

NETWORK NEWS

2009 Special Edition
FISTULA FIRST

Fistula First - Tough Road Ahead

It's difficult to believe that we are entering into our 6th year of the Fistula First project. The nation and our Network have made great strides in increasing AVF use. Network 8 has had a 22.1 percentage point increase from the 2002 baseline (CDC Survey) to the current 48.4% prevalence (December 2008 Fistula First data). The nation has experienced a 19.2 percentage point increase, as well, with 51.6% currently using AVF. And, while many argue that the catheter rates have increased with the Fistula First Initiative, rates have remained fairly steady in Network 8. (See chart below of FF data.) Despite the improvements, we are far from the national goal of 66% AVF prevalence, with only 44% of facilities having met the Network 8 goal of 50%. Additionally, 13% of facilities are still struggling with high catheter rates ($\geq 25\%$), as "catheter cultures" have developed.

As Network 8 nears the CMS March deadline for meeting our contract AVF goal of 49.7%, we anxiously await the results. While many facilities continue with high improvement rates, the overall Network improvement rate has decreased from an average of 0.3 percentage points/month, in

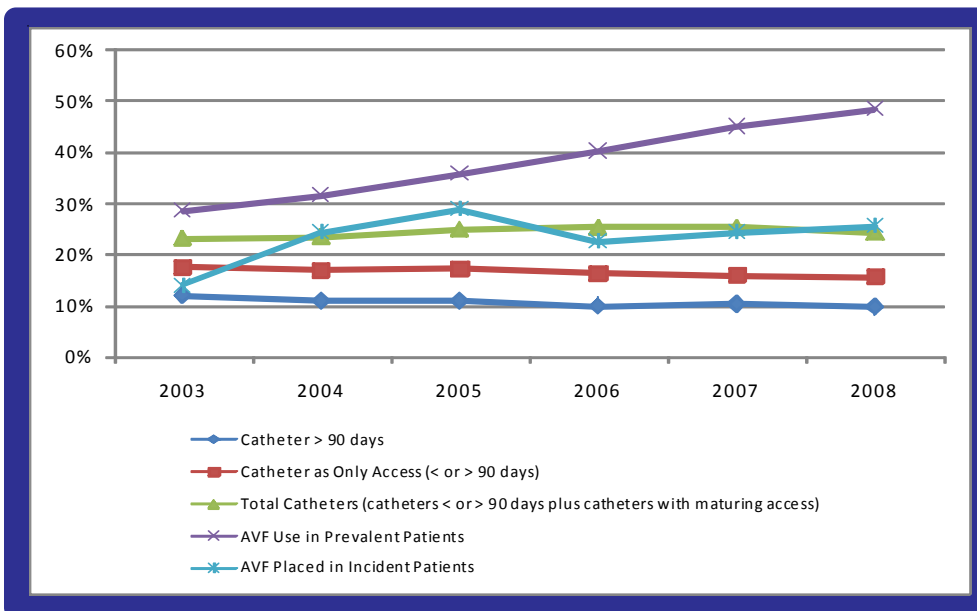
the first half of 2008, to .18 percentage points/month, in the second half.

Why the decrease? Our theory is that as higher rates are obtained, it becomes more difficult to achieve results. The low fruit has been picked. We are now in the more difficult phase. Others have theorized that dialysis facilities are now focused on implementing the new Conditions for Coverage and gearing up for CROWNWeb, having less time to focus on vascular access. We are interested in your theories and welcome you to share them with us by phone or email. Whatever the reasons, we must continue to focus on improved vascular access outcomes. If your AVF and catheter rates are not at goal, changes must be made. Actions to consider, if not already in place:

- Develop a written action plan and follow it! (CforC requirement)
- Communicate with primary care providers (PCPs), hospitals, and community health centers regarding diagnosis and treatment of CKD patients. Direct them to educational resources for patients and professionals.
- Begin patient education at first point of care – CKD clinic, hospital (utilize acute care nurses).

