

FistulaFirst

The National Vascular Access Improvement Initiative (NVAII)

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NVAII (“FistulaFirst”)

Rationale

A-V Fistulae are Superior to Grafts and Catheters:

- ↑ Patency
- ↓ Morbidity & Mortality
- ↓ Costs:

Per annum Cost Savings¹

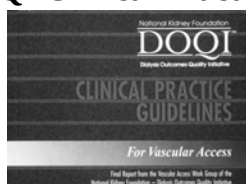
- \$ 4500. vs. AVG
- \$ 9000. vs. Catheter

Most VA-related Complications, Mortality & Costs are due to Grafts & Catheters

¹ Eggers et al

NKF-K/DOQI Clinical Practice Guidelines

- ↓ Access Patency
- ↑ Complications
- ↑ Mortality
- ↑ Costs



- ↓ AVF
- ↑ AVG
- ↑ Caths

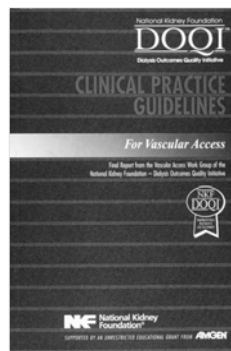
“In Order to Reverse these Trends.... Centers need to Implement Strategies to Increase Native Fistula Construction..”



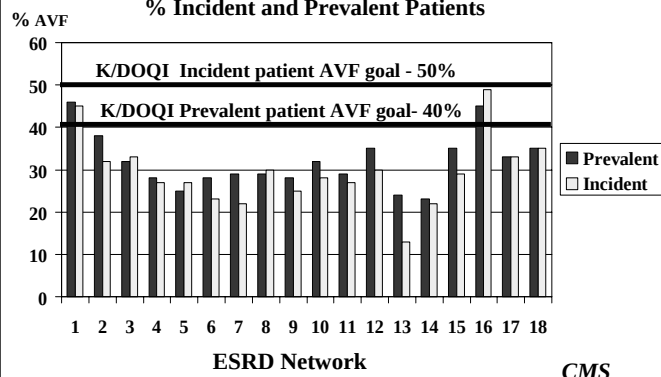
NKF-K/DOQI Clinical Practice Guidelines

GOALS OF ACCESS PLACEMENT: A-V FISTULAE

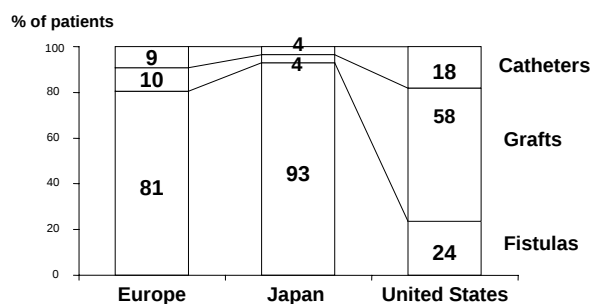
- An AVF should be attempted in **50%** of new patients (Incident rate goal).....
- **40%** of AVF's expected to develop (Prevalent rate goal)
- Re-evaluate every patient for an AVF after every access failure
- Track AVF construction and failure rate (CQI/QA)



Distribution of AVF Rates by ESRD Network: % Incident and Prevalent Patients



High AVF Use Among Prevalent Hemodialysis Patients in Europe & Japan vs. U.S.¹



¹ Dialysis Outcomes and Practice Patterns Study (DOPPS)

Increasing Autogenous Fistulae

Can we achieve the same high AVF rates in this country?

Impact of a Local AVF Initiative

A-V Fistulae: 98 %

A-V Grafts: 0

Catheters: 10 %

Vo Nguyen, MD
Olympia, WA



The National Vascular Access Improvement Initiative (NVAII) 2003-2006

Sponsored by the Centers for Medicare and Medicaid Services



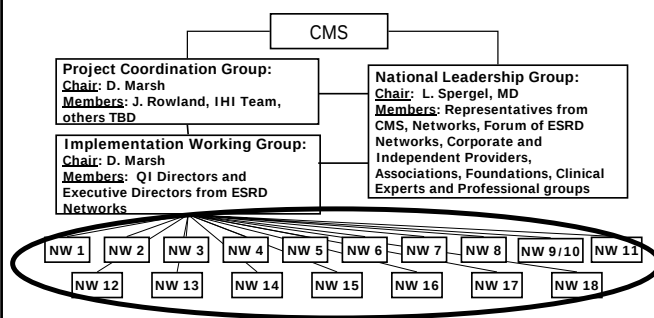
NVAII ("FistulaFirst"): GOAL

Goal is to *maximize* autogenous AVF construction & success rate.....

