Role of Nephrologists in Access Placement in Patients with CKD Stages 4-5

1. RPA believes that nephrologists must accept responsibility and accountability for leading the effort in assuring that patients with CKD Stages 4-5 are appropriately prepared for renal replacement therapy (RRT). For guidance in this area nephrologists should consult the RPA clinical practice guideline on Appropriate Patient Preparation for Renal Replacement Therapy for further information (www.renalmd.org). Nephrologists are expected to take the lead in ensuring that patients have an appropriate access in place at the initiation of dialysis with a goal toward minimizing the use of central venous catheters (CVC). Regardless of the modality selected the use of a CVC should be the last option for dialysis access (i.e. Catheter last approach) when all other forms of dialysis modality and access have been considered.

2. The Fistula First Breakthrough Initiative (FFBI) (www.FistulaFirst.org) strategic plan is supported by all providers in the renal community. As the FFBI evolves, the consideration of Catheter Last is a parallel process that can improve outcomes and reduce costs of care for patients receiving RRT, and as such nephrologists should adhere to FFBI principles. The attached goals are proposed to achieve improved quality of care for patients with CKD 4-5 in conjunction with FFBI.

3. The nephrologist should see new patients in a timely fashion when the eGFR is less than 30 ml/min, particularly with evidence of proteinuria or progressive disease; nephrologists should aggressively pursue vascular access placement when the eGFR is 20 ml/min and consider initiation of RRT at 10 ml/min. Pre-emptive transplantation and peritoneal dialysis (particularly as a bridge treatment to hemodialysis) is a priority in this patient population.

4. The nephrologist should develop a collaborative, co-management approach with primary care physicians (PCPs) to assist with identification and appropriate referral of patients with advanced CKD.

5. The nephrologist should identify laboratories (in particular hospital-based) that are not reporting eGFRs and will work to achieve reporting of eGFRs.

6. The nephrologist should refer patients to CKD education programs at stage 4 to receive appropriate RRT education that includes information on hemodialysis, peritoneal dialysis, transplantation, and comfort interventions. Families should be involved in these discussions. If a patient is considering maintaining a CVC and opposing a vascular access, the nephrologist should consider having the patient sign an “informed non-consent” document.

7. The nephrologist should send patients for vessel mapping when the eGFR is 20ml/min and work to have results sent to the vascular surgeon.
8. The nephrologist should establish a working relationship with an access surgeon who supports the goals of the FFBI program. Vessel mapping results and discussions of the anticipated patient start date for RRT should be provided to the surgeon. There should be less than a three-week scheduling time to get the patient both an appointment with a surgeon and a vascular access procedure. All patients should start dialysis with a permanent access or an assessment and plan to have a timely placement of an access and only the rare patient should begin with a CVC only.

9. The nephrologist should seek to have all AVFs evaluated four-six weeks after placement, and if the fistula is not mature, the patient should be sent to an interventionalist with special interest in vascular access management. The access surgeon should be apprised of interventions and prepared to intervene for potential revision or new access in a timely fashion. Nephrologists should obtain training in the examination of an AVF; alternatively, he or she should ensure that there is qualified staff in place capable of examining the maturity of an AVF.

10. For any patient whose only option is to start dialysis with only a CVC, the nephrologist should ensure that a plan is in place for a permanent access without a CVC within 80 days.

11. The nephrologist should work with his/her local hospital to develop a vascular access management program (see www.renalmd.org for assistance)