- Initiate discharge planning with new dialysis patients to include vascular access planning (vessel mapping, cardiac clearance and surgical evaluation).
- Communicate with radiology departments regarding proper vessel mapping procedures for vascular access.
- Communicate goals and outcomes with surgeons, assessing preferences for pre-op evaluations.
- Base surgeon referral patterns on documented outcomes.
- Appoint vascular access coordinator – HUGE improvements reported with this action.
- Provide cannulation training, revise/implement cannulation policies – (using best cannulator for new AVF, proper needle size, etc., consider buttonhole cannulation).
- Evaluate AVG and catheter patients for possible AVF – "Sleeves-up" protocol to assess for AVG outflow vein to be converted to AVF, vessel mapping of catheter patients.
- Measure outcomes of patient education and revise plan if ineffective.
- Request social worker intervention for patient non-compliance (missed appointments, refusal of permanent access placement or cannulation).
- Ask the Network for help, as needed. We can provide assistance in a number of ways, and we're only a phone call away.

Remember: Only changes in an action plan will result in changes in outcomes. The tougher road ahead will be a challenge, but by combining our efforts we can ensure each patient has the best vascular access and care possible.



2728 Data Analysis

For the third consecutive year, Network 8 recently reviewed the CMS Medical Evidence forms (2728 form) to determine the relationship of CKD care to vascular access used during first outpatient hemodialysis treatment. Forms submitted to the Network from June 1, 2007-May 31, 2008 were selected for review; however, physicians submitting less than ten forms were excluded from analysis.

Analysis revealed that 60.3% of patients initiated hemodialysis during this time period with catheter as only access, regardless of prevalence of CKD care. Catheter percentages were significantly lower in patients under care > 12 months (37.1%) when compared to those receiving no nephrology care (79.4%). AVF placement was also greater in this category. However, no improvements in incident catheter or AVF rates were seen over the previous year's analysis.

After analysis, each physician submitting 10 or more 2728 forms received a letter from the Network 8 Medical Review Board noting the vascular access in use on first outpatient

dialysis for his/her patients. The purpose of the letter was to inform and highlight the need for earlier vascular access placement—not to reprimand physicians.

Additional contacts were made with nephrologists with a high percentage of patients initiating dialysis with catheter as only access to determine root causes and possible methods of improvement. Barriers identified include:

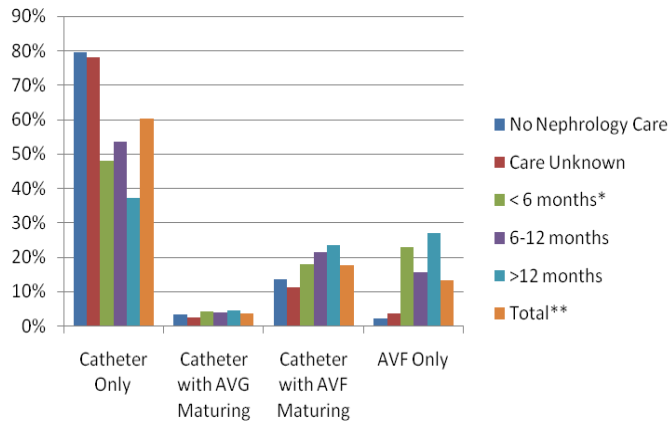
- Late or no referral prior to need for dialysis
- Patient non-compliance – failure to keep scheduled appointments with nephrologists and surgeons
- Patient denial of disease process and refusal of permanent access placement
- Lack of insurance
- Limited surgeon access
- Improper completion of 2728 form

Network support offered:

- Communication/educational efforts with primary care providers
- Communication with hospital administrators
- Patient and staff education
- Involvement of acute dialysis nurses and discharge planners in vascular access planning
- Surgeon education

Serious efforts must be made to admit as many patients as possible with permanent access placed, as facilities are experiencing the development of “catheter cultures.” As new patients see prevalent patients using catheters, they are more prone to refuse permanent access placement. If you need assistance with your vascular access improvement initiatives, please contact the Network QI department.

