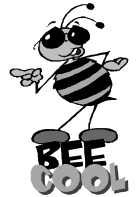


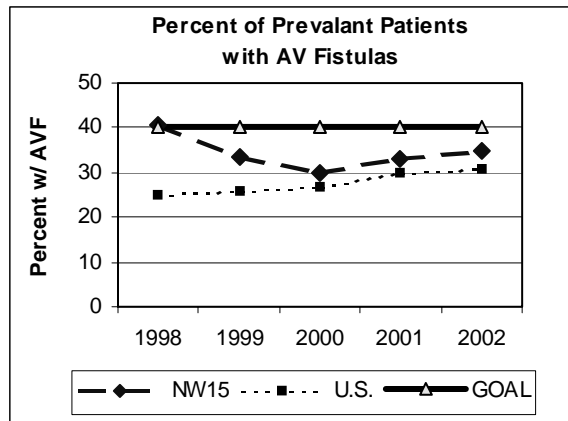


## QI Update - Spotlight on AV Fistulas



NVAII is the acronym for the *National Vascular Access Improvement Initiative* a 3-year, nation-wide campaign to increase the use of arterial venous fistulas (AVF). This project was launched July 1, 2003, by the Centers for Medicare & Medicaid Services (CMS) along with the 18 ESRD Networks and the Institute of Healthcare Quality (IHI).

The NVAII mission is to make sure that every eligible patient receives his/her optimal form of vascular access (in the majority of cases, AVF) and to avoid vascular access complications through appropriate monitoring and intervention. The NVAII goal is to attain CPM and K-DOQI standards for AVF use by June 2006. (See graph for Network #15 AVF rates.)



Medical literature provides convincing evidence that AVF is the preferred access--citing lower complication rates, longevity, and lower costs. K-DOQI Practice Guidelines suggest that at least 50% of incident and 40% of prevalent hemodialysis patients should dialyze by AVF; but proponents maintain that a much higher rate can be achieved, a fact that has been demonstrated by facilities within Network #15. The NVAII will create a new level of cooperation across professional disciplines and care settings, harnessing the best of what is known about improving vascular access.

A national work group representing nephrologists, vascular surgeons, dialysis nurses, corporate chains, Networks, and CMS has been examining the structure of this project for several months. System problems, such as financial barriers, were

identified and key recommendations emerged. Eleven clinical and organizational changes known as "change concepts" or "key strategies" (see page 2) were articulated and detailed in a recent mailing to Network #15 facility Administrators and Medical Directors. Currently, tools are being


identified/developed to help implement these recommendations. As the project progresses and demonstrates success, new tools will be added and disseminated to facilities.

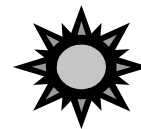
Network #15's strategy integrates a variety of activities that target the different needs of varied audiences. We will emphasize improved communication between the nephrologist, the vascular surgeon, the interventional radiologist, and dialysis staff. All Network #15 facilities will be involved to some degree. Data collection will be requested, but should not be burdensome, and may fall within the scope of your present collection practices.

You can provide additional help by

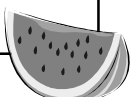
notifying us immediately if:

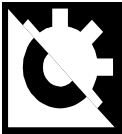
- You are doing quite well with AVFs and would like to share your success/expertise with other units, or
- You have a "super surgeon" who would be a good mentor for other surgeons, or
- You are just interested in helping out with this project.

Contact Darlene Rodgers, Karen Strott, or Lynne Wright at the Network #15 office (303-831-8818). 



