D. Fistula First (FF) Initiative.

The development of Quality Improvement Projects (QIP) is mandated in the ESRD Network contracts with CMS. The QIPs are developed and directed by the MRB, then reviewed, approved and monitored by the Board of Trustees. In 2010, the majority of quality improvement efforts were focused on continuing and improving AV fistula rates through the Fistula First Initiative.

**Background:** In 2003, all 18 of the ESRD Networks and CMS, along with clinicians, dialysis providers, and patients, developed a three-year plan called the National Vascular Access Improvement Initiative (renamed Fistula First in 2004). This plan implements strategies for the improvement of patient vascular access outcomes to reach the CMS goal and K/DOQI guidelines for AV fistula use of >65% prevalence.

Fistula First aims to build on established methods to increase fistula use, and to take advantage of system-level diagnosis and strategies for improvement. Collaboration between ESRD Networks, providers, physicians, vascular surgeons, and health professionals is key to spreading the change ideas for improving AV fistulas.

**2010 Primary objectives:**

- To increase the prevalence rate of AV fistula in Network 9 from 51.1 percent in March 2010 to 54.1 percent in March 2011 (an increase of 3.0 percentage points) and to increase Network 10 from 54.2 percent in March 2010 to 56.6 percent in March 2011 (an increase of 2.4 percentage points).
- To increase the awareness of early referral for vascular access in the incident CKD patient.
- To educate providers, physicians, and vascular access surgeons on documentation of AV fistula assessment pre-hemodialysis access placement.
- To educate providers, physicians, and vascular access surgeons on the AV fistula improvement strategy.
- To provide resources and tools to providers to assist with developing initiatives for placement and assessment of AV fistula and catheter reduction.
- To educate medical directors, providers, and the facility interdisciplinary team on the best practices of a Quality Assessment and Performance Improvement (QAPI) program for vascular access management.
Progress toward these goals by December 2010 is detailed in Figure 44:

**Figure 44.**
**Network 9/10**
**Fistula First Percentages**
**Fistula Prevalence as of December 2010**

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<tr>
<td>Achieved Goal</td>
<td>51.1%</td>
<td>53.6%</td>
<td>54.2%</td>
<td>56.3%</td>
<td>&gt;65%</td>
<td>66%</td>
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**Actions.** The national Fistula First Breakthrough Initiative (FFBI) coalition conducted an extensive root cause analysis in 2009. This root cause analysis was used to develop a strategic plan that identified priority areas to be addressed.

The following seven strategies were developed into an operational plan to increase the AV fistula utilization rate to 66% in prevalent hemodialysis patients for ESRD Networks and to assist Quality Improvement Organizations (QIOs) in reducing the gap between the statewide baseline AV fistula rate and 66% for incident hemodialysis patients:

- **Strategy 1: Nephrologist as Leader** - Encourage and support nephrologists to take a leadership role and be accountable for vascular access management in all hemodialysis patients.
- **Strategy 2: Leveraging Partnerships** - Partner to improve AV fistula placement and utilization rates.
- **Strategy 3: Hospital Systems** - Modify hospital systems to promote AV fistula placement.
- **Strategy 5: Addressing Access Problems** - Promote fast-track protocols for rapid identification and referral of vascular access problems which include failure to mature, revision of the failing AV fistula, and placement of an AV fistula.
- **Strategy 6: Practitioner Training and Credentialing** - Promoting training, experience, and credentialing of healthcare professionals in the area of hemodialysis vascular access management.

The staff of Network 9/10 utilized tools and resources from www.fistulafirst.org for education and technical support and marketed new tools that were developed through FFBI to providers and professionals. The staff of Network 9/10 participated on FFBI activities at the national, regional and local level.

The Quality Improvement Department developed a vascular access management resources handbook using many of the tools provided on the FFBI Web site. The 3P’s (Prevention of Catheters, Placement and Use of AVF, Preservation of AVF) of Vascular Access Success Handbook was developed using best practice protocols, algorithms, and Fistula First resources. The intent of the “3 P’s” handbook is to guide hemodialysis vascular access improvement efforts and change existing practices through Quality Assessment and Performance Improvement (QAPI) projects. This handbook brings together a number of best-practice concepts and suggested tools in support of those concepts. Some tools were included as hardcopy and many are available as a downloadable resource on The Renal Network, Inc. Web site, www.therenalnetwork.org.