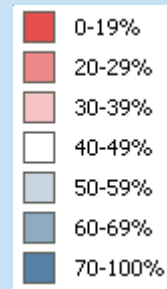
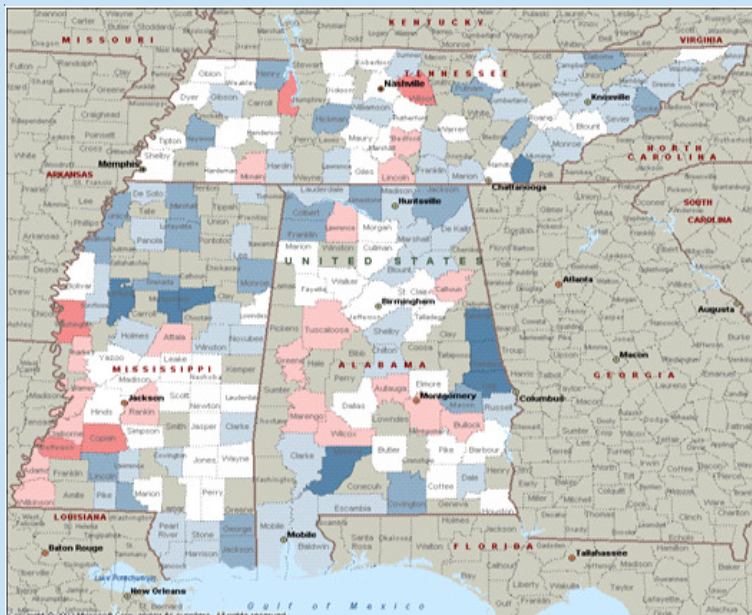
And finally, if you or one of your staff members is responsible for completing portions of the 2728 form, please make certain that you follow form directions closely and consistently. Make every effort to determine and record accurate information. If you are unfamiliar with this form, call Judy Carter at the Network office to discuss. Accurate data “up front” saves everyone time in the end.



* Category of < 6 months is not included on form, but calculated when answer “yes” to patient under care of nephrologist and no time frame selected.

**Total equals percentage of access types overall, regardless of whether patient under care of nephrologists or category of time

% AVF by County - December 2008



Vascular Access and the New Conditions for Coverage

As is well-known by most of North America, the new ESRD Conditions for Coverage became effective on October 14, 2008. To assist you with understanding and complying with the Conditions, we want to take this opportunity to focus on expectations for vascular access, which is addressed in four different sections of the Conditions.

Infection Control

1. The use of catheters for hemodialysis is the most common factor contributing to bacteremia in dialysis patients—the risk of bacteremia is seven times greater with catheter than with arteriovenous fistula (AVF).
2. Catheter insertion sites should be routinely assessed by staff at each treatment. ** State surveyor training includes instruction that this be done before treatment begins.
3. Staff should follow KDOQI Vascular Access guidelines (2006): “Airborne contaminants from both patients and staff are prevented best by the use of surgical masks when the catheter lumens or exit site are exposed. Wearing clean gloves and avoiding touching exposed surfaces further decreases the risk for infection. Aseptic technique includes minimizing the time that the catheter lumens or exit site are exposed.”
4. Facility must have a surveillance program for catheter-related infections and infections must be recorded/trended.
5. Facility must also investigate any catheter-related events leading to “life-threatening or fatal outcomes”.

Patient Assessment

Vascular access is next discussed under the patient assessment condition, which requires comprehensive interdisciplinary team assessment of patient needs. To clarify, the interdisciplinary team consists of the patient or patient’s designee, a registered nurse, a physician treating the patient for ESRD, a social worker and a dietician. Each patient must receive a comprehensive and individualized assessment which is then used to develop an individualized plan of care.

That said, what must be assessed in relation to vascular access? Per the Interpretive Guidance from CMS:

1. Each patient should be evaluated for the most appropriate type and location of vascular access, and
2. Whether or not the vascular access functions well enough to ensure adequate dialysis treatments, which may require
 - § Referral to radiologist or Interventionalist for vessel mapping prior to access placement; and/or
 - § Referral to vascular surgeon for access creation/placement

Patient Plan of Care

Once the comprehensive assessment has been completed, vascular access must then be addressed in the patient plan of care. At V550, the Conditions specifically state:

1. “The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.”

