and Medical Directors in April 2008, including peer-comparison graphs of fistula-in-use and long-term catheter rates.</p> <p>Results: peer-comparison graphs continued to be effective at increasing fistula rates, and were effective at reducing long-term catheter rates as well. The one fourth of Network facilities with the lowest fistula rates improved by 11%, while the one fourth of facilities with the highest long-term catheter rates improved by 20%.</p>

Reduction of Long Term Catheter Use – Conference Workshop	
Reduce long-term catheter use at twelve target facilities by December 2008.	<p>The workshop was completed in May 2008. Long-term catheter rates were monitored at each facility every two months after intervention (i.e. July, September, November 2008)</p> <p>Results: facilities that attended the workshop and submitted action plans reduced their aggregate long-term catheter rates by 7%.</p>
Reduction of Long-Term Catheter Use – Facility Action Plans	
Reduce long-term catheter use at eight target facilities by December 2008.	<p>Action plan requests were mailed in April 2008. The first re-measure was July 2008. A CMS-approved query was used to look for additional root causes if facilities were not improving.</p> <p>Results. Half of the target facilities reduced long-term catheter use, by 3 to 42%.</p>
100% Lab Data on Serum Albumin – Mailing and Facility Action Plans	
Raise percentage of patients meeting CPM target within twelve months of intervention.	<p>The resource mailing included technical education, outcomes graphs, and best practices. Progress was monitored in July 2008, October 2008, and January 2009.</p> <p>Results: three fourths of facilities with 10-20% of patients meeting serum albumin targets raised their percentage by ten points or more, and more than one fourth of facilities with 20-35% of patients meeting targets raised their percentage by ten points or more.</p>
Serum Albumin Root Cause and Best Demonstrated Practice Analysis	
Conduct root cause analysis with six facilities with lowest albumins, and utilize best practices information from facilities with the highest albumins to assist them in improving their albumin levels.	<p>The QI Director conducted phone interviews for root cause analysis. The resource mailing included technical education, outcomes graphs, and best practices. Action plans were submitted to the QI Director. The facilities submitted data to the Network: April 2008, July 2008, October 2008, and January 2009.</p> <p>Results: all of the six lowest facilities raised their percentage of patients meeting serum albumin targets. Their aggregate percentage rose from 5% to 33%.</p>
Dialysis Adequacy	
At selected facilities, raise percentage of patients meeting CPM/KDOQI dialysis adequacy target (URR \geq 65%) and Kt/V target (\geq 1.2), within four	<p>The QI Director conducted phone interviews for root cause analysis and is continuing to monitor progress.</p> <p>Status: project in progress. All target facilities have demonstrated improvement, and except for a few patients where exogenous barriers prevented improvement, all</p>

months of intervention.	goals have been met.
Standardized Mortality Ratios – Facility Action Plans	
Reduce SMR at three intervention facilities with high SMRs at the end of 2007.	<p>Expected mortality tables were obtained from USRDS. The Network developed a tool for computing 12-month rolling SMRs, which was used to calculate more current SMRs than were available from other data sources. The QI Director conducted phone interviews for root cause analysis with the one facility that remained high following the new calculation.</p> <p>Results: all of the facilities are now below the SMR threshold.</p>