to achieve in the short term, the current K/DOQI minimum benchmark of 50% construction in new (incident) patients with successful AVF use in at least 40% of prevalent patients.....

and in the long term, a 67% AVF rate in prevalent patients (CMS Breakthrough Initiative)

NVAII/ "FistulaFirst" National Implementation Structure



NVAII ("FistulaFirst") 11 key Change Concepts*

- | | |
|--|--|
| 1. Routine CQI review of vascular access | 6. Secondary AVFs in AVG patients |
| 2. Timely referral to nephrologist | 7. AVF evaluation/placement in catheter patients |
| 3. Early referral to surgeon for "AVF only" | 8. Cannulation training |
| 4. Surgeon selection | 9. Monitoring and Maintenance |
| 5. Full range of appropriate surgical approaches | 10. Continuing education |
| | 11. Outcomes feedback |

*A Change Concept is an approach to change proven to be successful, which is intended to stimulate specific strategies relevant to implementation of that Change Concept.

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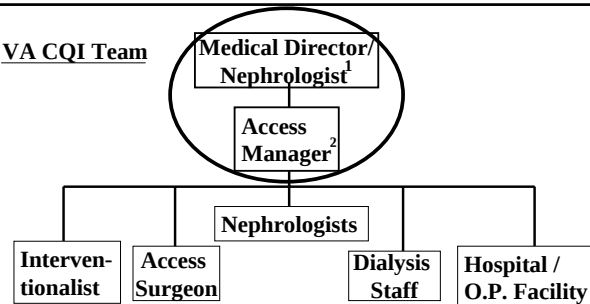
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1. Routine CQI Review of Vascular Access

Possible specific changes:

- Facilities and/or hospitals designate staff member responsible for vascular access CQI (VA Manager/Co-ordinator)
- Assemble multi-disciplinary vascular access team at facility or hospital level
- Investigate and track all non-AVF access placements and AVF failures

VA CQI Team



¹ Nephrologist must become informed and take Lead role in AVF initiative/ encourage patients/ develop relationship with surgeons

² Access Manager needs to be empowered by Medical Director & Team

Note: AVF Initiative is introduced at a Multi-disciplinary Conference, VA Team is assembled & database established

ABSTRACT

A Multidisciplinary Vascular Access Care Program (VACP) Enables Implementation of Dialysis Outcomes Quality Initiative (DOQI). C. Duda, L. Spengel, J. Holland, T. Tucker, J. Bosch and S. Bander.

GAMBRO Healthcare, Inc., Lakewood, Co.

GAMBRO Healthcare designed and implemented a VACP to facilitate implementation of company-wide VA standards of care and DOQI. The VACP is a comprehensive, proactive, multidisciplinary team approach to the management of VA care. The program is based on monthly access flow monitoring (Transonic HD01) and a continuous improvement process (CIP) by the VACP team to implement best demonstrated practices in VA care with focus in the areas of: education, assessment, monitoring, diagnosis, intervention, documentation and CIP. The VACP multidisciplinary CIP team is under the leadership of the dialysis facilities' Medical Director(s) and has representation from all disciplines involved in VA care, including the dialysis staff, representatives from the local hospitals, and particularly the surgeons and radiologists performing the VA procedures.

In January, 1998, GAMBRO's first VACP multi-center implementation was initiated in Southeast Georgia and continues presently. The project involved 6 dialysis facilities and one central tertiary referral hospital comprising a geographical range of 250 miles, frequently necessitating overnight hospital admissions. These data represent the Control Group (CG) period that averaged 254 patients from 1/97 – 12/97 compared to the Experimental Group (EG) which continued with this same population from 1/98 – 4/99. The EG increased 19% to 302 patients (pts.) over 16 months.