Per the Interpretive Guidance, meeting the requirement to “achieve and sustain” vascular access will necessitate that the medical record contain:

1. Documentation regarding the evaluation and rationale for the current vascular access—including “why the patient was determined to not be a candidate for a fistula” if access is not an AVF.
2. An active plan for creation/insertion of permanent vascular access if patient has been dialyzed using central venous catheter for more than 90 days OR information explaining why a catheter is the most appropriate access for the patient.

The requirements for vascular access monitoring for symptoms of stenosis, also noted in the Interpretive Guidance, specify:

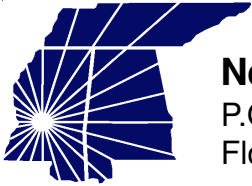
1. On-going program for vascular access monitoring: physical exam, observance of changes in adequacy or access pressures during dialysis, cannulation problems, or prolonged bleeding after needle removal. In addition, patient education should address self-monitoring of access.
2. On-going program for vascular access surveillance, such as access flow measurements, static venous pressure ratios, Doppler flow studies, or dilution-technique studies such as Transonics or CritLine™ done on a routine basis (not once in a blue moon).

Quality Assessment and Performance Improvement (QAPI)

Finally, vascular access is a component of the mandatory QAPI program for each facility. Per the Interpretive Guidance:

1. The intent of vascular access QAPI is “to improve the rate of used and preservation of fistulas; decrease inappropriate use of catheters; and finally, to improve the care provided for all types of vascular access.”
2. Specifically, the Measures Assessment Tool, an appendix to the Conditions, currently recommends:
 - < 10% patients dialyzing with cuffed catheter for > 90 days, and
 - 65% of patients dialyzing with AVF access
3. The QAPI program should include efforts to decrease catheter use and infections related to such.

More information about the Conditions of Coverage, including the entire Interpretive Guidance document and a “quick-look” synopsis of such can be found on the Network 8 website: www.esrdnetwork8.org or by contacting the QI department at 601-936-9260.



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arteriovenous

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AVF — The first choice for hemodialysis

Fistula First Recognition

The following facilities met the Network 8 Fistula First Goal of having at least 50% of prevalent patients using AVF during 4th quarter 2008. Facilities with $\geq 25\%$ prevalent patients with catheter as only access were not included. Those in bold print have met or exceeded the National Fistula First goal of 66%. Congratulations!

ALABAMA

ATHENS DIALYSIS

ATMORE DIALYSIS CENTER

BIRMINGHAM EAST DIALYSIS

BOAZ DIALYSIS

DAVITA CENTER POINT DIALYSIS

DCI PHENIX CITY

FLORENCE DIALYSIS

FMC ANDALUSIA

FMC AUBURN

FMC BAY MINETTE

FMC CAHABA VALLEY

FMC CHAMBERS

FMC CLANTON

FMC DAUPHIN ISLAND PKWY

FMC EASTERN SHORE

FMC FAIRFIELD

FMC FORT PAYNE

FMC HAMILTON

FMC HUNTSVILLE

FMC JACKSON (TOMBIGBEE)

FMC LANGDALE

FMC MAGNOLIA

FMC MOBILE

FMC MONROEVILLE (WHETSTONE)

