The 3Ps of Vascular Access Success

P - Prevent Catheter
P - Place and Use Fistula
P - Preserve Fistula
Agenda for Today’s Call

Part 1: Introduction to the 3Ps Project

Part 2: QI Approach

Part 3: Using the 3Ps Handbook

Part 4: What The Network Expects

Part 5: Open Discussion
Introduction to the 3Ps Project

The “3Ps of Vascular Access Success” handbook was developed in support of our Vascular Access Improvement Initiatives.
Introduction to the 3Ps Project

The initial purpose of the handbook was to pull together best practices, useful tools, and other resources that currently exist.
Introduction to the 3Ps Project

The best practices and tools were grouped by themes:

• Prevent Catheter
• Place and Use Fistula
• Preserve Fistula

www.esrdnetwork4.org/3p
www.therenalnetwork.org/qi/3Ps.php

“The 3Ps of Vascular Access Success”

The Renal Network, Inc.
ESRD Networks 4, 9 & 10
Introduction to the 3Ps Project

It is expected that this project will grow as more best practices are identified.

If something is working for you, submit it to the Network office.
Quality Improvement

Our approach to quality improvement in healthcare needs to be focused on identifying areas for change, creating change, and measuring change.
IHI Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in an improvement?
<table>
<thead>
<tr>
<th>QA</th>
<th>Quality Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A process of measuring health outcomes by tracking and analyzing quality indicators on an ongoing basis. Analyze facility processes to identify barriers to achieving desired outcomes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PI</th>
<th>Performance Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development and initiation of facility processes of care and operations that include elements that must positively affect the desired outcomes.</td>
<td></td>
</tr>
</tbody>
</table>
Quality improvement in healthcare needs to be focused on identifying areas for change, creating change, and measuring change.
“Change is a departure from an existing process or way of doing something, to a new process or a different way of doing the same thing.”

Exekiel Oseni, CISA, ACA, ACIP, ACS
Change Management in Process Change
Volume 1, 2007
Creating Change

- Evaluate processes
  People, Policies, Procedures, Equipment
- Determine barriers to change
- Identify ways to overcome barriers
- Seek out best practices
- Create environment of collaboration
Using the **TEAM** to Drive Improvement

- Multidisciplinary
- Common Goal
- Day-to-Day Knowledge
- Physician Buy-in
The Interdisciplinary Team

- Medical Director
- Nurse Manager
- Dietitian
- Social Worker
- Biomed Tech
- Others
  - Other Nephrologists(?)
  - Surgeon
  - Staff members including PCTs
Process Change

- People
- Policy
- Procedure
- Equipment
Developing Your QAPI Plan

- Identify strategies
- All team members need to have a role
- Someone needs to be accountable and in charge
- Tasks need to be assigned and dates set to re-evaluate
- Plan needs to be dynamic … needs to be reviewed at least monthly
“How will we know a change is an improvement”

Collect and Trend Data

- Identify sources of data
- Review and trend data monthly
- Analyze by various characteristics
- Draw conclusions with the team
Evaluate and Re-evaluate

- Review plan regularly
- Use data to determine:
  - Are we improving?
  - Are we seeing unintended consequences?
  - Does the plan need revision?
  - Should we bring others to the team, and if so, who is the best person to help?
“What do you do at the end?”

Evaluate!

- Did we achieve our overall goal?
- If no, why not?
- If no, what new strategies can we develop and try?
- If yes, make it a permanent change.
- Are there best practices we can adopt?
- Are there additional resources we need?
- Are there new partners we can bring to the team?
Quality Assessment

- A process of measuring health outcomes by tracking and analyzing quality indicators on an on-going basis.

- Analyze facility processes to identify barriers to achieving desired outcomes.
Quality Assessment with Planned Change leads to Performance Improvement

Part 2
Using 3Ps – Getting Started

Understand Your Current Population
• **Tool T49**, Page 101
  “Vascular Access Data Collection Tool”

Understand Your Barriers
• **Tool W34**
  “QAPI Vascular Access Barriers Questionnaire”

Seek Best Practices (using handbook)
• Tools available in book and on-line

Use rapid-cycle quality improvement techniques
• **Tool T50**, Page 102
  “PDSA Worksheet”
Using 3Ps – Example

“My unit has a lot of catheters, what can I do now?”

Develop a Protocol for Catheter Indications and Removal

Nephrologists should make every effort not to admit "catheter only" patients without a permanent access plan to the clinic. Require "catheter only" patients' nephrologists to document a plan for permanent access. Once patients arrive in the unit with a catheter only, they become part of the "catheter culture" and it becomes very difficult to counsel them to change.

