

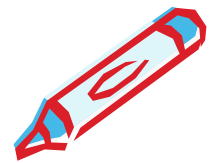


Vascular access Management

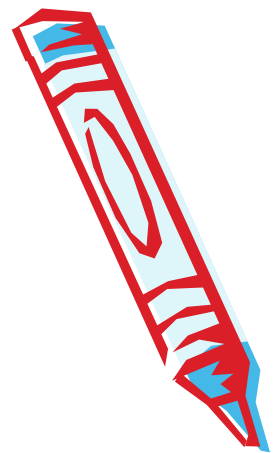
The Role of the Coordinator
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MetroHealth



History of Vascular Access Management at MetroHealth



- Each individual Nephrologist wrote the referral and had to follow through with the referral to make it happen
- No central collection/management of the information about the access plan and no statistical analysis
- No central management handling access interventions (every HD unit for themselves)



Wants and Needs of the Dept



- Physicians were asked what they wanted individually and what they wanted as a group prior to hiring a vascular access coordinator.
- The greatest need was a centralized management process.



Development of the Position



- Lots of changes through this last 2 yrs
- Prior to this position it was individually physician driven,
- No central collection point, there was an RN that assisted but not centrally coordinated
- No one person making sure that procedures and orders were carried out



Problems before the Coordinator



- Vascular Surgery dept. was no longer printing any referrals for services.
- The referring dept was to call after the request and setting up the appointments.
- Nephrology division didn't realize this change happened so they didn't understand why the referrals were not being addressed



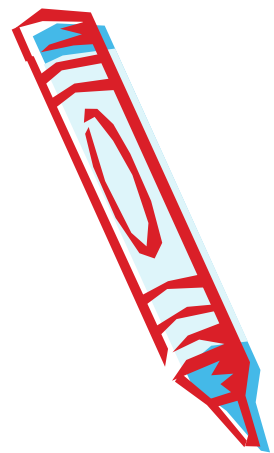
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- Interventional Radiology referrals were handled by each individual HD unit.
- Poor communication with the MD when there was an access problem because it was unit driven
- Interventions not done as timely as needed.



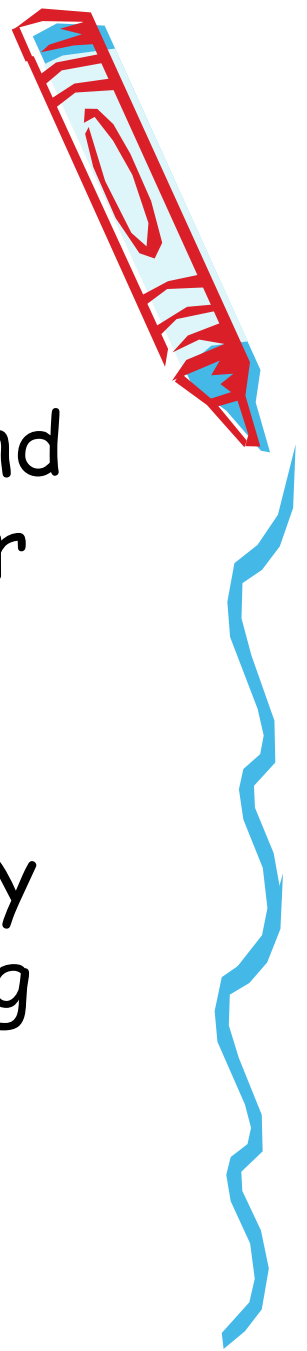
Everyone for themselves

- The doctors trying to handle the education component and making sure the pt attended the CKD class
- Each individual doc monitoring for each point of access planning
- Each Dialysis unit had someone different handling the interventions and referrals
- No Metro driven collection of data about the pts and their progress with access planning or interventions of problems

