



HOW DID WE DO IT??
WILDWOOD DIALYSIS CENTER'S
STORY ABOUT CATHETER
REDUCTION

U. S. Renal Care

WHO HAS BEEN INVOLVED

- At the facility level
 - Medical Director
 - Facility Administrator (Access coordinator)
 - All Clinical staff (R.N. and C.H.T.)
 - Unit assistant
 - Dietitian
 - Social Worker
 - Other area sister facility administrators

Basically every one on staff was aware of goals for increasing fistula rates and decreasing catheters



MORE PEOPLE INVOLVED

CONTINUED...

- Vascular surgeon's office
 - Surgery schedulers
 - Around April 2012 began over the phone education with the largest vascular provider's office to our facility about the changing QIP requirements, financial impact on facilities and impact for patients due to inferior ratings for all of our facilities in N.W. Ohio
 - In January 2013 a formal meeting occurred with 4 vascular surgeons, 3 surgery schedulers, the vascular office manager, myself, our medical director and all 7 of our facilities administrators and access coordinators



AND MORE...

- Interventional Radiology
 - Medical Director for leading provider to our units
 - R.N. in charge of Interventional Radiology
 - Meeting held at Wildwood in June 2012 with our sister facility administrators to address barriers of scheduling same day declots to prevent catheter placement
 - Discussed barrier of vascular surgeons performing fistulagrams versus performing access surgeries
 - Barrier of one I.R. department having limited hours to accommodate our patients



COMMUNICATION

- At the facility level we have a board in the hallway with the current years goals for the QIP and monthly statistics for our unit.
- Staff at a glance can see where our fistula rates are at and catheter rates. We include permanent catheter rates and >90 day catheter rates.
- A quick glance document in place for all staff is updated monthly from our QAPI manual, only patient's names who have catheters are on this list.
- Keeping staff engaged is problematic due to the demands of their jobs every day.
- Reminding staff of how important and vital they are to this process is imperative.



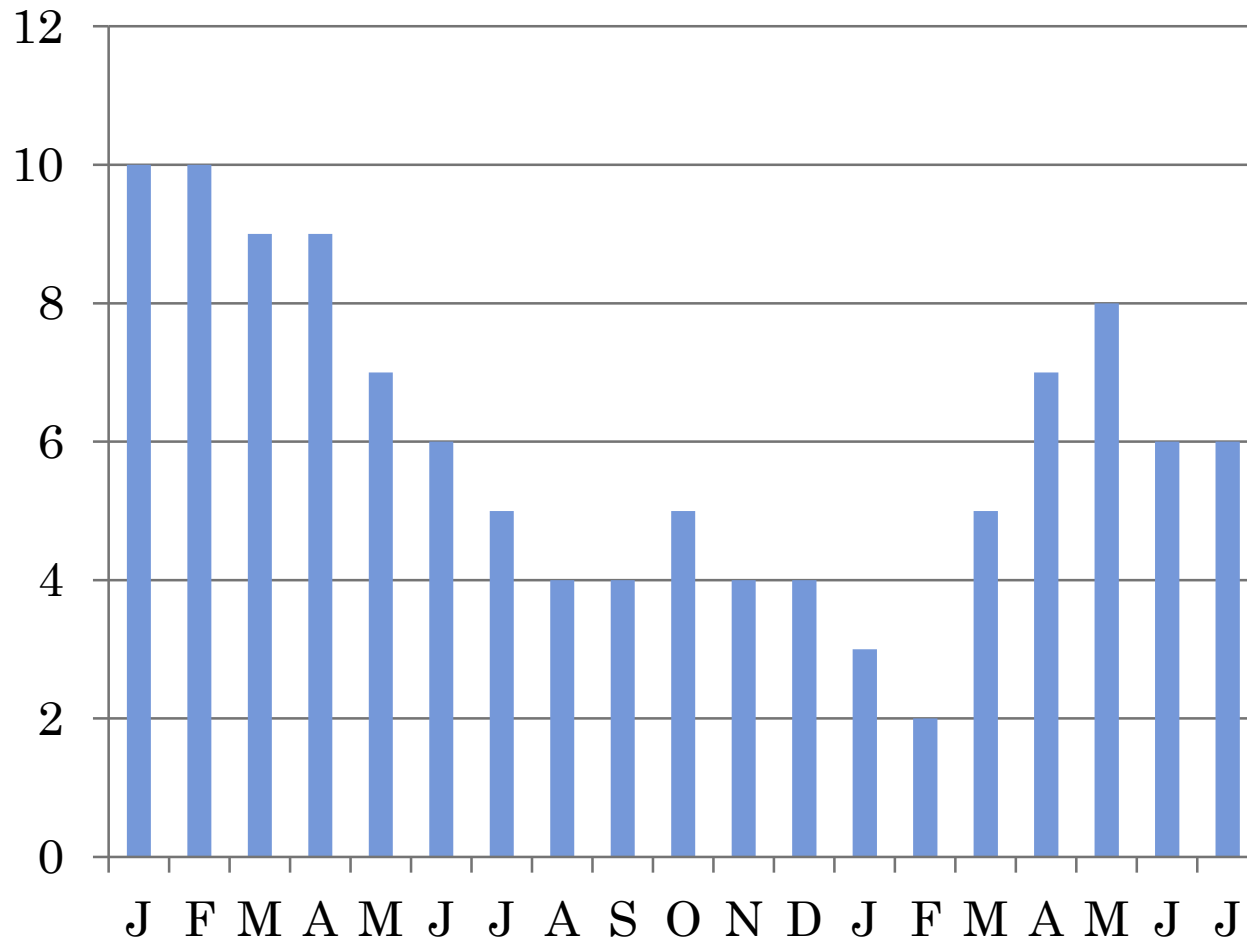
COMMUNICATION WITH SURGEONS

- The following items were presented to the surgeons at our meeting in January 2013. These areas were listed as barriers for our units and patients.
 - Delay in scheduling
 - Delay in interventions- should surgeons perform IR related procedure
 - Vacation issues- when surgeons are gone, who can cover a specific surgeons patient
 - Follow through with scheduling- patients not receiving return calls with surgery dates and follow up appointments
 - Customer service with office staff difficult at times



HOW HAS THIS MODEL WORKED FOR US?

%>90day catheters



WHAT WE HAVE LEARNED

- It is possible to reduce catheters if everyone is actively involved.
- Keeping clinical staff involved is very important.
- Identifying your barriers and overcoming them is a must. Our barriers were mirrored at our sister facilities.
- Educating vascular surgeons.
 - We learned when preparing for the meeting in January that surgeons receive percentages of fistulas based on their billing from the surgeries performed. NOT what is actually used in the facility.
 - Therefore, surgeons have a false sense of accomplishment.
 - Surgeons are not aware of Medicare QIP requirements.



CONCUSION

- The team consists of our facility, vascular surgeons, their office team, interventional radiology and nephrologist. It can include anyone you need to make your plan work.
- Information generated within our systems may not be what we think. Investigate as needed.
- Keep your team focused and motivated.