Recommended tools:
- Vascular Access Poster and Cards (T7, Pages 30-31)
- Catheter Evaluation Tool (T8, Page 32-33)
- Catheter Reduction Tool for Facilities (T9, Page 34)
- Project: Cath-Out (T10, Page 35)
- 90-Day Count Down! Planning for Catheter Removal! (T11, Page 36)
- Catheter Assessment Algorithm (T12, Page 37)
- CVC Management Flowchart (T13, Page 38)
- CVC Tracking Tool (T14, Page 39)
- Reducing CVC Infections Diagram (T20, Page 46)
- Change Concept 7 (T43, Page 95)
- Fistula Fast Track What To Do When Fistula Was Not First (W33)
Using 3Ps – Example

### 90-day Count Down! Planning for Catheter Removal!

Use a form for each catheter patient and review during monthly CQI meetings.

<table>
<thead>
<tr>
<th>Patients Name:</th>
<th>OK</th>
<th>CAUTION</th>
<th>ALERT!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Member Assigned:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter Placement Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Catheter Removal Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Directions:** Select the reason(s) below that best justify the continued use of this catheter and place the corresponding letter in the date column(s) to the right.

A. A new permanent access is maturing (access has not yet been used routinely for dialysis) (Circle) AVF AVG Comment:

B. A living donor transplant has been scheduled

C. The patient is in PD Training; PD imminent

D. A temporary catheter while patient’s permanent access is revised/decotted to be used again

E. The patient has no other viable sites for a permanent access

F. The patient is not medically suitable at this time for a permanent access

Comment:

G. Surgery for permanent access has been scheduled within 30 days.

Access type: 

Hospital: 

Surgeon: 

Date:

H. The patient has a referral scheduled with the surgeon within the next 30 days

Surgeons Name: 

Appointment Date & Time:

I. The patient had a referral with the surgeon for a permanent access, but failed to keep appointment

Surgeons Name: 

Reason: 

Was appointment Rescheduled?

J. The patient is a candidate for a permanent access, needs referral and has not yet had one. Will Refer to surgeon. (Name):

K. The patient is a candidate for a permanent access and needs referral to surgeon, but refuses to go. The medical director will speak to the patient.

L. The patient is a candidate for a permanent access, but refuses to have a permanent access placed. The medical director will speak to the patient.

M. The patient was not assessed this month (i.e., hospitalized all month or receiving dialysis at other unit). Follow-up Plan:

N. Other:
Using 3Ps – Example

“I want to try more Self-Cannulation Techniques at my unit to empower our patients.”
Using 3Ps – Example

**The 3Ps of Vascular Access Success**

The 3Ps handbook was designed to guide your hemodialysis vascular access improvement efforts and change existing practices through Quality Assessment and Performance Improvement (QAPI) projects. This handbook brings together a number of best practice concepts and suggested tools in support of those concepts.

All dialysis facilities in The Renal Network will receive a hardcopy handbook through the mail after September 6, 2011.

**WebEx Learning Session – “3Ps for Vascular Access Success” Program Launch Presentation**

Select the date that works best for you. The same presentation will be provided on both days.

- **Monday, September 27, 2010**
  - Noon – 1 pm Eastern
- **Thursday, September 30, 2010**
  - Noon – 1 pm Eastern

*Please enroll at least one day prior to the date of the event to ensure receipt of your confirmation email. Please do not wait until the day of the event to enroll.***

**Enrollment Instructions**
1. **Open Internet Explorer**
2. Go to [https://www.w3.org](https://www.w3.org)
3. Log in to the event 3Ps for Vascular Access Success on Monday, September 27, 2010 – 12:00-1:00 p.m. EDT or Thursday, September 30, 2010 – 12:00-1:00 p.m. EDT
4. Click on the “Enroll” button to the right of the event title.
5. Enter the required information and submit.
6. Immediately upon submission of this information, you will receive an email with detailed instructions for joining the meeting.
7. If you experience any difficulties enrolling in joining the event, please contact the JMC/WAVES Helpdesk at (815) 440-8555.