In the CG only 6.7% of newly diagnosed pts. arrived at the dialysis clinics with AVF's as their permanent access compared to 44% of pts. in the EG by the last month of the study.

In conclusion, a dedicated multidisciplinary team approach to VA care resulted in a 44% reduced incidence of thrombosis and significantly improved (*) clinical outcomes compared to standard care.

Criteria	CG	EG
% of Grafts	71.0%	61.5%
% of Fistulae (AVF)	14.6%	25.2%
Incidence Thrombosis per pt./per mo. (pppm)	0.087	0.049*
Hospital Admissions for VA ppm	0.1	0.07*
Hospital Days for VA ppm	0.53	0.27*
Missed Outpt. Treatments due to VA ppm	0.29	0.16*

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2. Timely referral to nephrologist
3. Early referral to surgeon for "AVF only" evaluation
4. Surgeon selection
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2. Early Referral to Nephrologist

Possible specific changes:

- Primary care physicians use established CKD referral criteria to ensure timely referral to nephrologists
- Nephrologists propose & document AVF plan for all patients expected to require renal replacement therapy
- Designated nephrology staff person educates family and patient to protect vessels for AVF

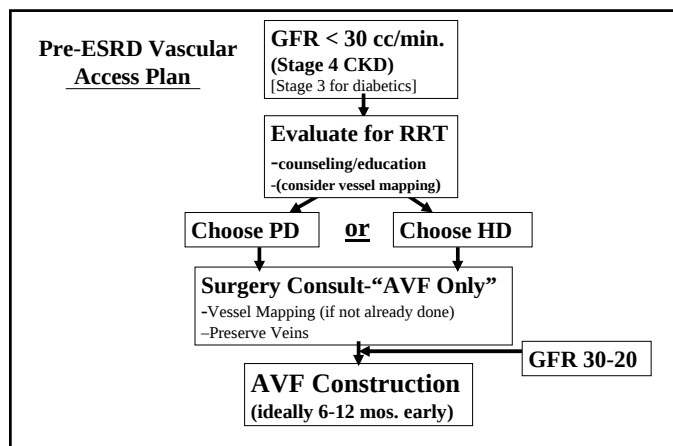
Early Patient Referral to Nephrologist-- (Late Referral often leads to Catheter & "hurry-up" AVG)

Near-term options:

- Establish Referral Criteria (CKD Stage 4-GFR < 30)
- Disseminate Information & guidelines to PCP's
- Choose RRT early/ Plan AVF & Protect Sites
- Consider Vessel Mapping prior to Surgery Referral

Longer-term options:

- Pre-ESRD/CKD Program/Early Patient & Family Counseling
- Track Referral Patterns/Provide Feedback to PCP's, Nephrologists
- Strict Catheter Protocol for Placement & Removal



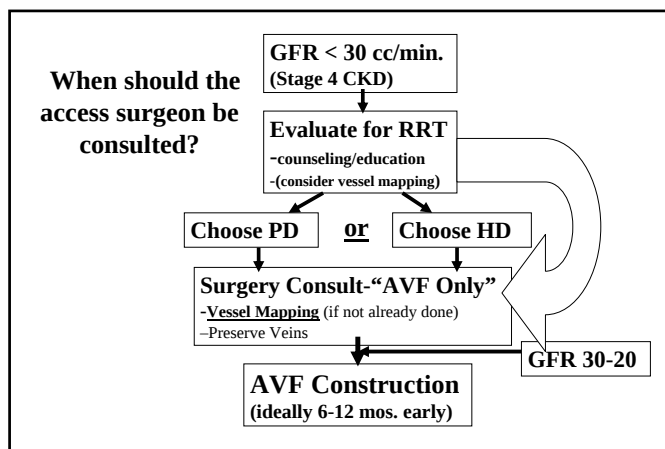
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3. Early Referral to Surgeon for “AVF Only” evaluation

Possible specific changes:

- Nephrologist/skilled nurse evaluates and encourages patient to have AVF
- Nephrologist refers patient for vessel mapping/AVF evaluation by Stage 4 CKD
- Nephrologist refers patient to surgeon for “AVF only” evaluation