Inside This Issue	
<i>In loving Memory . . . .</i>	(Insert)
Change Concepts . . . . .	2
Data Notes . . . . .	3
2728 - Ain't it Great! . . . .	4





## Change Concepts for Increasing the Prevalence of AV Fistulas for Hemodialysis



Here are 11 key clinical and organizational changes for increasing AV fistula use and improving hemodialysis patient outcomes:

### 1. Routine CQI review of vascular access

- Designate staff member in dialysis facility (RN if feasible) to be responsible for vascular access CQI.
- Assemble multidisciplinary vascular access CQI team in facility or hospital:
  - Minimally, Medical Director and RN (VA CQI Coordinator).
  - Ideally, representatives from all key disciplines, including access surgeons and interventionalists.
- Investigate and track all non-AVF access placements and AVF failures.

### 2. Timely referral to nephrologist

- Primary care physicians utilize ESRD/CKD referral criteria to ensure timely referral of patients to nephrologists.
  - Establish meaningful criteria for physicians who don't perform GFR or creatinine clearance testing.
- Nephrologist documents AVF plan for all patients expected to require renal replacement therapy.
- Nephrology staff educate patient and family about how to protect vessels, providing a reminder bracelet when possible.

### 3. Early referral to surgeon for "AVF only" evaluation and timely placement

- Nephrologist/skilled nurse performs appropriate evaluation and physical exam prior to surgery referral.
- Nephrologist refers for vessel mapping where feasible, prior to surgery referral.
- Nephrologist refers patients to surgeons for "AVF only" evaluation, no later than Stage 4 CKD (GFR<30). Surgery scheduled with sufficient lead time for AVF maturation.
- Nephrologist defines AVF expectations to surgeon, including vessel mapping (if not already performed).
- If timely placement of AVF does not occur, nephrologist ensures that patient receives AVF evaluation and placement at the time of initial hospitalization for temporary access (e.g. catheter).

### 4. Surgeon selection based on best outcomes, willingness, and ability to provide access services

- Nephrologists communicate standards and expectations to surgeons performing access, and provide training in current techniques for AVFs.

- Nephrologists refer patients to surgeons willing and able to meet the standards and expectations.
- Surgeons are continuously evaluated on frequency, quality, and patency of access placements. Data collection ideally is initiated and reported at the dialysis center as part of ongoing CQI process, and can be aggregated at the Network level.

### 5. Full range of appropriate surgical approaches to AVF evaluation and placement

- Surgeons utilize current techniques for AVF placement, including vein transposition.
- Surgeons ensure mapping is performed for any patient not clearly suitable for AVF based only on physical exam.
- Surgeons work with nephrologists to plan for and place secondary AVFs in suitable AV graft patients.

### 6. Secondary AVF placement in patients with AV grafts

- Nephrologists evaluate every AV graft patient for possible secondary AV fistula conversion, including mapping as indicated, and document the plan in the patient's record.
- Dialysis facility staff and/or rounding nephrologists examine outflow vein of all graft patients ("sleeves up") during dialysis treatments (monthly, at a minimum). Identify patients who may be suitable for elective secondary AVF conversion in upper arm and inform nephrologist of suitable outflow vein.
- Nephrologists refer to surgeon for placement of secondary AVF before failure of AVG.

### 7. AVF placement in patients with catheters where indicated

- Regardless of prior access (e.g. AV graft), nephrologists and surgeons evaluate all catheter patients as soon as possible for AVF, including mapping as indicated.
- Facility implements protocol to track all catheter patients for early removal of catheter.

### 8. Cannulation training for AV fistulas

- Facility uses best cannulators and best learning tools (e.g., videos) to teach AVF cannulation to all appropriate dialysis staff.
- Dialysis staff use specific protocols for initial dialysis treatments with new AVFs and assign the most skilled staff to such patients.

**“The starting point for improvement is to recognize the need.”**

— Imai

- Facility offers option of self cannulation to patients who are interested and able.


## 9. Monitoring and surveillance to ensure adequate access function

- Nephrologists and surgeons conduct post-operative AVF evaluation at four weeks to detect early signs of failure and need for intervention .
- Facilities adopt standard procedures for monitoring, surveillance, and timely referral for the failing AVF.
- Nephrologists, interventional radiologists, and surgeons adopt standard criteria, and a plan for each patient, to determine the appropriate extent of intervention on an existing access before considering a new placement.

