

# Scenario I

- Urban Facility, part of a Small Dialysis Organization

## **PATIENT POPULATION**

- 59 pts.
- 63.7 average age
- 42% > 65 years
- 54% female
- 76.3% African American, 23.7% white
- Causes of ESRD: 44% diabetes, 37% hypertension, 10.2% glomerulonephritis
- Average years on dialysis 4 years
- 11% nursing home patients
- All patients are in-center hemo

## **BASELINE RATES (March 2010)**

- 38.7% AVFs
- 11.3 % AVGs
- 21% CVC > 90 days

## **ATMOSPHERE (September 2010)**

- Staff feels hopeless
- Patients are too sick for surgery
- Elderly population not candidates for AVFs
- New patients with no pre-ESRD care
- Busy surgeons
- Non-maturing AVFs

## **CHANGES IMPLEMENTED BY MARCH 2011**

In September 2010 they appointed a Vascular Access Manager (VAM), she works 30 hours a week, MWF and TTS shifts. She put processes in place to have new patients referred for vessel mapping within the first week of being admitted to the unit. They established a Vascular Access team that includes the nurse manager and patient care technicians. Facility feels like the key to success is having someone “own” this job. They had to talk with their surgeons about only putting in AV fistulas and if it’s not maturing within 60 days then an intervention is needed, they often use an Access Center. The VAM identified “Expert” cannulators to stick new AV fistulas. Patients with infections due to CVCs receive extra education and are usually persuaded to get a permanent access. The staff realized that they will always have new patients with CVCs and some patients that refuse permanent access. Each month the Facility Administrator shares their access rates with the staff and they celebrate, they feel like they’ve really overcome a hurdle. The project ended in March 2011, these processes remain in place and the facility has an AVF rate of 62.3% as of July 2011.

## **RE-MEASUREMENT RATES (March 2011)**

- 58% AVF
- 11.6% AVG
- 10.1 % CVC > 90 days

*South Laburnum Dialysis, LLC*  
*July 2011 rate, 62.3% AVF*

At each Kick-off meeting participants were asked to identify barriers the facility in Scenario 1 faced and ideas to overcome those barriers. The discussion is summarized below and linked to the Fistula First Change Concepts which can be found on the Fistula First website at [www.fistulafirst.org](http://www.fistulafirst.org).

<b>Barriers Identified</b>	<b>Strategies to Overcome Barriers</b>	<b>Related Change Concept</b>
Lack of leadership	Identify Vascular Access Manager	#1
Lack of patient and staff education	Implement staff and patient education	#10
Lack of surgeon interest/accountability	Identify facility expectations for the surgeon	#3, #4, #5
Late referrals to nephrologists	Educate PCPs	#2
Emergent starts in hospital	Work with hospitals to provide vessel mapping before discharge	#12
Lack of processes in place	Develop processes and procedures	#1
Elderly patient population	Identify surgeon that can utilize full range of appropriate surgical approaches to AVF evaluation and placement	#5
Non-maturing AVFs	Implementing monitoring and maintenance policy	#9
Patients not candidates for AVFs	Implement “sleeves up” protocol, patients with AVG might be a candidate for a secondary AVF	#6

## Scenario II

- Urban Facility, part of a Large Dialysis Organization

### **PATIENT POPULATION**

- 124 pts.
- 61.2 average age
- 45.2% > 65 years
- 52.4% female
- 44.4% African American, 55.6% white
- Causes of ESRD: 36.4% diabetes, 39.5% hypertension, 19.4% other/unknown
- Average years on dialysis 3.7 years
- 14.5% nursing home patients
- 76.6% in-center hemo, 4% home hemo, PD

### **BASELINE RATES (March 2010)**

- 56.9% AVFs
- 13.7 % AVGs
- 9.2% CVCs > 90 days

### **ATMOSPHERE (September 2010)**

- A lot of staff turnover
- Staff without dialysis experience
- Had good rates why did they need to be better, 66% AVF unrealistic
- CVC patients refusing permanent access

### **CHANGES IMPLEMENTED BY MARCH 2011**

Clinic Manager sat down with staff and talked to them about needing to implement new processes to increase their AVF rates, they started a “Star Cannulation Program” and using the buttonhole technique. The facility designed a bulletin board for the waiting room that describes the reasons for having a CVC and the importance of having the CVC removed within 90 days. The staff passes a CVC tray around to their CVC patients, who were surprised at how long it was. Patients that previously were scared to get a permanent access were asking to be scheduled for an AVF. When new patients are admitted to the unit the staff have them scheduled for vessel mapping before the end of their first treatment. The staff feels that they have been successful because they have worked as a team and met this challenge head on.

### **RE-MEASUREMENT RATES (March 2011)**

- 70.2% AVFs
- 14% AVGs
- 4.4 CVC > 90 days

*BMA – North Roanoke  
July 2011 rate, 76.1% AVF*

At each Kick-off meeting participants were asked to identify barriers the facility in Scenario 2 faced and ideas to overcome those barriers. The discussion is summarized below and linked to the Fistula First Change Concepts which can be found on the Fistula First website at [www.fistulafirst.org](http://www.fistulafirst.org).

Barriers Identified	Strategies to Overcome Barriers	Related Change Concept
Staff turnover	Engage staff and make them feel apart of the team, share monthly vascular access feedback reports with staff, share successes	#10, #11
Staff complacency	Stress the importance of Continuous Quality Improvement (CQI)	#1
Inexperienced staff	Implement staff training program	#8, #10
Patient refusal	Engage patients differently, empower them to be an advocate for their own care	#10, #13
Lack of process in place to remove catheters	Develop and implement protocol to monitor catheters	#7