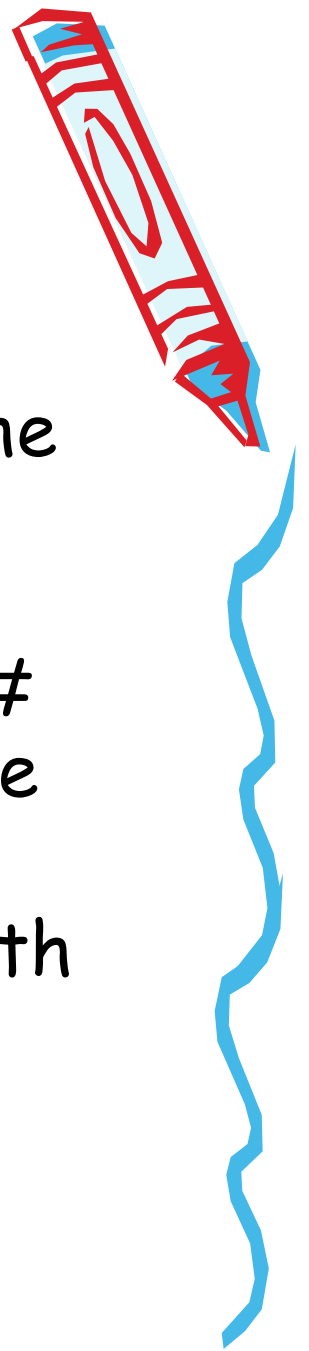


Vascular Coordinator/NP

- All requests for vascular access and planning begin with the coordinator to facilitate the process
- Development of relationships with the Vascular Surgery and Radiology to speed up the process by knowing who to call and when.



First Steps to Access planning.

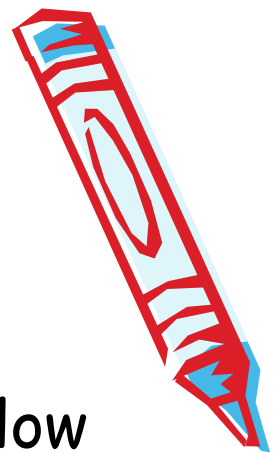


- Vascular planning starts with sending the pt to the CKD class so they are more informed of their choices.
- Schedule of the class + contact phone # given to each pt, and then a f/u with the educator + attendance compliance
- Collecting the data about compliance with attendance.



Vascular access requests

- Orders for vein mapping as the pt dropped below 30 GFR, or as soon as the NP is notified of a new start with a catheter
- And/or a vascular surgery assessment ordered to plan for the appropriate access, AVF vs. AVG
- Vein saving technique taught to the pt by vascular as well as the Nephrology providers
- Getting the surgery done as soon as needed



Other Access interventions

- The dialysis units were instructed to send to the coordinator reports about the transonic assessments especially if there seemed to be a significant change.



Continued

- The nursing staff of all HD units were instructed to contact the coordinator if there was an access failure. She would then set up the appropriate care with Interventional Radiology.



Developing communication with Radiology



- What phone # to call was the first step and who are you talking to.
- Feel free to ask the radiologist what they think needs to be done.
- Send the pt back to vascular if interventions become too freq.



The Vascular Surgeon

- Knowing who to call for the appointment, making sure the referral is has appropriate information, and a follow up communication tool for them to send you a report after the assessment.



Nephrology Adm. Assistant



- Need for a competent secretary who can assist the coordinator with the administrative tasks i.e.: phone, fax, collection of pt data
- Develop a written guide of information that others can follow
- Taking time to teach and provide written resources for support.