NVAII (“FistulaFirst”)

The Surgeon’s Role

- Learn & utilize current AVF options & techniques, including vein transpositions
- Perform vessel mapping on all patients if suitable vessels not identified on physical exam
- Work with nephrologists, interventionalists & dialysis staff to plan and construct secondary AVFs in patients with failing AVGs
- Take aggressive approach to salvage of the failing fistula

NVAII (“FistulaFirst”)

The Surgeon’s role

- Goal is to *maximize* autogenous AVF construction & success rate.....
- to achieve in the short term, the current K/DOQI minimum benchmark of 50% construction in new (incident) patients with successful use in at least 40% of prevalent patients.....
- and in the long term, a 67% AVF rate in prevalent patients (CMS “Breakthrough Initiative”)

NVAII (“FistulaFirst”): the Surgeon’s Role

Pre-Operative AVF Planning

- **History:** diabetes, peripheral vascular disease, catheters, PICC lines, surgery, trauma, pacemaker...

- Physical Exam:

- Artery suitability: pulses, bilateral BP, status of peripheral circ. /Allen’s test (ideally Doppler assisted)
- Vein suitability: soft, straight, superficial, >2.5mm

Vessel Mapping: (Doppler Ultrasound/Venography)

Increases AVF options & success rate, ensures vessel suitability (patent, adequate lumen diameter: A>2.0mm, V>2.5mm, adequate vessel function).

Post-Op: Exam for early failures at 4 wks. post-op

Access Procedure Diagram

(Show Access Type, Location, Configuration & Direction of Flow)

DIALYSIS ACCESS PROCEDURE DIAGRAM
Fill in Dialysis Facility and/or Nephrologist

Patient Name: _____
 Diagram Completed by: ☐ Surgeon ☐ Interventional Radiologist ☐ Nephrologist
 Patient Signature (if Interventional Radiologist): _____
 Date: _____
 Facility Name: _____
 Page # _____

Access Type	Access Location	Access Configuration	Access Direction of Flow
☐ Arteriovenous (AV) Fistula	☐ Left Arm	☐ End-to-end	☐ End-to-side
☐ Arteriovenous (AV) Graft	☐ Right Arm	☐ End-to-end	☐ End-to-side
☐ Arteriovenous (AV) Catheter	☐ Left Arm	☐ End-to-end	☐ End-to-side
☐ Arteriovenous (AV) Catheter	☐ Right Arm	☐ End-to-end	☐ End-to-side
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NOTE: Please show Configuration of access, Vessels Involved, and Direction of Access Flow

Diagram: A line drawing of a human torso showing the location of the dialysis access on the left arm.

Additional Information:

Other description of procedure (if patient access not present, explain reason): _____

Procedure Indication (if relevant): _____

Also procedure successful? (Yes/No) (state one): _____

Recommendation/Comments: _____

Additional use information/indications: _____

Special caution instructions: _____

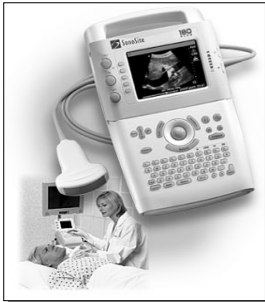
Patient Follow-up:

1. Patient to schedule appointment with Surgeon/Nephrologist (state one) in _____ (state one)

2. Patient appointment has been scheduled (state one) _____

Other Notes: _____

Ultrasound: Stethoscope of the 21st Century



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4. Surgeon Selection

Possible specific changes:

- Nephrologists refer to access surgeons willing & able to meet specific AVF standards and perform all AVF procedures (use questionnaire)
- Surgeons should be familiar with the basic principles of dialysis and the needs & problems of dialysis patients
- Surgeons are evaluated on frequency, quality, and patency of AVF placements (outcomes & feedback)