Nationally, Network 9/10 participated on the FFBI conference calls for Network Quality Improvement Directors (QIDs) on January 13, April 21, May 12, June 9, July 14, August 11, September 8, October 13, and November 11, 2010. The Quality Improvement Director attended a FFBI Learning Session development conference call on February 19, 2010.

Vascular Access Advisory Panel. A panel of experts oversees the Fistula First Initiatives, under the direction of the MRB. This Vascular Access Advisory Panel (VAAP) was organized at the beginning of the Fistula First Initiative in 2004. The VAAP continued its activities during 2010.

Members of the panel include:

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<th>Name</th>
<th>Institution</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tim Pflederer, M.D., Chair</td>
<td>Renal Care Associates</td>
<td>Peoria</td>
<td>Illinois</td>
</tr>
<tr>
<td>Anil Agarwal, M.D.</td>
<td>Ohio State University</td>
<td>Columbus</td>
<td>Ohio</td>
</tr>
<tr>
<td>George Aronoff, M.D.</td>
<td>University of Louisville</td>
<td>Louisville</td>
<td>Kentucky</td>
</tr>
<tr>
<td>Stephen Ash, M.D.</td>
<td>Wellbound</td>
<td>Lafayette</td>
<td>Indiana</td>
</tr>
<tr>
<td>Michael Brier, Ph.D.</td>
<td>University of Louisville</td>
<td>Louisville</td>
<td>Kentucky</td>
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The VAAP is charged with developing and implementing strategies to achieve Fistula First goals, under the direction of the MRB. The VAAP met twice during 2010, once in May and once in October. Conference calls were scheduled during interim times to continue the work of this advisory body. Reports of VAAP activities were made continuously to the MRB. Network staff participates on the national FFBI coalition, so ideas between these two groups are shared routinely.

Although at year-end the CMS contract goal in Network 9 had not been met, interim targets were achieved and the staff of Network 9/10 worked with facility staff members toward improving the AV fistula rates for the regional population of Illinois, Indiana, Kentucky and Ohio.

**Data Distribution.** Fistula First Facility Specific Reports were sent to all hemodialysis programs in February 2010 to show fourth quarter 2009 data, June 2010 to show first quarter 2010 data, September 2010 to show second quarter, December 2010 to show third quarter 2010 data, and February 2011 to show fourth quarter 2010 data.

This quarterly FF data report gives facilities the number of prevalent fistula needed to meet fistula percentage goals based on the total number of patients and the number of patients with a fistula in their facility. It displays graphs illustrating quarterly results, as well as progress over time compared to the state, Network and United States where
applicable. It also graphs same population size facilities to each other in their Health Service Area (HSA) so that facilities can use this report to compare themselves to other facilities of like size regarding AV fistula rates in their area.

This report provides the dialysis facilities with a tool which can be used in conjunction with other facility methods of continuous quality improvement (CQI) to identify patients suitable for conversion to a fistula. The FF data report is sent to facility medical directors, administrators, and nurse managers quarterly.

These data also enable the Network to target facilities with poor outcomes for intervention. Facilities with good outcomes are utilized for positive intervention and mentoring.

Communications. Stakeholders were identified as the facility medical director, administrator, nurse manager, vascular access coordinators, nephrologists, patients, vascular access surgeons, and interventional radiologists. Individual databases are continually updated and maintained to enable ongoing communications with these audiences. Information and educational materials regarding the Fistula First Initiative were sent to the various stakeholders by mail and email as appropriate and necessary.
January 2010 - QIP participant conference calls were held. Thirty-one facilities that had made quarterly interim goals were highlighted on these conference calls. Representatives from these facilities reported, providing details on their successful techniques for improvement. All facilities that attended were given the opportunity to ask questions regarding any aspect of the QIP or other challenges.

January 12 & 14, 2010 - A WebEx entitled QAPI & Vascular Access Management II consisted of two best practice programs describing fistula improvements based on a sound QAPI program. 159 participants representing 148 facilities attended these WebEx conferences.

February 3, 2010 - An announcement was emailed to facility Vascular Access Coordinators (VACs) regarding the Bruit Audio educational sound bites available for patient and staff education on FFBI Web site. By listing to these sound bites the staff member can actually hear the sound of a good bruit and a bad bruit.

February 9, 2010 - An announcement was emailed to facility medical directors, nurse managers, and VACs regarding the development of an AVF Assessment and Cannulation Resources area on the Network Web site. This Web page provides tools, training guides, protocols, master cannulator information, and PowerPoint slides to be used for staff education and training.

