Root Cause Analysis

Facility AVF Rate < Desired Goal

Facility Goal = AVF > _____ %

Take Action with Your Surgeons

-Refer to surgeon early for 'AVF only' evaluation and timely placement.
-Select surgeon based on best outcomes, & ability to provide access services.
-Provide education on full range of appropriate surgical approaches to AVF evaluation and placement to surgeons. (DVD/CD set as resource)
-Educate all patients how to care vessels prior to fistula placement. Encourage them to tell their other health care providers as well.
-Partner and talk often with your surgeons and nephrologists. Encourage your medical director and nephrologists to develop a partnership.
-Educate surgeons on new reimbursement guidelines, including 'G codes'.

Take Action with Your Patients

-Refer patients to surgeon early, within the first month of treatment at your facility.
-Educate patients on advantages and disadvantages of vascular access types.
-Educate family or caregiver on vascular access.
-Assign facility staff to follow patient through process of having AVF placed, including appointment reminders, facilitate scheduling and transportation, follow up education, etc.
-Talk with each indicated patient who is not dialyzing with AVF monthly to re-educate and recommend AVF.
-Encourage patient to know access and where needles are placed at last treatment.
-Dispell AVF patients myths through education and encouragement.

Renal Network 11

Surgeon Barriers

AVF not being placed due to limited communication between nephrologist and surgeon

-No facility involvement
-No partnership developed between surgeon and nephrologist

Patient has limited vessels for AVF placement

-Poor peripheral vein use (cath, IV, BP cuff) limits vessels that can be used
-Patient knowledge deficit
-Primary care provider knowledge deficit
-Lack of diagnostic testing
-No surgeon time
-Equipment/space not available

AVF not primary choice for access by surgeon

-Poor reimbursement for AVF
-Surgeon has limited knowledge/ experience with AVF
-Lack of education/ mentor to learn new techniques

Patient Barriers

AVF placed, but patient refuses to use

-Fear of pain during needlesticks
-Fear of needle infiltration
-Anxiety over needles in arm
-Potential time commitment to allow clotting
-Body image issues

Nonadherence: Surgeon follow-up fistula care

-Limited transportation to surgeon appts.
-Dementia/memory leads to forgetting appts.
-Fear of pain/procedure
-Pain/swelling complications prevent exercise of AVF

Patient refusal to have AVF placed

-Fear of pain from surgery
-Fear of complications from surgery
-Anxiety over body image changes
-Compounding health issues
-Anxiety over use of fistula (pain, clotting time, etc.)
-Lose convenience of catheter
-Feedback from other patients

AVF Goal Not Met

Facility Barriers

Collaborative team not in place

-Goals of facility, nephrologist, and surgeon not aligned.
-No or limited communication with surgeon or nephrologist.
-No 'cheerleader' on staff to push AVF only in facility.
-Facility does not have 'vascular access' role in facility in charge of review and monthly monitoring of all patient vascular access.

High initial fistula failure rate

-Poor cannulation due to new staff or poor technique
-Poor fistula placement by surgeon
-Lack of surgeon follow up after fistula placement

Low Prevalent and Incident AVF Rate

-Prevalent patients refuse permanent access (cath)
-Prevalent patients using AVG and don't want AVF
-No point person to educate patients and refer them for AVF
-Lack of enthusiasm to affect change in facility
-Vascular access not part of quality improvement program, in which patients with VA other than AVF are reviewed monthly.

Nephrologist Barriers

Referral to surgeons who are not AVF advocates

-Specific referrals required for some physician groups.
-Nephrologists not familiar with surgeon techncique to base referrals
-No partnership developed with surgeon placing AVF.
-Does not refer for 'AVF only'

No partnership with nephrologist and surgeon

-Physical distance between facility and nephrologist.
-Physical distance between nephrologist and surgeon
-Limited communication between surgeon and nephrologist
-Nephrologist not part of facility CQI process
-No surgeon partner available who is AVF advocate

Late referral to surgeon

-Patient does not have vascular access plan of care
-Facility not involved with patient referral
-Pre-ESRD patient not referred at appropriate time
-No or limited pre-ESRD care by nephrologist
-Primary care physician did not refer to nephrologist timely
-No hurry to change established access as catheter or AVG
-Secondary AVF for AVG not considered

Take Action in Your Facility

-Make AVF part of your CQI program and review each patient not dialyzing with AVF monthly.
-Appoint a staff to be a 'cheerleader' for AVF and monitor patient access and follow up with surgeon and nephrologist when problems arise.
-Perform routine access monitoring.
-Talk with your medical director about starting partnership with surgeons.
-Educate and empower staff on Fistula First program.
-Implement cannulation training program (See resources)
-Refer patients to nephrologist and surgeon for secondary AVF if using AVG.

Take Action with Your Nephrologists

-Encourage nephrologists to refer patient for vessel mapping prior to surgeon appointment.
-Encourage nephrologist to evaluate all AVG patients for appropriateness of AVF before AVG failure.
-Encourage nephrologist to evaluate all catheter patients for AVF.
-Encourage nephrologist to write referral to surgeon for 'AVF only eval and placement'.
-Encourage nephrologist to take part in CQI discussions of vascular access.
-Talk with your surgeons and nephrologist and assist them to develop a partnership to place AVF first.
-Collaborate with nephrologist to implement vascular access plan of care for each patient.
-Encourage nephrologist to refer to surgeon who is able and willing to place AVF first.
-Request assistance from nephrology and corporate resources to collaborate with nephrologists.