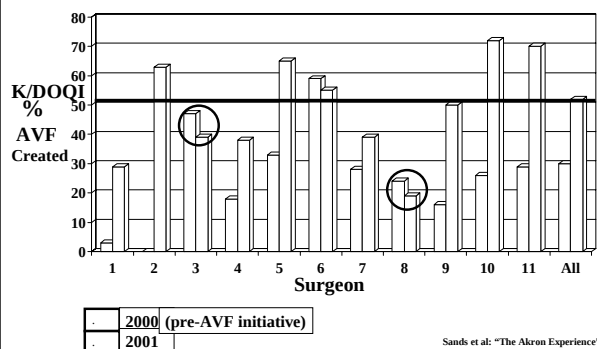
4. Surgeon Selection

Incident AVF rate by surgeon at a regional center

3. Breakdown of permanent accesses by Surgeon:

CQI minutes 8-11-03		Fistula	Graft	% Fistula
Dr.		12	14	46
Dr.		7	5	58
Dr.		2	16	11

% AVF Created by Group of Surgeons



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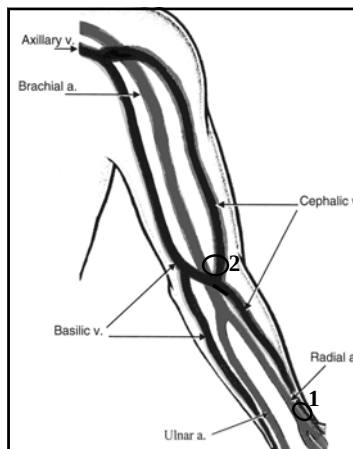
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5. Full range of appropriate surgical approaches

Possible specific changes:

- Surgeons learn & utilize current techniques for AVF placement, including vein transpositions
- Surgeons ensure vessel mapping is performed if suitable vein not identified on physical exam
- Surgeons work with nephrologists & staff to plan and place secondary AVFs in AVG patients



Historical AVF Options

1. Radial-cephalic (Brescia-Cimino) AVF
2. Brachial-cephalic AVF

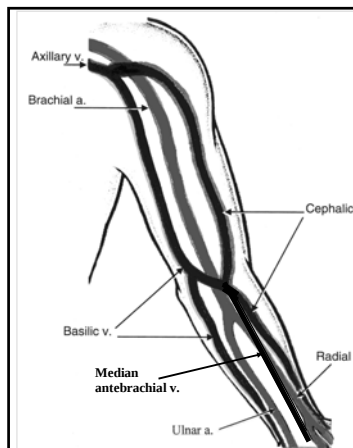
1° Autogenous A-V Fistula Options Simple Direct A-V Fistulae

- >Radial-Cephalic (Forearm)
- >Brachial-Cephalic (Arm)
- Proximal Radial-Median antebrachial (forearm)

Vein Transposition A-V Fistulae:

- Cephalic vein (forearm): Radial a.-Cephalic v.
- Basilic vein (forearm): Radial a.-Basilic v.
- Cephalic vein (arm): Brachial a.-Cephalic v.
- >Basilic vein (arm): Brachial a.-Basilic v.
- Saphenous vein (thigh): Femoral a.-Saphenous v.
- Femoral vein (thigh): Sup. Fem. a.Fem. v.

Vein Translocations (vein relocated to another anatomic site)



In each patient:

- Which veins and arteries have been identified as being suitable (i.e. what are my vein conduit and arterial inflow options) ?
- Which AVF option do I select—and Why?
- Where is the best site for anastomosis?

L. Spergel, MD

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CC #6: Secondary AVFs in AVG patients

Possible specific changes:

- Nephrologist evaluates every patient with failing/failed AV graft for a secondary AVF
- Dialysis facility staff and/or rounding nephrologist examine outflow vein of all graft patients (“sleeves up”) monthly
- Nephrologist communicates with interventionalist & surgeon after every graft failure....and refers to surgeon for construction of secondary AVF *prior* to loss of AVG