February 11, 2010 - A “Medical Director/Surgeon as Partners” WebEx was held. A total of 74 attended the WebEx (36 of these were surgeons or nephrologists and 38 were nurses/VACs). 66 facilities were represented and there have been 26 requests for the WebEx on CD.

February 15, 2010 - An announcement was emailed to facility medical directors, nurse managers, and VACs regarding the development of a Successful QAPI for Vascular Access Management Resources area on the Network Web site. This Web page provides tools, protocols, and algorithms to be used to improve QAPI processes.

February 16, 18, & 19, 2010 - QIP participant WebEx conference calls were held. Discussion focused on vascular access management and QAPI. Additionally, Network staff highlighted performance issues and best practice discovered during Network site visits and conference calls.

February 26, 2010 - Mailed a Surgical Quality Report to facility medical directors and VACs. This report displays a facility yearly fistula rate compared to region, state, Network, and US to be used to communicate to surgeon partners.

March 9, 2010 - A WebEx entitled “Hospital Systems Change” was held for representatives of hospital-based facilities. This WebEx highlighted the new Hospital Systems Change Concept developed by FFBI and two best practice
approaches to improving processes for placing fistulas before leaving the hospital. Attendees included 70 medical directors, 64 administrators, and 47 nurse managers.

- April 2010 - Root Cause Analysis (RCA) QIP participant conference calls for Network 9 were held. The presentation surrounded conducting a root cause analysis and developing an action plan. All facilities that attended were given the opportunity to ask questions regarding any aspect of the QIP, the QAPI process, or other challenges.

- April 9, 2010 - An announcement was emailed to facility medical directors and VACs regarding a one page Patient Educational Vascular Access Flyer available for patient and staff education. The flyer is housed on the FFBI Web site and describes the advantages and disadvantages to all three vascular access choices.

- April 20 & 21, 2010 - A Cannulation WebEx was held. A total of 189 participants attended the WebEx representing 144 facilities.

- May 2010 - An announcement was emailed to facility medical directors, nurse managers, VACs, nurse practitioners, and surgeons regarding the NN&I “Vascular Access Management in the US – Current Challenges & Potential for Improvement” webinar that was held May 19, 2010. The Executive Director, Assistant Director, QID and QICs from Network staff attended this webinar. We also provided the link to the recording to above medical professionals, following the webinar.

- July 12, 2010 - Letters were sent to identified facility medical directors informing them of their progress toward fistula goal and that they would be participating in the “Promising Stars” focus group. The letter reinforced the yearly goal of a four percentage point increase to be realized by March 31, 2011.

- August 18, 2010 - An announcement was emailed to facility medical directors, nurse managers/administrators, VACs, surgeons, and nurse practitioners regarding a CKD Webinar on Vascular Access Management Prior to Dialysis, sponsored by ESRD Network 7. The Network QID and QIC along with 21 participants from Network 9/10 representing 13 facilities attended this Webinar on August 19, 2010.

- August 24, 2010 - A QAPI – Vascular Access Best Practice WebEx was held. A total of 174 participants attended the WebEx representing 168 facilities.

- August 26, 2010 - A QAPI – Medical Director in Charge WebEx was held. A total of 51 participants attended the WebEx representing 48 facilities.

- September 7, 2010 - An announcement was emailed to facility medical directors, VACs, and surgeons regarding an FFBI Surgeon workshop to be held November 12, 2010 in Chicago, IL.
September 13, 2010 - An announcement was emailed to facility medical directors, nurse managers/administrators, and VACs regarding the release of the FFBI/NKDEP Vascular Access Provider videos.

September 13, 2010 - An announcement was emailed to facility medical directors, nurse managers/administrators, and VACs regarding the release of two new FFBI tools added to Change Concept 9: a) Assessment and Monitoring of the Newly Placed AVF for Maturation and b) The Detection of Access Dysfunction in Permanent Vascular Access.

September 16, 2010 - The 3Ps for Vascular Access Management Handbook was mailed to facility nurse managers. The handbook houses best practices, tools and resources to be used by facilities in vascular access management and QAPI. Facility interdisciplinary teams were instructed to review the handbook at the next monthly QAPI vascular access management meeting and consider utilizing one or more tools/best practices that have been made available.

September 27 & 30, 2010 - The 3Ps for Vascular Access Management Handbook WebEx was held. A total of 232 participants attended the WebExes. The WebEx introduced the handbook, discussed principles of QAPI, and presented examples of how the facility interdisciplinary teams could utilize the handbook.

