Access for Success

AN AV FISTULA IS THE GOLD STANDARD FOR DIALYSIS ACCESS

February 9, 2016

BEST PRACTICE: I made a poster for our lobby that showed the benefits of not having a catheter. Placing in the lobby worked well, because patient families helped to encourage the patients. It really helped to decrease our catheter rates. Families were concerned for infection. Also, summertime is around the corner, and they will want to get ready to swim!

Q&A

QIA Activity Questions

Q: Is every clinic in this project? How I would know if my unit was in this project?
A: Selected facilities are involved in this project. A complete list of participating facilities is located on our website http://esrd.ipro.org/qia/vascularaccessqia/

Q: Where can I print the slides? Will the dialog be available with the slide decks?
A: The slides and recording are available on our website http://esrd.ipro.org/events/

Q: Please clarify that clinics with census less than 25 patients do not have to participate in this project.
A: Please contact your Network QI representative to discuss.

Q: where is the Reporting form located?
A: http://esrd.ipro.org/vascular-access/qia/

Q: If the AVF has a segment patched with a Procol piece, would this access be considered an AVF still, or is it now a graft for crown web?
A: The access would be considered a graft

Q: Do we update the CAP quarterly?
A: If you have not decreased your long-term catheter rate for 3 consecutive months, please complete the quarterly reporting form found at: http://esrd.ipro.org/vascular-access/qia/

Q: Do the units get "penalized" for pt's having a catheter who have a history of multiple failed access
A: CMS does not have exclusion criteria for vascular access. The facility would still have to count those patients who have a catheter regardless for failed accesses.

Q: Does the Network have a preference as to who enters Crown Web data? It has been suggested that only clinicians enter data, as they have a more vested interest in the correct information being shared.

A: The Network has no preference. Certainly the information should be verified and remain as accurate as possible to achieve the maximum score for the QIP, and other initiatives, but who should enter would be a clinic or corporate leadership decision.

Q: Are you going to explain some of these forms that are required to fill out, along with the tracker on excel?
A: There are instructions for the excel tracker and the forms were explained throughout the webinar – if you have additional questions please contact the Network.

Q: Please clarify...for NHSN we are to report access that have clotted off as well. For example patient has catheter due to two failed fistulas we would count this patient as having catheter and fistula?
A: That is correct, in NHSN the access of highest risk should be reported – in CROWNWeb and for the purposes of this QIA it is the access in use that is reported.

Q: Why was the call ended so early?
A: We are using a new conference call service, and there were back end issues that ended the call abruptly. This will not happen in the future.

Q: Can you please put the contact information again.

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Peritoneal Dialysis:

Q: We have a very large PD population. There is no option in Crown Web to get "credit" for PD catheter placements. Can this be added? See below

Q: We have a large PD population. Any comment regarding "credit" for placing a PD catheter as a way to reduce CVC? See below

Q: any comment regarding PD catheters and getting "credit" for placing one? See below

A: In terms of PD, that's certainly a benefit and we encourage that, certainly the credit is given by CMS and the Network for this, but we still do focus on reducing LTC rates

Barriers:

Q: Any suggestions for barriers with bariatric patients, especially when there are issues with the access.

A: Some surgeons are doing liposuction techniques that allow for access in bariatric patients. This would be a surgical skill issue.

Q: What are people typically seeing for a time frame from vein mapping to avf placement? Our wait times are extremely long. 2-3 months or more. What is acceptable?

A: This timing varies one region to another and from one surgical practice to another. There are areas where this is done within days, so ideally within a week to two weeks, but varies by access to surgeons.

Q: The biggest barrier we are facing are the new admissions coming to the unit with only a CVC and they are higher in acuity and age

A: Unfortunately that is what we hear quite often, and is not always a barrier. That said, there is also literature that beyond a certain age catheters are a realistic option.

Q: How would you approach a patient who previously had access placement and never developed. Pt now refused to have any conversation regarding access placement

A: I would recommend having a patient with a similar experience possibly attempt a peer-to-peer discussion. Reach out to your Network for information about possible patient advisory committee members that may be able to assist.

General Q&A:

Q: Do you have any supporting materials that support getting an internal access while waiting for a transplant? Especially when the surgeon and/or nephrologist refuse to send the patient to get an access or the surgeon refuses to do the procedure?

A: KDOQI guidelines recommend that if the patient is not waiting for a surgery date with a living related donor they should begin to move through the process of permanent access placement. If the patient is resistant to hemodialysis or needle placement a transition to PD while awaiting transplant is also an option. Trade a CV catheter for a PD catheter. No needles, either way!

Q: We have 7 peds and 5 of them with catheters. Do you recommend pediatric patients get vascular access right away?

A: Recommendations for permanent access are different with children. Ninety-five percent of children transplant within one year of starting dialysis, which determines the patient's path to access placement. NKF KDOQI guidelines recommend if the patient is not going to be transplanted within one year, is greater than 20 kilograms and will not be placed on PD a permanent access is the best choice.

Q: Regarding access plans - Is there any tracking of the Nephrology Offices as far as accesses in place when they are in Stage 4 of CKD so they don't start dialysis with a catheter?

A: There is not at the Network or other level. Since the placement is surgically driven, it would really be up to the nephrology groups to identify those not placing accesses early. There is also some evidence that suggests that accesses placed too early sometimes do not fare well once needed. It's a fine balance and tough topic among physicians.

Q: Do you have any educational material to support our teams when discussing access plans with the Nephrologist while the patient is in stage 4. We get a lot of push back and support information would be helpful coming from IPRO.

A: Unfortunately we don't. It's in a lot of literature, but since the ESRD Networks scope of work and focus is ESRD, we don't have materials developed for CKD discussions. The FFCL website does have information about this for reference, however.

Q: Do you have any information about a program showing patients a model of the heart and explaining where the catheter sits to discourage 'holding on' to the catheter.

A: We are actually working on a poster for patients with this image to be distributed in the coming months. Many of the units have these visual models to show patients as well for reinforcement.

The Fistula First resources are great for provider staff and physicians as well, and can be found on our webpage: http://esrd.ipro.org/vascular-access and click the links within this page.