FMC MONTCLAIR

FMC NORTH ALABAMA

FMC ODYSSEY DIALYSIS

FMC ONEONTA

FMC OPELIKA

FMC PARKWAY

FMC PCD ALEXANDER CITY

FMC PELL CITY

FMC PORT CITY

FMC PRICHARD

FMC SCOTTSBORO

FMC SYLACAUGA

FMC TOULMINVILLE

FMC TUSKEGEE

FMC WEST MOBILE

GADSDEN DIALYSIS

OZARK DIALYSIS

ROANOKE DIALYSIS CLINIC

RUSSELLVILLE DIALYSIS

SHEFFIELD DIALYSIS

SOUTH BALDWIN DIALYSIS CENTER

VA BIRMINGHAM

MISSISSIPPI

COLLINS DIALYSIS

DSI LEXINGTON

FMC ABERDEEN

FMC BAY ST LOUIS S. MS KIDNEY CTR

FMC BROOKHAVEN

FMC CLARKSDALE

FMC D'IBERVILLE

FMC EUPORA

FMC GREENWOOD

FMC GRENADA

FMC GULFPORT S. MS KIDNEY CTR

FMC HOLLY SPRINGS

FMC INDIANOLA

FMC LOUISVILLE

FMC MACON

FMC MCCOMB

FMC NEWTON

FMC OXFORD

FMC SARDIS

FMC SOUTHAVEN

FMC STARKVILLE

FMC TUNICA

FMCTUPELO

FMC WINONA

HATTIESBURG CLINIC DIALYSIS

LUCEDALE DIALYSIS

MEDICAL MALL DIALYSIS

OCEAN SPRINGS DIALYSIS

PACHUTA DIALYSIS

PEARL RIVER DIALYSIS

SILVER CREEK DIALYSIS

SINGING RIVER DIALYSIS

TYLERTOWN DIALYSIS

VA JACKSON

WIGGINS DIALYSIS

TENNESSEE

APPALACHIAN DIALYSIS CENTER

BROWNSVILLE DIALYSIS

CARRIAGE DIALYSIS

CHATTANOOGA KIDNEY CENTER

CLARKSVILLE DIALYSIS

COLLIERVILLE DIALYSIS

COOKEVILLE DIALYSIS

CROSSVILLE DIALYSIS CLINIC

CUMBERLAND DIALYSIS

DCI BEECH LAKE

DCI BROWNSVILLE

DCI DAYTON

DCI JACKSON

DCI KNOXVILLE

DCI MARYVILLE

DCI PARIS

DCI SEVIERVILLE

DCI SOUTHERN HILLS

DSI CENTRAL MEMPHIS RENAL CNTR

FMC ATHENS

FMC BRADLEY

FMC CENTERVILLE

FMC DIALYSIS ASSOC. OF SMYRNA

FMC DIALYSIS FORT SANDERS

FMC DIALYSIS NEWPORT

FMC EASTERN TENNESSEE

FMC FRANKLIN

FMC GRACELAND

FMC JOHNSON CITY

FMC MEMPHIS GERMANTOWN

FMC MEMPHIS MIDTOWN

FMC N KNOXVILLE DIALYSIS CNTR

FMC NEW MARKET

FMC OAK RIDGE

FMCTULLAHOMA

FMC WEST KNOXVILLE

FMC WINCHESTER

GALLERIA DIALYSIS

HARPETH DIALYSIS CLINIC

HUMBOLDT DIALYSIS

KNOXVILLE DIALYSIS CENTER

MANCHESTER DIALYSIS CLINIC

MCMINNVILLE DIALYSIS CLINIC

MEMPHIS EAST DIALYSIS

MORRISTOWN DIALYSIS CENTER

PICKWICK DIALYSIS

SUMNER DIALYSIS

WHITEBRIDGE DIALYSIS

Fistula First and CROWNWeb

On February 1, 2009, CMS moved, in a modified fashion, CROWNWeb from its testing environment to a production/implementation environment. CMS launched CROWNWeb to a small, select group of providers across the country—both large- and small-dialysis organizations, as well as independent dialysis facilities across the country. As a pilot Network, Network 8 has communicated directly with the dialysis facilities that will be part of phase I implementation.

Until your facility is phased in to CROWNWeb implementation, you must continue with your normal business operations and reporting requirements as usual. Facilities that are not part of the first phase of implementation may continue to meet their requirements under the ESRD conditions for coverage by continuing to use prior submission methods. **This includes monthly Fistula First data submissions via paper form or Excel spreadsheet.** **January data is due to the Network 8 office by February 20.**

Vascular access information is included in the clinical data to be entered into CROWNWeb, once your facility is phased in to the project. Additional data elements will be required, beyond those currently required for Fistula First data submission. Examples include: date access type changed, AVF usable date, and frequency/type of vascular access monitoring and surveillance, which are now required by the conditions for coverage. More information will be made available, as CROWNWeb is fully implemented.