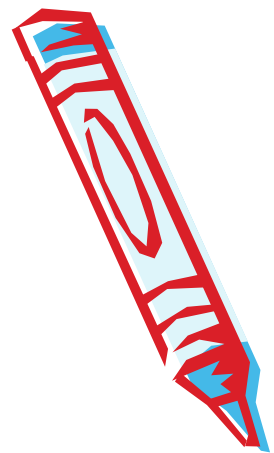
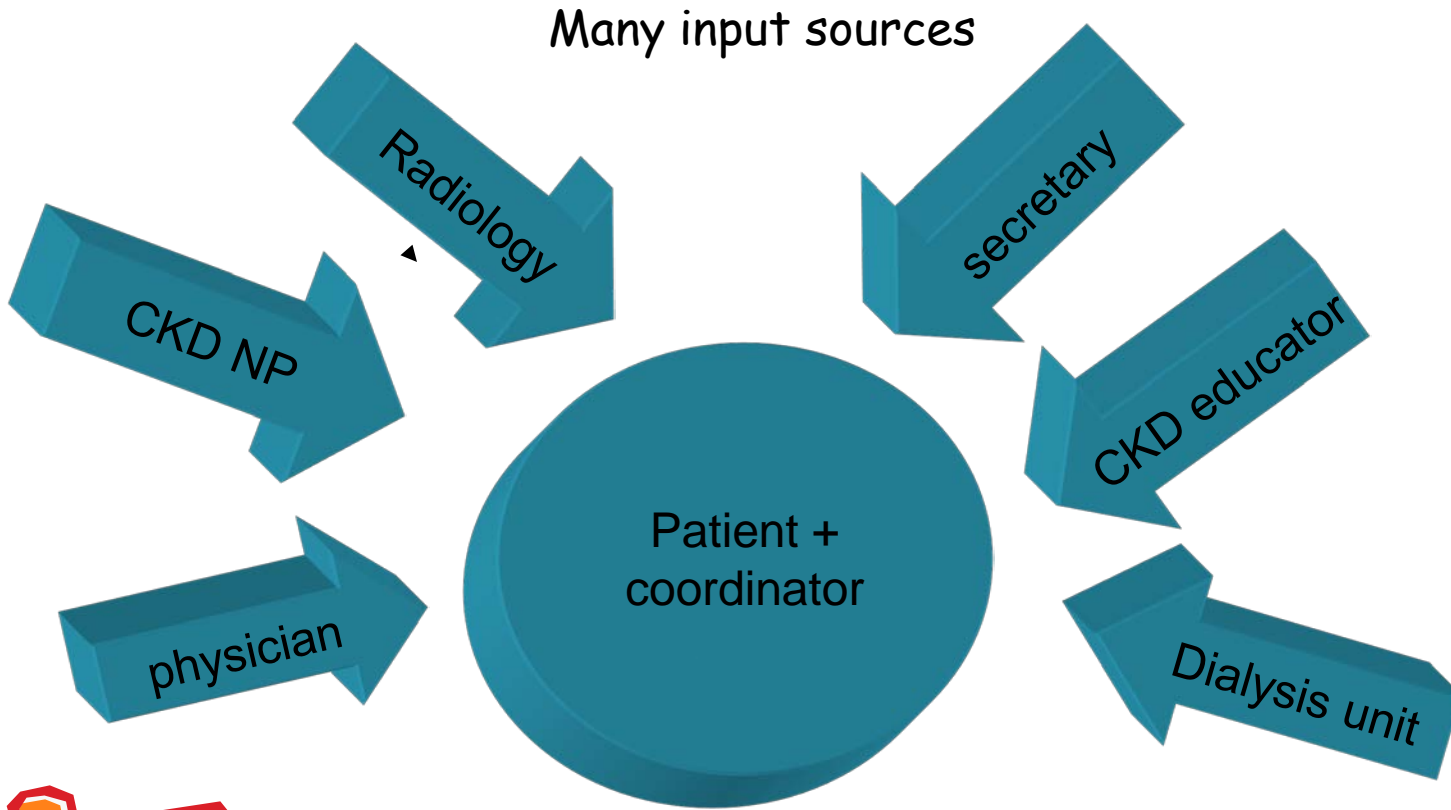
The Patient



- Early education = the pt understands their choices and the process
- Support for those pts that are getting close to the time for HD = they are more able to accept that next step.
- Teaching the pt about their AVF or AVG = they can report when there is a problem