**Handbook Tools**

- **Handbooks**
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)
  - 3Ps for Vascular Access Success (PDF, size: 40 KB)

**Full national release on Late Spring 2011**
Using 3Ps – Example

Part 3

Using ‘Tandem Hand’ Technique to Facilitate Self-Cannulation in Hemodialysis

Stuart Mott
Harold Moore

It is generally established that self-cannulation extends the life expectancy of the native arteriovenous fistula (AVF) (Hakim and Himmelfarb, 1998; Heber, Carter, Carter, & Soper, 2005; Mohlin, 1995; Perera et al., 2004; Remi et al., 2002), associated with fewer complications (Hakim and Himmelfarb, 1998; Heber et al., 2005; Mohlin, 1995; National Kidney Foundation [NKF], 2004; Perera et al., 2004; Remi et al., 2005). The use of the buttonhole technique was first reported some 30 years ago (Twardowski & Kubara, 1973; Twardowski, Lebcek, & Kubara, 1977). But it has not been significantly utilized in the U.S. The buttonhole technique is particularly attractive for self-cannulation and has been recommended in the NKF’s Kidney Disease Quality Initiative (KDQI) guidelines (2000) as the method of choice for self-cannulators. This article discusses a method found by the authors' success in teaching patients to self-cannulate.

The Tandem Hand Technique

Phase 1

The patient is instructed in learning to self-cannulate needs to be assigned to a vascular access nurse or physician who will supply information relative to self-cannulation and direct both the patient the benefits and possible problems relative to the process of self-cannulation.

Phases 1

Using ‘Tandem Hand’ Technique to Facilitate Self-Cannulation in Hemodialysis

Stuart Mott
Harold Moore

I t is generally established that self-cannulation extends the life expectancy of the native arteriovenous fistula (AVF) (Hakim and Himmelfarb, 1998; Heber, Carter, Carter, & Soper, 2005; Mohlin, 1995; Perera et al., 2004; Remi et al., 2002), associated with fewer complications (Hakim and Himmelfarb, 1998; Heber et al., 2005; Mohlin, 1995; National Kidney Foundation [NKF], 2004; Perera et al., 2004; Remi et al., 2005). The use of the buttonhole technique was first reported some 30 years ago (Twardowski & Kubara, 1973; Twardowski, Lebcek, & Kubara, 1977). But it has not been significantly utilized in the U.S. The buttonhole technique is particularly attractive for self-cannulation and has been recommended in the NKF’s Kidney Disease Quality Initiative (KDQI) guidelines (2000) as the method of choice for self-cannulators. This article discusses a method found by the authors’ success in teaching patients to self-cannulate.

The Tandem Hand Technique

Phase 1

The patient is instructed in learning to self-cannulate needs to be assigned to a vascular access nurse or physician who will supply information relative to self-cannulation and direct both the patient the benefits and possible problems relative to the process of self-cannulation.

Stuart Mott, MD, BS, MPH, is a Reader in Medicine, University of Oxford, Oxford, UK, and a member of Britain’s Clinical Research Council.

Harold Moore, MA, BA, BS, PhD, is a Research Associate, Division of Nephrology, School of Medicine, University of Massachusetts, Boston, MA.

The views expressed in this article do not necessarily reflect the views or policies of the Department of Health and Human Services, or any organization or agencies employed by the U.S. Government. The authors assume full responsibility for the contents and conclusions reached in this article, which is a direct result of the Health Care Quality Improvement Program initiated by the Center for Medicare & Medicaid Services, which has managed the identification of quality improvement projects derived from analysis of patient care, and hospital reported spinal data. The findings on the part of the investigators may not be generalizable.

Fistula First: Vascular Access Update

Lynda Ball, Contributing Editor

Using ‘Tandem Hand’ Technique to Facilitate Self-Cannulation in Hemodialysis

Stuart Mott
Harold Moore

It is generally established that self-cannulation extends the life expectancy of the native arteriovenous fistula (AVF) (Hakim and Himmelfarb, 1998; Heber, Carter, Carter, & Soper, 2005; Mohlin, 1995; Perera et al., 2004; Remi et al., 2002), associated with fewer complications (Hakim and Himmelfarb, 1998; Heber et al., 2005; Mohlin, 1995; National Kidney Foundation [NKF], 2004; Perera et al., 2004; Remi et al., 2005). The use of the buttonhole technique was first reported some 30 years ago (Twardowski & Kubara, 1973; Twardowski, Lebcek, & Kubara, 1977). But it has not been significantly utilized in the U.S. The buttonhole technique is particularly attractive for self-cannulation and has been recommended in the NKF’s Kidney Disease Quality Initiative (KDQI) guidelines (2000) as the method of choice for self-cannulators. This article discusses a method found by the authors’ success in teaching patients to self-cannulate.