CC #6: Secondary AVFs in AVG patients

Goal

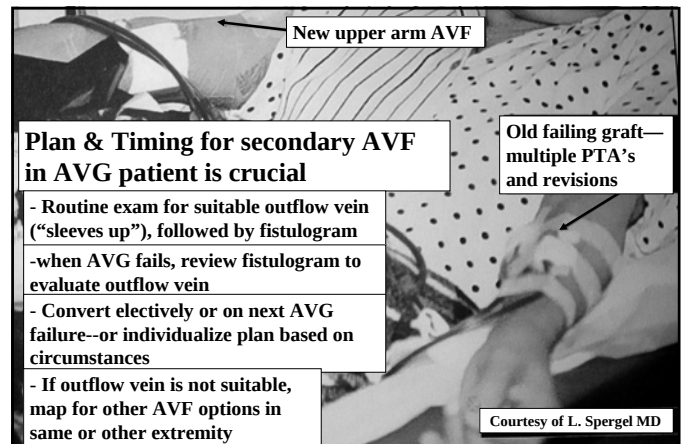
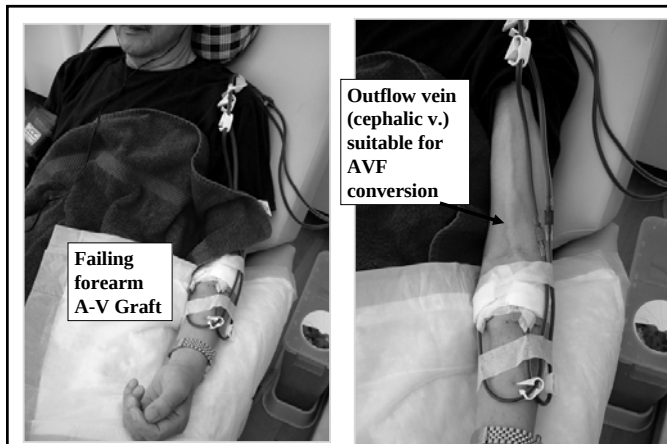
- To transition from an AVG to an autogenous AVF in all patients where appropriate & feasible -- ideally prior to graft loss
- “every patient should be re-evaluated for construction of an autogenous A-V fistula after failure of every dialysis A-V access”-- K/DOQI guideline 29
- A powerful AVF prevalence strategy

CC #6: Secondary AVFs in AVG patients

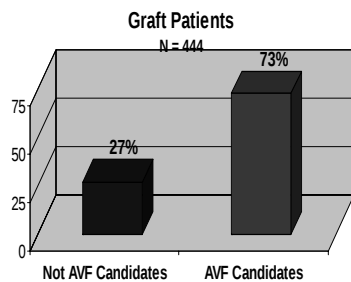
Definition

An AVF constructed following an AVG:

- Conversion of an existing AVG outflow vein to a direct AVF where feasible
or
- Exam & Vessel Mapping for alternate options when outflow vein is not suitable



AVF Candidates in Prevalent Graft Patients



Sands et al NKF 2001

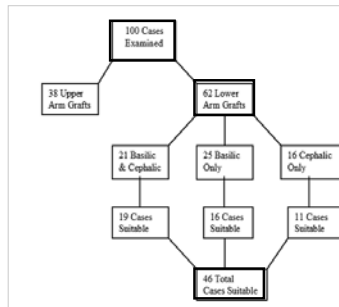
Identification of 2° AVF Candidates

Candidates for secondary fistulas can be identified by:

- Angiogram (fistulogram) - at time of AVG intervention
- Ultrasound
- Physical examination in dialysis facility ("Sleeves Up")

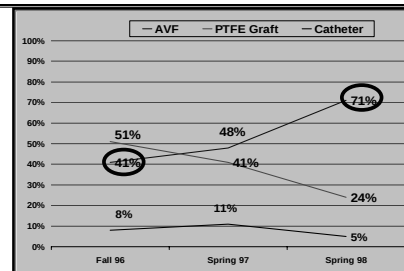
Secondary Fistula Identification

- Study of 100 consecutive patients with arm grafts
 - Referred for angioplasty or thrombectomy
- Utilized only the studies routinely performed for the procedures being done



Beathard GA. Seminar Dial 17:230-233, 2004

Impact of Secondary Fistulas in Prevalent Graft Patients



AVF increased to 71% by replacing failing grafts with AVF

Vo Nguyen et al: ASN 1999 ABS. A1085

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7. AVF Placement in Catheter Patients

Possible specific changes:

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

CATHETERS

Higher Catheter Use is Associated with Increased Infection, Morbidity, Mortality & Hospitalization

¹ Dialysis Outcomes and Practice Patterns Study (DOPPS): 2 yrs./ 7 Countries / 10,000 pts.