## 10. Education for care givers and patients

- Staff in-servicing on a routine basis, and education programs in vascular access.
- Continuing education for all caregivers should include periodic in-services by nephrologists, surgeons, and interventionalists.
- Facilities educate patients to improve quality of care and outcomes (e.g., prepping puncture sites; applying pressure at needle sites).

## 11. Outcomes feedback to guide practice

- Networks work with dialysis providers to give specific feedback to all decision-makers on incident and prevalent rates of AVF, AVG, and catheter use.
- Review data monthly or quarterly in facility staff meetings. Present and evaluate data trended over time for incident and prevalent rates of AVF, AVG, and catheter use. 

## Resource Alert

Network #15 still has copies of the booklet “Choosing a Treatment That’s Right for You.” Written for patients in easy-to-understand terminology, it explains hemodialysis, peritoneal dialysis, and kidney transplantation.

The Network also has Spanish language copies of the booklet “Depresión.” This booklet provides in-depth information about what depression is, who is susceptible, and how it can be treated.

If you would like copies contact Network #15 at 303-831-8818 and ask for Karolyn .

## Data Notes

The “dog days of summer” have us panting and chewing on our tails. Also, we can’t help but scratch at a few pesky issues:



- ⇒ Many facilities persist (with best intentions, no doubt) in sending Monthly Patient Status Reports. Feel free to keep these at your facility, but do not send them to us. Quarterly Rosters encourage you to report patient changes that slipped through our net of attention.
- ⇒ Speaking of efficient, imagine a well-oiled machine. Now imagine a fax machine. Please do not BOTH fax and mail your forms to the Network. With well over 200 facilities reporting to us, you can also imagine the nightmare of that duplicate copies present.
- ⇒ Think BLUE. See BLUE. EnVISION blue. Facilities using VISION to report patient events must also use BLUE ink on forms that go to Social Security.
- ⇒ Zip codes are like belly buttons: nearly everybody has one. And we must keep accurate belly buttons for patients in our registry. This information is used in demographic surveys and studies. Please send address updates (via the 501 form) for patients who change zip codes.
- ⇒ Have you visited our website? What a place to be. You will find information that speaks to facility staff, renal professionals, and dialysis patients. You can glance at upcoming and ongoing events, and even download forms! We invite you to stop by often: [www.esrdnet15.org](http://www.esrdnet15.org).

*How hot is it* So hot, the devil himself was caught sucking an ice cube.

Stay cool.



Network #15, Information Systems Department

# In Loving Memory . . .

On August 8, 2003, after nearly three decades of service dedicated to the ESRD community, Sharon K. Stiles, executive director of ESRD Network #15, ended her valiant battle with breast cancer. Sharon is survived by her husband David, daughters Emily Askins and Jennifer Serpa, mother Eunice Kahrs, sisters Majeane Sparks and Mary Kahrs, brother Wayne Kahrs, and two of the greatest joys in her life, grandchildren Ethan and Lydia Askins.

Sharon was a graduate of the University of Michigan School of Nursing. Early in her career, she was a clinical specialist in Nephrology at the Borgess Medical Center and a member of the team that developed Michigan's first community-based renal dialysis and renal transplant program. She was cofounder, vice president, and associate director of the Community Action Program to Control Hypertension (CATCH), and part of the Medical Review Board for the Michigan ESRD Network (old Network #14). Relocating to Colorado, Sharon joined the staff of Network #15 and in August 1981 was promoted to executive director. She was actively involved with renal and healthcare organizations including ANNA, NKF, and NRAA, and was a LORAC member emeritus.

Sharon's family has designated the following charitable organizations for donations honoring her life and life's service: The First Presbyterian Church of Littleton (Music Program), 1609 W. Littleton Blvd., Littleton, CO 80120; and the Qualife Wellness Community, 1741 Gaylord St., Denver, CO 80206.