The Tandem Hand Technique

Phase 1

The patient is instructed in learning to self-cannulate needs to be assigned to a vascular access nurse or physician who will supply information relative to self-cannulation and direct both the patient the benefits and possible problems relative to the process of self-cannulation.

Stuart Mott, MD, BS, MPH, is a Reader in Medicine, University of Oxford, Oxford, UK, and a member of Britain’s Clinical Research Council.

Harold Moore, MA, BA, BS, PhD, is a Research Associate, Division of Nephrology, School of Medicine, University of Massachusetts, Boston, MA.

The views expressed in this article do not necessarily reflect the views or policies of the Department of Health and Human Services, or any organization or agencies employed by the U.S. Government. The authors assume full responsibility for the contents and conclusions reached in this article, which is a direct result of the Health Care Quality Improvement Program initiated by the Center for Medicare & Medicaid Services, which has managed the identification of quality improvement projects derived from analysis of patient care, and hospital reported spinal data. The findings on the part of the investigators may not be generalizable.

Fistula First: Vascular Access Update

Lynda Ball, Contributing Editor

Using ‘Tandem Hand’ Technique to Facilitate Self-Cannulation in Hemodialysis

Stuart Mott
Harold Moore

It is generally established that self-cannulation extends the life expectancy of the native arteriovenous fistula (AVF) (Hakim and Himmelfarb, 1998; Heber, Carter, Carter, & Soper, 2005; Mohlin, 1995; Perera et al., 2004; Remi et al., 2002), associated with fewer complications (Hakim and Himmelfarb, 1998; Heber et al., 2005; Mohlin, 1995; National Kidney Foundation [NKF], 2004; Perera et al., 2004; Remi et al., 2005). The use of the buttonhole technique was first reported some 30 years ago (Twardowski & Kubara, 1973; Twardowski, Lebcek, & Kubara, 1977). But it has not been significantly utilized in the U.S. The buttonhole technique is particularly attractive for self-cannulation and has been recommended in the NKF’s Kidney Disease Quality Initiative (KDQI) guidelines (2000) as the method of choice for self-cannulators. This article discusses a method found by the authors’ success in teaching patients to self-cannulate.

The Tandem Hand Technique

Phase 1

The patient is instructed in learning to self-cannulate needs to be assigned to a vascular access nurse or physician who will supply information relative to self-cannulation and direct both the patient the benefits and possible problems relative to the process of self-cannulation.

Stuart Mott, MD, BS, MPH, is a Reader in Medicine, University of Oxford, Oxford, UK, and a member of Britain’s Clinical Research Council.

Harold Moore, MA, BA, BS, PhD, is a Research Associate, Division of Nephrology, School of Medicine, University of Massachusetts, Boston, MA.

The views expressed in this article do not necessarily reflect the views or policies of the Department of Health and Human Services, or any organization or agencies employed by the U.S. Government. The authors assume full responsibility for the contents and conclusions reached in this article, which is a direct result of the Health Care Quality Improvement Program initiated by the Center for Medicare & Medicaid Services, which has managed the identification of quality improvement projects derived from analysis of patient care, and hospital reported spinal data. The findings on the part of the investigators may not be generalizable.

Fistula First: Vascular Access Update

Lynda Ball, Contributing Editor

Using ‘Tandem Hand’ Technique to Facilitate Self-Cannulation in Hemodialysis

Stuart Mott
Harold Moore

It is generally established that self-cannulation extends the life expectancy of the native arteriovenous fistula (AVF) (Hakim and Himmelfarb, 1998; Heber, Carter, Carter, & Soper, 2005; Mohlin, 1995; Perera et al., 2004; Remi et al., 2002), associated with fewer complications (Hakim and Himmelfarb, 1998; Heber et al., 2005; Mohlin, 1995; National Kidney Foundation [NKF], 2004; Perera et al., 2004; Remi et al., 2005). The use of the buttonhole technique was first reported some 30 years ago (Twardowski & Kubara, 1973; Twardowski, Lebcek, & Kubara, 1977). But it has not been significantly utilized in the U.S. The buttonhole technique is particularly attractive for self-cannulation and has been recommended in the NKF’s Kidney Disease Quality Initiative (KDQI) guidelines (2000) as the method of choice for self-cannulators. This article discusses a method found by the authors’ success in teaching patients to self-cannulate.

The Tandem Hand Technique

Phase 1

The patient is instructed in learning to self-cannulate needs to be assigned to a vascular access nurse or physician who will supply information relative to self-cannulation and direct both the patient the benefits and possible problems relative to the process of self-cannulation.