² Pastan et al: Vascular access and increased risk of death among hemodialysis patients.

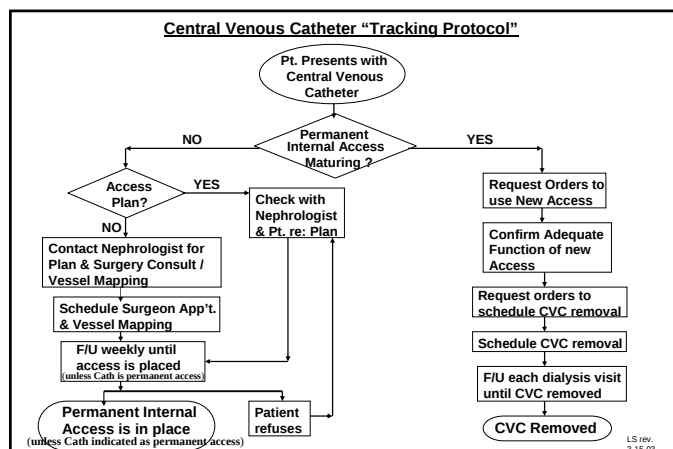
Reducing Catheter Use

Remedial Strategies

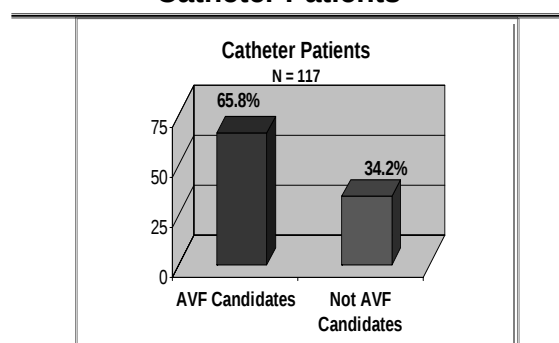
- Early Referral to Nephrologist & Surgeon for Permanent Access
- Monitoring & Timely Intervention for Access Failure

- Surgical Evaluation & Placement of Permanent Access during initial Hospitalization

- **Protocol for Catheter Indications & Removal**



AVF Sites in Prevalent Catheter Patients



Sands et al NKF 2001

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8. Cannulation Training / AVF Care

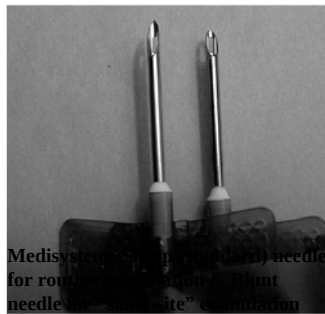
Possible specific changes:

- Facility uses best cannulators and best teaching tools to teach AVF cannulation (including "buttonhole" technique)
- Dialysis staff use specific protocols for initial dialysis treatments with new AVF's / the most skilled staff assigned to such patients
- Facility offers option of self-cannulation to patients who are interested and able

“Buttonhole” (same-site) cannulation (for AVF’s only)



Courtesy of L. Spergel, MD



Medisystem (Medisystem) needles for routine “buttonhole” cannulation

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9. Monitoring and Maintenance

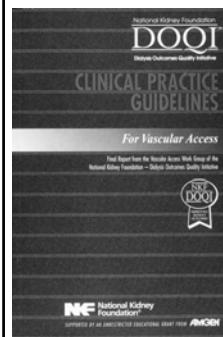
Possible specific changes:

- Nephrologists and surgeons conduct post-operative physical evaluation of AVF’s in 4 weeks to detect early signs of failure
- Facilities adopt standard procedures for monitoring, surveillance, and timely referral for the failing AVF
- Medical team adopts criteria for types and extent of intervention for access salvage

Access Monitoring & Surveillance Techniques

K/DOQI DEFINITIONS:

- **Monitoring:** routine physical examination of the access
- **Surveillance:** periodic evaluation by means of tests



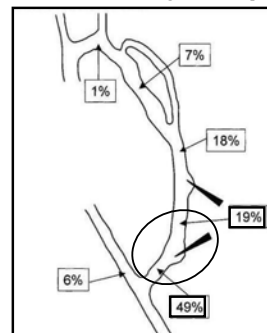
Mandatory post-op physical exam @ 4 wks., because.....