Sharon will be missed daily by the family of coworkers who mourn her passing.



## I Hear Bells

She stops to say *good morning* every day  
at every door in the hallway.  
She takes all the hugs we lift and won't refuse a kiss  
to make ends meet.  
She has a history, but her story won't be told in paperback:  
She owns a fine, strong spine. She doesn't lack for taste.  
She seldom wastes time on things that mean little, knowing  
that life is built by choices, and dreams, and sowing a purple  
path.  
She goes to bat for what she believes  
and bleeds.  
She's wed to family and work, skipping neither duty,  
so ruby slippers might click her either place.  
She squeezes hope into empty space.  
She sees music in a westward view and new leaves, stretching.  
She hears color in scenery ... a drumbeat ... poetry.  
Art will always court her hand and land a partner.  
She doesn't decline to dance.

And when her hair had the chance to betray what it grieved—  
treatments, fallout, a Thursday routine—  
the strands showed only grace.  
Silver, in the face of sickness so unfair.  
Beautiful white and silver-plated hair.

-- Cyns Nelson  
Network #15

A large, light pink awareness ribbon is centered on the page. The ribbon is tied in a loop at the top, with two long tails extending downwards. The text is overlaid on the upper part of the ribbon.

Sharon K. Stiles

February 11, 1945 - August 8, 2003

# 2728 – Ain't it GREAT!!



## Patient Signatures Required

Network #15 can no longer accept any 2728 forms (ESRD Medical Evidence Reports) that are missing patient signatures *unless the patient has died and date of death is on the form*. We recommend obtaining a patient signature (or that of an authorized family member) as soon as dialysis begins so that you avoid the problem of a patient transferring before signing the 2728. If the patient refuses to sign, please call the Network at 303-831-8818.

## Supplemental 2728

Don't forget to send a SUPPLEMENTAL 2728 if a patient changes from an in-center modality to a home modality within 90 days of beginning dialysis. Use the regular

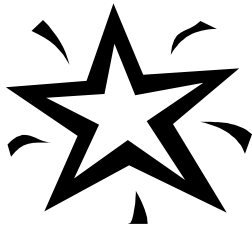
2728 form and write the word "supplemental" at the top. Complete fields 1-7 of Section A and all of section D (36-43); obtain patient and doctor signatures; then send the blue copy to SSA and the green to the Network.

## Incomplete 2728s

Please fill out the 2728 in its entirety. All too frequently we receive forms that are missing field 10, INSURANCE COVERAGE, and fields 11 and 12, HEIGHT and WEIGHT. Also, remember that 2728s need to be received by the Network within 45 days of the patient's first regular treatment (field 23) or the form will be considered late, and this will be reported to CMS. ☺

## Reach for the Stars!

### Network #15 Stars ...



These facilities have made outstanding efforts to improve their patients' albumin levels:

- ✧ Phoenix Artificial Kidney Center
- ✧ RCG Central Denver
- ✧ FMC Las Vegas, NM
- ✧ Bridgerland Dialysis
- ✧ RCG Lake Havasu
- ✧ RCG Rocky Mountain
- ✧ RCG Maryvale

## Eyeball! Eyeball! Eyeball!

In July, Network #15 mailed the 2003 *Dialysis Facility Report*, prepared by UM-KECC, to all dialysis facilities. We encourage every Medical Director and/or Administrator to review that information and submit comments **no later than September 16th, 2003**. (Details were included in the mailing.)



Be sure this report gets your careful attention--contents will be sent to your State Survey Agency!



## Network #15

Supported by Centers for Medicare & Medicaid Services Contract No. 500-03-NW15. The opinions and conclusions expressed are those of the authors. They do not necessarily reflect CMS policy. The authors assume full responsibility for the accuracy and completeness of the ideas presented.

## ESRD Network #15

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