For those of you who are not familiar with CROWNWeb (Consolidated Renal Operations in a Web-enabled Network), it is electronic data-submission software, implemented by CMS, to be used by dialysis facilities and ESRD Networks to improve data consistency, reduce complexity, and provide secured electronic data collection. The new Conditions for Coverage require that all ESRD facilities submit patient information (events, forms, and clinical data) to the Networks electronically (instead of on paper).

If you have questions regarding the CROWNWeb system, please contact the Network 8 data department.

Available Fistula First Tools

The following tools are currently available from Network 8 and the Fistula First website: www.fistulafirst.org. Please contact the Network 8 QI Department to request materials.

Nephrologist specific

- Sample letter to PCP from Nephrologist with CKD referral guidelines
- VAMP© Vascular Access Monitoring & Surveillance Flow Chart - Larry Spergel, MD
- Evaluation for secondary AVF - "Sleeves Up" policy
- Management of patient with central venous catheter algorithm
- PICC Line Recommendations http://www.fistulafirst.org/pdfs/PICC_line_7-08.pdf
- Vein Preservation Recommendations http://www.fistulafirst.org/pdfs/vein_preservation_document_7-08.pdf

Nephrologist/Surgeon/Interventionalist specific

- National Kidney Foundation Kidney Disease Outcomes Quality Initiative (K/DOQI) Clinical Practice Guidelines for Vascular Access (limited supply)
- Practitioner's Resource Guide to Hemodialysis AVFs - article by Gerald Beathard, MD
- Practitioner's Resource Guide to Physical Examination of Dialysis Vascular Access - Gerald Beathard, MD
- Autologous AVF Algorithm - Larry Spergel, MD
- Hemodialysis Access Referral Form with Access Diagram

Surgeon/Interventionalist specific

- CD/DVD set: Creating AVF in All Eligible Hemodialysis Patients - William Jennings, MD & Larry Spergel, MD (limited supply)
- Vascular Access Intervention Reporting Tool
- Procedure for Duplex of Upper Extremity Vessels Prior to AVF Surgery - Chris Griffith, MD, James Reus, MD, Kevin Robinson, MD, Richard Krug, MD, Diane Seagroves, RVT, Memorial Nephrology Associates - Vo Nguyen, MD, Olympia, WA
- Interventionalist Education and Resources Outline http://www.fistulafirst.org/professionals/interventionalist_education.php
- Management of Cephalic Arch Stenosis PowerPoint presentation http://www.fistulafirst.org/pdfs/TFSAAD_Cephalic_Arch_Stenosis.pps

Dialysis Staff specific

- Fistula First Toolkit
- Cannulation Camp - article by Debbie Brouwer, RN, CNN
- Fistula First Cannulation DVD (video and tools) - also available on the Fistula First website
- MediSystems Constant Site (Buttonhole) Cannulation video and materials
- Buttonhole Technique Materials for staff and patients - developed by Lynda Ball, BSN, RN, CNN, Northwest Renal Network (Network 16)
- Understanding Your Hemodialysis Access Options - patient booklet from AAKP
- FAQ Brochure for Patients and Families http://www.fistulafirst.org/pdfs/FF_Patient_FAQ_Broch-fistula-08.pdf

All

- Patient Assessment Videos:
Secondary AVF: http://www.fistulafirst.org/videos/spergel_assessment.php
Upper arm AVF: http://www.fistulafirst.org/videos/beathard_assessment.php
Forearm AVF: http://www.fistulafirst.org/videos/asif_assessment.php

2009 Fee Schedule Includes 30% Increase in RVU's for AVF Surgical Code 36821!

CMS recently announced a 30% increase in RVU's for AVF surgical code 36821 (AV fusion direct any site), with the publication of the 2009 Physician Fee Schedule. The information can be found in the Federal Register/Vol. 73, No. 224, published Wednesday, November 19, 2008, on page 70007, using the link below:

<http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf>

A reliable source has said that this increase will make reimbursement equivalent to but not higher than that for insertion of AV graft.

Network 8, Inc., a CMS contractor, is the quality improvement organization serving the dialysis and transplant centers in Alabama, Mississippi, and Tennessee. For more information regarding the Fistula First initiative or other Network 8 services, contact Ann Pridgen, RN, CDN, Quality Improvement Director.



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