**Technical Expert Panel Composition (Membership) List Web Page Posting**

### Project Title:

End-Stage Renal Disease Vascular Access Technical Expert Panel

***Dates:***

* The Call for TEP nomination period closed on February 5, 2015

***Documents:***

* The TEP Membership List is posted below in the download section.
* The TEP meeting Agenda and Call in information is posted below in the download section.

### Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) to review the NQF endorsed Vascular Access measures (Minimizing Use of Catheters as Chronic Dialysis Access, and Maximizing Placement of Arterial Venous Fistula) and consider possible revisions to the existing measures, including potential risk adjustment.

Of the three vascular access options, the AV fistula has been widely considered the best option for long-term vascular access. AV fistulae have a longer median survival, require less costly and invasive intervention to maintain patency and are less likely to become infected than AV grafts. However, successful creation of a functional AV fistula requires the presence of adequate superficial veins and arterial supply (usually radial or brachial artery), surgical skill, and generally three months or more time after the initial surgery to allow the fistula to “mature” before use. In addition, fistulae have a higher primary non-function rate, defined as failure to mature enough to ever use successfully for dialysis compared to AV grafts. Thus, achievement of high AV fistula prevalence in a population of dialysis patients requires a concerted effort to preserve superficial veins, availability of a team member with appropriate surgical skills, proper patient selection, and future planning for access placement. Placement of a usable AV graft is associated with a much lower primary non-function rate, and does not rely as heavily on intact superficial veins compared to AV fistula creation.

Observational studies published over a decade ago highlighted the marked differences in vascular access distribution across countries represented in the early DOPPS cohort. Of note, the US dialysis population had very low AV fistula prevalence rates and some of the highest rates of tunneled venous catheter use, particularly in incident patients. In addition, major regional differences in the occurrence of AV fistula use and overall vascular access distribution were present within the US Medicare dialysis population. These data were seen as an opportunity for improvement (both for patient outcomes as well as cost reduction for the Medicare ESRD Program). The Fistula First Project was initiated over a decade ago, with the goal of increasing AV fistula use in US chronic dialysis patients. Prior to Fistula First, approximately 30% of all US dialysis patients used AV fistulae for regular dialysis access. Under the current CMS Fistula first, Catheter Last initiative, the most recent data demonstrate that 63 % of prevalent US dialysis patients use AV fistula as regular access for dialysis.

This success has not been without some unintended outcomes. Several editorial publications have suggested that the Fistula First Project’s success has resulted in greater use of tunneled catheters, or at the least, less reduction in use of tunneled catheters than could have been achieved over the last decade. These authors express concern that the price of raising the overall AV fistula rate in the population has come at the cost of prolonged catheter use, particularly in those patients who are marginal candidates for AV fistula, including the elderly and chronically ill patients. Given the increased difficulty of creating AV fistulae in patients with poor superficial veins and/or inadequate arterial supply, attempting to create an AV fistula in some subsets of the US dialysis population may result in high failure rates, resulting in longer exposure to the risks associated with use of a tunneled catheter (bacteremia, vein thrombosis, possibly inadequate dialysis). These authors advocate for increased use of AV grafts and less emphasis on AV fistulae, with the assertion that reduction in use of tunneled venous catheters should be the goal of vascular access care in chronic dialysis patients.

Of note, there is a scarcity of literature describing controlled interventional trials testing the hypothesis that attempting to create AV fistulae in old and or frail patients is associated with poorer overall outcomes. However, the model outlined by advocates for relaxed efforts at AV fistula creation in elderly and frail patients has some clinical face validity. In addition, observational studies on this topic may be particularly affected by confounding, given the importance of comorbidities and unobserved clinical factors (e.g. presence of intact superficial veins) in the outcomes of interest.

***Project Objectives:***

The University of Michigan Kidney Epidemiology and Cost Center, through its contract with the Centers for Medicare and Medicaid Services, will convene a technical expert panel to evaluate the existing NQF-endorsed vascular access measures, considering the issues raised above. Specific objectives will include:

* Review of the current NQF endorsed Vascular Access measures (Minimizing Use of Catheters as Chronic Dialysis Access, and Maximizing Placement of Arterial Venous Fistula)
* Consider revisions to the vascular access measure set
* Consider including potential risk adjustment

### TEP Requirements:

We sought a TEP of approximately *9*  individuals with the following perspectives and areas of expertise:

* Subject matter expertise: Clinical providers (nephrologists and nurses) with expertise in chronic dialysis and vascular access; interventional radiologists and nephrologists; researchers in the area of vascular access; and surgeons with expertise in dialysis vascular access.
* Patient/consumer/family perspectives and experiences
* Health care disparities (experts in treatment of pediatric and geriatric population)
* Performance measurement
* Quality improvement
* Purchaser perspective
* Expertise in Medicare dialysis data

### TEP Expected Time Commitment:

* TEP members should expect to come together for one to three teleconference calls prior to the in-person meeting held April 2015, in Baltimore, MD.
* The in-person meeting (April 22-23, 2015).
* After the in-person meeting, additional conference calls may be needed.