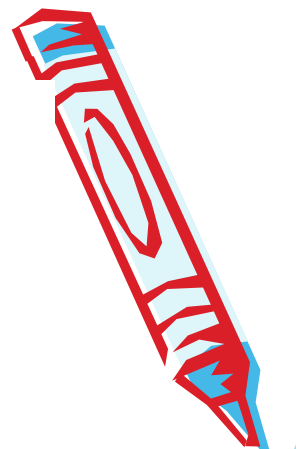
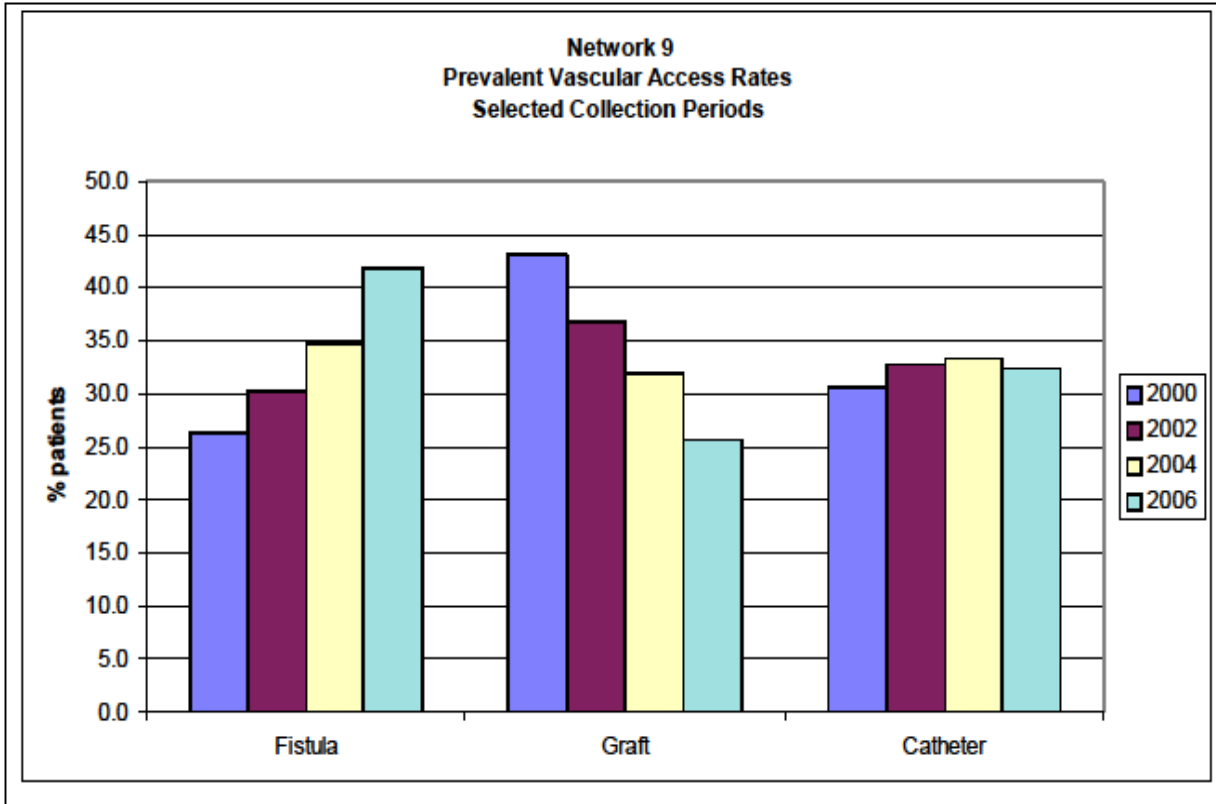
Centralized Pt management