September 24, 2010 - A Vascular Access Learning Session was held in Chicago, IL. Topics included bundled payment, catheter reduction, placing and using fistula, and preserving fistula. There were 113 participants at the learning session representing 66 facilities.

October 1 & 2, 2010 - The Network Executive Director, Quality Improvement Director, and Quality Improvement Coordinator attended the Cincinnati Vascular Access Symposium. A total of 88 participants, representing 17 facilities, attended this symposium which satisfied their QIP learning session attendance requirement.

November 4, 2010 - A Fistula Placement and Assessment Intervention WebEx was held. Topics included progress toward goal, continued expectations, and QAPI principles. 19 facilities from Network 9 and 9 facilities from Network 10 attended the WebEx. An email was sent to the facility nurse managers and medical directors providing a link to access the WebEx recording. 28 of the facilities from Network 9 and 4 of the facilities from Network 10 viewed the recording. The WebEx slides are on the Web site.

November 4, 2010 - A Vascular Access Learning Session was held in Philadelphia, PA. Network 9/10 facilities were invited to attend to satisfy their QIP learning session attendance requirement. There were five participants, representing five facilities from Network 9/10, in attendance at this learning session. Topics
included bundled payment, catheter reduction, placing and using fistula, and preserving fistula.

- **November 12, 2010** - An FFBI Surgeon workshop was held in Chicago, IL. Fourteen surgeons from the Network 10 area and 10 surgeons from the Network 9 area attended the workshop.

- **Physician specific incident CKD patient vascular access data reports** were sent to nephrologists in July 2010 (January 2, 2010 – June 30, 2010 incident data) and February 2011 (July 1, 2010 – December 31, 2010 incident data). The information provided on this report is generated from the CMS 2728 Medical Evidence and Medicare Entitlement form and displays the percent of accesses a nephrologist’s patients were using when they began ESRD.

- The AVF Monthly Tracking Report was sent to facility VACs and medical directors every month. This report displays the facility prevalent fistula rate and shows their interim outcomes toward the final goal.

- Facility Vascular Access Coordinators (VAC) were sent bi-monthly electronic newsletters listing vascular access management and QAPI resources and tools. Each newsletter had a different theme/topic presented.

- Medical director letters were sent in February, June, July, and November 2010 providing information on vascular access interim outcomes, reminding of the goal, and stressing the importance of improving processes.

- To promote Fistula First goals continuously, educational resources have been developed which can be easily shared. The Fistula First page on the Network Web site was updated regularly adding the above mentioned materials as they were provided by mail or email. The materials provided to our stakeholders were developed both from Networks 9/10 and the national Fistula First Breakthrough Initiative.

- The Network has acted as a community outreach partner by providing information on Fistula First through conference calls quarterly to state surveyor groups and the quality improvement organizations.

**Conference Calls, Site Visits, and Presentations.** Network staff conducted many individual facility conference calls and site visits in 2010. MRB members and the CMS Regional Project Officer assisted in some of the conference calls. Staff also partnered with LDOs to present at physician meetings and quality meetings.

- **January 19 – February 1, 2010** - Fourteen facility site visits were conducted in this time frame. Facilities that were visited were selected based on poor vascular access outcomes (<40% prevalent fistula/>50 patients). A packet of best practice tools was given to each facility. Facility staff and Network staff
discussed processes and barriers. Network staff gave suggestions to making improvements.

- February 2, 2010 - The Quality Improvement Director was invited by FMCs Vice President of Quality Improvement to present to 59 FMC facility nurse managers in the Chicagoland area. The presentation focused on the role of the ESRD Network and expectations regarding vascular access management. Other presentations were regarding FMCs catheter reduction initiative and management and surveillance of vascular access.

- February 3 – 10, 2010 - Four facility conference calls with the MRB chair and Network staff were conducted in this time frame. Facilities called were selected due to poor vascular access outcomes (<40% prevalent fistula/>50 patients). A packet of best practice tools was sent to each facility. These facilities were required to submit action plans and QAPI meeting minutes for review by the Network QI staff. During the telephone calls, facility staff and Network staff discussed processes and barriers to fistula placement. The Network staff and MRB chair provided suggestions for making improvements.