Stuart Mott, MD, BS, MPH, is a Reader in Medicine, University of Oxford, Oxford, UK, and a member of Britain’s Clinical Research Council.

Harold Moore, MA, BA, BS, PhD, is a Research Associate, Division of Nephrology, School of Medicine, University of Massachusetts, Boston, MA.

The views expressed in this article do not necessarily reflect the views or policies of the Department of Health and Human Services, or any organization or agencies employed by the U.S. Government. The authors assume full responsibility for the contents and conclusions reached in this article, which is a direct result of the Health Care Quality Improvement Program initiated by the Center for Medicare & Medicaid Services, which has managed the identification of quality improvement projects derived from analysis of patient care, and hospital reported spinal data. The findings on the part of the investigators may not be generalizable.
Both Network offices (Pittsburgh and Indianapolis) are using the 3Ps handbook for very similar Vascular Access Utilization projects, but it is important to note the different timelines, goals and documentation requirements.
ESRD Network 4

a. Catheter Reduction QIP
b. Improve AV Fistula Rate QIP
c. Promising Stars Focus Group
d. Change Drivers
NW4: Catheter Reduction QIP

WHY?

KDOQI guidelines: < 10% chronic catheter rate

- Lower blood flow rates as compared to AV fistulae or graft
- Decreased clearance of toxins
- Decreased adequacy of the dialysis
- Systemic and local infections occur more often
- The catheter associated mortality rate catheters is 1.5 times higher than those patients with AV fistulae or grafts
NW4: Catheter Reduction QIP

Goals:
• To decrease the number of dialysis facilities with a chronic catheter rate ≥ 25%
• To decrease the total number of patients using a chronic catheters by 3%

(chronic catheter = catheter in use for 90 or more days)

Facility selection criteria:
• Chronic catheter rate ≥ 25%
• Facility census (March 2010) ≥ 30 patients
• Not selected for any other QIP

22 facilities selected in this QIP
**NW4: Catheter Reduction QIP**

**Expectations**

- Attend a Vascular Access Learning Session (example: November 4 in Philly)

- Use the “3Ps of Vascular Access Success” handbook to guide your efforts

- Submit a Root Cause Analysis (5 Why’s) by September 30th
NW4: Catheter Reduction QIP

Expectations

- Submit an Action Plan by September 30th (with updates provided quarterly)

Fax completed form by September 30, 2010 to David Moskovitz at 412-325-1811 or email to dmoskovitz@nw4.esrd.net
NW4: Catheter Reduction QIP

Expectations

✓ Submit the Monthly Incident Patient Tracking Tool by the 10th of each month (September’s data is due by October 10th, etc)
NW4: Improve AV Fistula Rate QIP

WHY?

CMS implemented a high priority goal of 66% AV Fistula rate across the nation.
NW4: Improve AV Fistula Rate QIP

Goal:

• To increase the number of dialysis facilities with a poor AV Fistula rate by four-percentage points by March 2011.

Facility selection criteria:

• AVF rate < 55%
• Facility census (March 2010) ≥ 30 patients
• Not selected for any other QIP

80 facilities selected in this QIP
NW4: Improve AV Fistula Rate QIP

Expectations

✓ Attend a Vascular Access Learning Session (example: November 4 in Philly)

✓ Use the “3Ps of Vascular Access Success” handbook to guide your efforts

✓ Submit a Root Cause Analysis (5 Why’s) by September 30th

5 Whys- Root Cause Analysis Form – CATHETER REDUCTION

Facility Name: ________________________________
Provider Number: ________________________________
Date: ________________________________
Project Contact Name: ________________________________
Email Address: ________________________________

Possible Causes of High Catheter Rates:

• Too many catheters only less than 90 days (too many incident catheters)
• Too many catheters only >90 days
• Too many non-maturing AVF’s
• Other

1. Why is the facility catheter rate too high? Because

2. Why

3. Why

4. Why

5. Why

Action to be taken - See Action Plan

Part 4
NW4: Improve AV Fistula Rate QIP

Expectations

✓ Submit an Action Plan by September 30th
(with updates provided quarterly)
NW4: Improve AV Fistula Rate QIP

Expectations

✓ Submit the Monthly Incident Patient Tracking Tool by the 10th of each month (September’s data is due by October 10th, etc)

*Incident patient= brand new to dialysis (not transient)
WHY?

CMS implemented a high priority goal of 66% AV Fistula Rate across the nation.