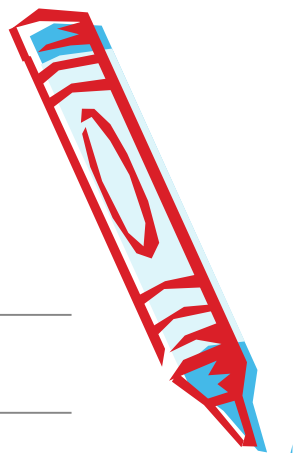
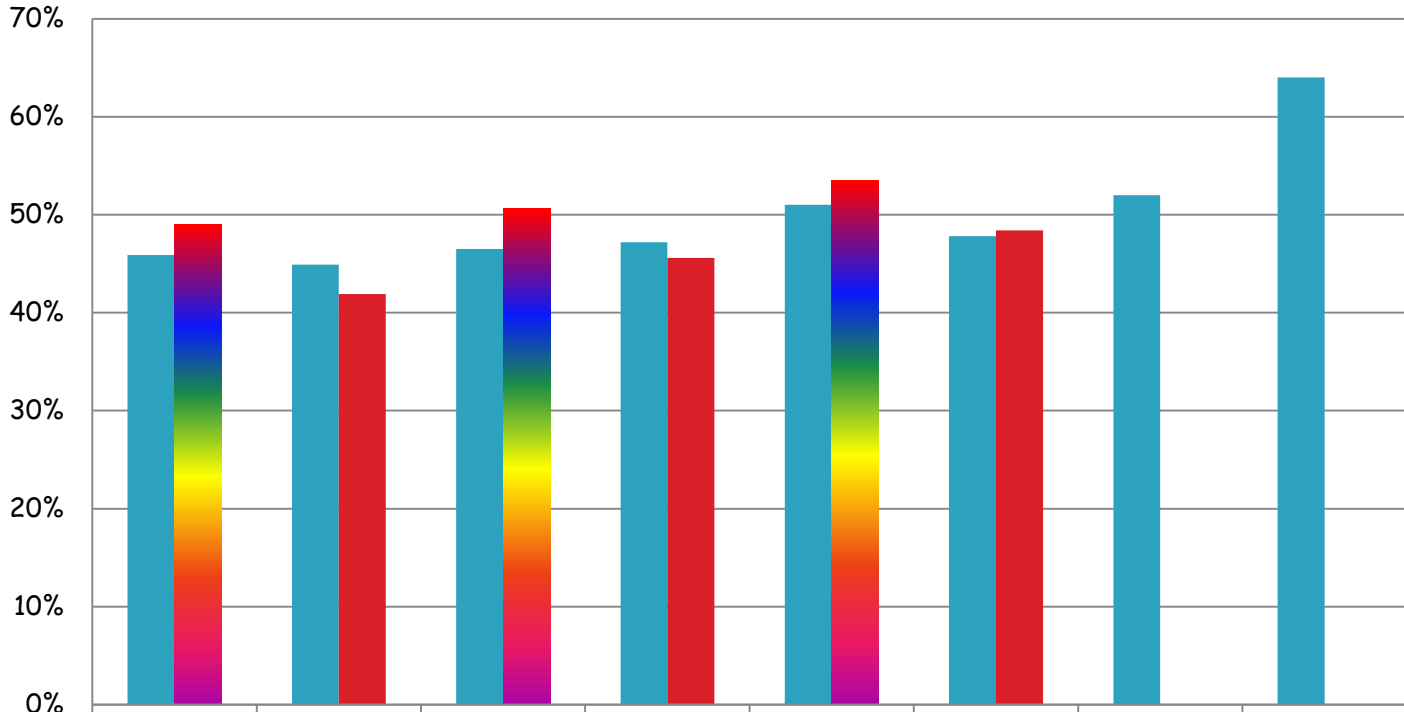
of patients that have been added to the renal access report

AVF's	AVG's	CATHETERS	PD's	VEIN MAPPINGS	ACCESS APPTS	CKD CLASSES	VEIN SAVING TECH	# UNIQUE PTS	# UNIQUE FLOWSHEETS
2008									
200	131	202	3	411	216	329	374	292	729
2009									
49	22	21	0	64	60	45	66	85	118
TOTAL									
249	153	223	3	475	276	374	440	331	847





Comparison

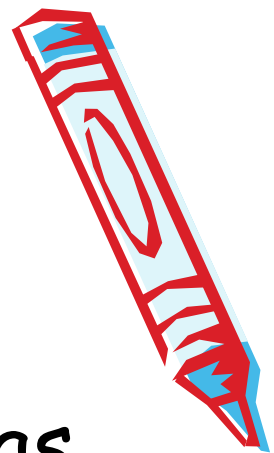


■ AVF%03/09	46%	45%	47%	47%	51%	48%	52%	64%
■ AVF%6/09	49%	42%	51%	46%	54%	48%		



Comparing data

- In 2007 our facility fistula rate was 41% and as of March this 2009 we have increased that to 47.2%
- This doesn't include the graft % that is around 30%
- This then leaves 23% catheter rate.



Catheter rate

- In 2008 the rate was 41% and now we are at around 23%.
- Of course the goal would be under 10%



Demographics of our pt population



- Many have no contact with a Nephrologist prior to acute renal failure.
- Many pts refuse access planning or ignore guidelines given by the vascular access coordinator.
- Many uninsured start dialysis and need assistance to access coverage, medicaid+medicare
- Some homeless, some with minimal support, many are financially impaired



Future Goals

- A better communication process with the acute dialysis unit @Metro and the coordinator related to new pts and their access needs.
- A bigger data collection process, probably a new program other than EPIC



And Finally, A Support system



- Develop a support group for the dialysis pts
- The ability to meet and talk about their feelings, network about problems like housing, medication acquisition, transportation etc
- Social support away from dialysis
- Studies support pts with greater social support decrease mortality rates

