June XX, 2010

Addressee
Street
City, State Zip

Subject: Vascular Access Initiative (VAI)

Dear Addressee

RPA is writing as part of a collaborative effort to improve the state of vascular access care nationwide. As you know, the ideal arterio-venous (AV) access for hemodialysis patients is an AV fistula (AVF), with AV grafts (AVG) an adequate substitute. Unfortunately, the use of central venous catheters (CVC) is sometimes a necessity but carries exorbitant morbidity, mortality and costs. The first year mortality rate of patients with ESRD on dialysis in the United States is 30% with an ongoing 24% mortality for patients on dialysis beyond two years, and the main causes for these outcomes are excessive rates of infection and cardio-vascular events. Most studies indicate that CVC are a significant if not primary factor accountable for the morbidity and mortality in ESRD patients.

Despite the renal community’s robust efforts to develop and implement practice guidelines about the appropriate placement of AV access, and the outstanding progress of the Fistula First Breakthrough Initiative (FFBI) in raising the percentage of incident patients with fistulas to 50%, the percentage of incident patients with a CVC has increased. Indeed, 82% of incident hemodialysis patients start dialysis with a CVC, 28% of all patients in the US have the catheter in place after 90 days, and far too many patients maintain a CVC as their permanent access.

The success of FFBI should be recognized but the push for the ideal access, an AVF, has had unintended consequences. Despite these efforts the rate of CVC has not changed. In addition, many patients have a non-usable AVF. This high percentage of non-usable AVFs suggests that there is a population of patients in whom AVFs should not be placed and for whom the AVG should be considered as perhaps the better option for avoiding the prolonged use of a CVC.

It is the renal community’s responsibility to reduce CVC use and maximize the number of AVF in use (with the recognition that AVG are a better alternative than CVC). Several segments of the community have initiated programs to achieve this goal. The dialysis providers have embarked on catheter reduction programs, the Networks have developed programs to decrease the use of PICC lines, the FFBI has expanded its efforts, and the RPA has developed relevant materials in both its clinical practice guideline on Appropriate Patient Preparation for Renal Replacement Therapy and the Advanced CKD Patient Management Toolkit. However, despite
these efforts it is alarming to learn that 65% of incident patients followed by nephrologists for greater than 6 months start their dialysis with a CVC.

As nephrologists, we must lead efforts to ensure that the patients receive the appropriate AV access at the initiation of dialysis, and most importantly that CVC use is minimized to the extent possible. There are multiple causes for the unsettling high-incident CVC rate, and in many cases these are not within the control of the nephrologist, but the fact that most of the patients we are managing start their treatments with a catheter is a telling statistic.

Achievement of this goal will require hard work and a coordinated plan within the renal community. A collaborative effort with our primary care physicians will be necessary to develop a co-management delivery system to identify CKD patients early. Nephrologists will need to be assertive about developing working relationships with the surgeons placing the access to prevent delays in surgery and appropriate annulations of access, among other issues. The dialysis providers need to develop vascular access teams and programs to address the issue of management of access in both incident and prevalent patients, and hospitals must be engaged to coordinate and facilitate the management of vascular access services provided in that setting of care.

Attached is the RPA’s statement on the role of nephrologists in access placement and reducing use of CVCs. Progress toward achieving our goal will require a proactive effort by all nephrologists. RPA will provide you with tools to assist you in this effort. We also encourage you to work with your dialysis providers, networks, access surgeons and colleagues in your communities to increase the placement of AV fistulas. RPA will continue to work at the regional and national levels with dialysis providers, the Networks, the Quality Improvement Organizations (QIO) and payers to accomplish our goal.

Success in this endeavor on behalf of our patients is an absolute necessity. Thank you in advance for your help contributing to our success. Any questions or comments regarding this correspondence or this initiative should be directed to RPA’s Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Sincerely,

Edward R. Jones, M.D.
President

CC: Barry Straube, M.D., Director and Chief Medical Officer, CMS
Jonathan Blum, Director, CMS Center for Medicare Management