Sclerosed vein

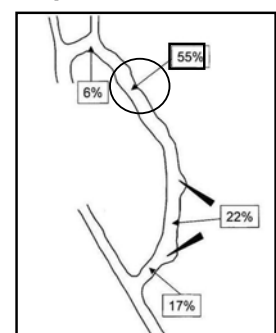
The majority of early AVF failures can be identified on physical exam alone within 4 weeks.

Location of Stenoses in Native Fistulae

Turmel-Rodrigues et al. Nephrol Dial Transplant 2000; 15:2029-2036



Forearm fistula (Cimino)



Upper arm fistula

Monthly Data Trends 2005												
Facility Name: Westview	Facility Number: 285			Division Name: Westview								
Data Element	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	DEC
Total # of Hemodialysis (HD) Patients (Pts) Census	90	91	91									
Total # of HD Patients with Diabetes	44	45	45									
% Patients with Diabetes	49%	49%	49%									
Total # of HD Patients with AV Fistula (AVF)	24	23	24									
% Patients with AV Fistula (AVF)	27%	25%	26%									
Total # of HD Patients with AV Graft (AVG)	53	60	60									
% Patients with AV Graft (AVG)	59%	66%	66%									
Total # of HD Patients with Catheter (CVC)	13	8	7									
% Patients with Catheter (CVC)	15%	9%	8%									
Facility Mean Kt/V												
Percent of Patients meeting Kt/V												
Total # of Vascular Access-related												
% VA-related Hospital Admits												
Total # of VA-related Hospital Dis												
Total # of VA Clotting Events (per												
# of Clotting Events Fistulae Pat												
% clotting events Fistula Patients												
# of Clotting Events Graft Patients												
% clotting events Graft Patients												
Total # of VA Infections												
# of Infections Fistulae Patients												
% of Infections Fistulae Patients												
# of Infections Graft Patients												
% of Infections Graft Patients												
Total # of VA-related Outpatient Events												
Total # of Missed Treatments (all reasons)												
Total # of Missed Treatments due to VA problems												
% Missed Treatments due to VA problems												
Total # of Patient Lost related to Vascular Access												
% of patients lost related to Vascular Access												

Track & Trend Performance in all areas of Vascular Access monthly--& provide feedback

FistulaFirst: Strategies to Increase Autogenous Fistulae

SUMMARY

- Establish a Vascular Access CQI program based on a Multi-Disciplinary Team approach
- Initiate an AVF Performance Improvement Initiative based on the 11 FistulaFirst Change Concepts and the K/DOQI Guidelines
- Track and Profile Outcomes

For questions related to the
FistulaFirst initiative, please contact
your local ESRD Network at:
<http://www.esrdnetworks.org/>
AND
visit the FistulaFirst Website:
<http://www.qualityhealthcare.org/IHI/Topics/ESRD/VascularAccess/>

ADDENDUM

Implementing the NVAII

Will

Ideas

Execution

- CMS is publicly committed to NVAII, including looking at key systemic issues & barriers
- National Leadership Group lends will assist with outreach to key Stakeholders
- Networks are required to be pro-active, inter-active and meet specific region-wide improvement targets
- Providers support AVF issue as a top priority

Implementing the NVAII

Will

Ideas

Execution

- The 11 change concepts draw from both research and practice, and have shown prior success:
 - Networks 1, 15, 16 have exceeded K-DOQI AVF Standards and demonstrated that AVF rates can be substantially increased
 - Dr. Vo Nguyen's practice is nearly 100% AVF
 - International examples (through DOPPs) show that high AVF rates can be achieved across a wide array of patient characteristics and co-morbidities

Implementing the NVAII

Will

Ideas

Execution

- Networks have developed initial implementation strategies, and are reaching out to their MRB's, facilities, and physicians
- Networks are linked through an "extranet" to facilitate exchange and learning
- NVAII project website is under development, including tools, resources, FAQs, improvement case studies, etc.
- Presentations at professional meetings have been scheduled and National Leadership Group will assist in reaching a wide and diverse audience