We believe those units that are performing well can do even better.
NW4: Promising Stars Focus Group

**Goal:**
- To increase and sustain the number of dialysis facilities that meet the target of 66% AV Fistula Rate.

**Facility selection criteria:**
- AVF rate between 55% and 64%
- Facility census (March 2010) $\geq$ 30 patients
- Not selected for any other QIP

52 facilities selected in this Group
Promising Stars Focus Group

Expectations

- Attend a Vascular Access Learning Session (example: November 4 in Philly)
- Use the “3Ps of Vascular Access Success” handbook to guide your efforts
Pick one new process/tool from the 3Ps book and implement in your facility

Report on that process quarterly (using the Process Implementation form) – first report due Nov. 1, 2010
NW4: Change Drivers

WHY?

It is important for all units, even those NOT selected in a QIP, to continue to strive toward and sustain the CMS goal of a 66% AV Fistula Rate.
NW4: Change Drivers

Goal:
- Continue commitment in achieving the 66% fistula rate, preserving AVF, and reducing catheter usage.

Facility selection criteria:
- Patient census (March 2010) < 30 patients
- Not selected for any other QIP
- Fistula rate may be > 64%

121 facilities selected in this Group
NW4: Change Drivers

Expectations

✓ Encouraged participation in a Vascular Access Learning Session (example: November 4 in Philly)

✓ Please consider using the “3Ps of Vascular Access Success” handbook and try something new.
ESRD Networks 9 & 10

AVF Facility Goals

March 2010 to March 2011
Individual facility AVF rate increases by 4-percentage points

Interim Goals

Monthly = increase by at least 0.33 percentage point
Quarterly = increase by at least 1.0 percentage point
ESRD Networks 9 & 10

a. Catheter Reduction QIP

b. Fistula Improvement QIP

c. Promising Stars Focus Group

d. All Other Facilities
NW9/10: Catheter Reduction QIP

Facility selection criteria:
- March 2010 AVF Rate of < 55% and Catheter Rate > 27%
- Total patients ≥ 30
  
  (catheter rate = all catheters in use, i.e. short and long-term)

Expectations:
- Complete and return the “5 Whys” root cause analysis and action plan by July 15, 2010
- Submit quarterly action plan updates to Network 9/10 – Due October 15
- Attend a learning session: Cincinnati Symposium, October 1-2 or Network Learning Session, Philadelphia, November 4
- Attend Network WebEx and conference calls as announced
- Review the 3Ps of Vascular Access Success Handbook with QAPI Team
- Report on action plans if new processes/tools are utilized
NW9/10: Fistula Improvement QIP

Facility selection criteria:
• March 2010 AVF Rate of < 55%
• Total patients ≥ 30

Expectations:
• Complete and return the “5 Whys” root cause analysis and action plan by July 15, 2010
• Submit quarterly action plan updates to Network 9/10 – Due October 15
• Attend a learning session: Cincinnati Symposium, October 1-2 or Network Learning Session, Philadelphia, November 4
• Attend Network WebEx and conference calls as announced
• Review the 3Ps of Vascular Access Success Handbook with QAPI Team
• Report on action plans if new processes/tools are utilized
Facility selection criteria:
- March 2010 AVF Rate of 55-62%
- Total patients ≥ 30

Expectations:
- Review the 3Ps of Vascular Access Success Handbook with QAPI Team
- Choose a new process/tool to put into use and report to the Network by October 15, 2010
- Submit quarterly updates on the success of the new processes put into place
- Take part in educational opportunities made available
NW9/10: All Other Facilities

Expectations:
- Review the 3Ps of Vascular Access Success Handbook with QAPI Team
- Consider utilizing new processes/tools as needed
- Attend Network WebEx and conference calls
- Take part in educational opportunities made available
THANK YOU!

The Renal Network, Inc.
ESRD Networks 4, 9 & 10

Network 4:  PA & DE
Suzanne Kirschbaum, RN, CNN
Director of Quality Improvement
(412) 325-2250
skirschbaum@nw4.esrd.net

David Moskovitz, RN
Community Outreach/QI Coord.
(412) 325-2250
dmoskovitz@nw4.esrd.net

Networks 9/10: IL, IN, KY & OH
Raynel Wilson, RN, CNN, CPHQ
Quality Improvement Director
(317) 257-8265
rkinney@nw10.esrd.net

Cindy Miller, RN, CPHQ
Quality Improvement Coordinator
(317) 257-8265
cmiller@nw10.esrd.net