- February 23 – March 2, 2010 - Three facility conference calls with an MRB representative, Network staff, and the CMS Project Officer (PO) were conducted in this timeframe. Facilities called were selected based on poor participation in the QIP. These facilities were not sending action plans/QAPI minutes and not attending required educational meetings and WebEx conferences. Action plans/QAPI meeting minutes were received and reviewed by Network staff and the MRB representative. Facility staff and Network staff discussed processes and barriers. Network staff and the MRB representative gave suggestions to making improvements. The CMS PO stressed importance of participating in Network initiatives as outlined in the Conditions for Coverage.

- April 7, 2010 - One facility conference call with a MRB representative, Network staff, and the CMS PO was conducted. The facility that was called was selected based on poor participation in the QIP. This facility was not sending action plans/QAPI minutes and not attending required educational meetings and WebEx conferences. Prior to the call, the missing action plans/QAPI meeting minutes were received and reviewed by Network staff and the MRB representative. Facility staff and Network staff discussed processes and barriers. Network staff and the MRB representative gave suggestions to making improvements. The CMS PO stressed importance of participating in Network initiatives as outlined in the Conditions for Coverage.

- May 18, 2010 - The Executive Director was invited by the FMC Chief Medical Officer to present to a Chicago Nephrology Group Practice. Discussion
surrounded Fistula First data, Medical Director responsibilities, and overcoming barriers to fistula placement. A total of 66 nephrologists were present at this meeting.

- June 2 – 24, 2010 - Ten facility site visits were conducted in this timeframe. Facilities visited were selected based on poor vascular access outcomes (<40% prevalent fistula/>35 patients). A packet of best practice tools was given to each facility. Facility staff and Network staff discussed processes and barriers. Network staff gave suggestions to making improvements.

- June 8, 2010 - The Quality Improvement Director presented fistula improvement data and QAPI best practices at the annual Network 9/10 Pediatric Renal Group meeting. A total of 31 participants were in attendance, representing 14 pediatric centers.

- June 11 – 29, 2010 - The Network staff conducted 14 facility conference calls in this timeframe. Facilities called were selected due to poor vascular access outcomes (<40% prevalent fistula/>35 patients). A packet of best practice tools was sent to each facility. These facilities were required to submit action plans and QAPI meeting minutes for review by the Network QI staff. During the telephone calls, facility staff and Network staff discussed processes and barriers to fistula placement. The Network staff provided suggestions for making improvements.

- June 22, 2010 - The Quality Improvement Director and Quality Improvement Coordinator were invited by the FMC Vice President of Quality Improvement to present to 18 FMC facility nurse managers in the Chicagoland area. The presentation focused on the upcoming vascular access management QIPs and the QAPI process. Other presentations were given by the FMC facilities in the LDO catheter reduction initiative, surgical techniques, and a surgeon’s perspective.

- June 29, 2010 - The Executive Director was invited by the FMC Chief Medical Officer to present to several Central Indiana nephrology group practices. Discussion surrounded Fistula First data, Medical director responsibilities, and overcoming barriers to fistula placement; 40 nephrologists were present at this meeting.

- July 1 – 8, 2010 - Three facility site visits were conducted in this timeframe. Facilities visited were selected based on poor vascular access outcomes (<40% prevalent fistula/>35 patients). A packet of best practice tools was given to each facility. Facility staff and Network staff discussed processes and barriers. Network staff gave suggestions to making improvements.
- September 3- 27, 2010 - The Network staff conducted 12 facility conference calls in this timeframe. Facilities called were selected due to poor vascular access outcomes (<40% prevalent fistula/>35 patients). A packet of best practice tools was sent to each facility. During the telephone calls, facility staff and Network staff discussed processes and barriers to fistula placement. The Network staff provided suggestions for making improvements.

- September 7 – 29, 2010 - Twenty-two facility site visits were conducted in this timeframe. Facilities visited were selected based on poor vascular access outcomes (<40% prevalent fistula/>35 patients). A packet of best practice tools was given to each facility. Facility staff and Network staff discussed processes and barriers. Network staff gave suggestions to making improvements.

- November 3, 2010 - An Ohio Summit was held in Columbus, OH. The Network Executive Director partnered with FMC management to present medical director responsibilities regarding vascular access management and AV fistula improvement to FMC facility medical directors.

- December 7 – 17, 2010 - Letters were sent to 13 medical directors on November 29, 2010 informing them they were expected to be on a conference call with an MRB representative in December 2010. Facilities called were selected based on poor vascular access outcomes (<40% prevalent fistula/>35 patients). Network staff also requested new action plans with updated actions due to poor outcomes.

### 2009-2010 Fistula First Completed Projects

The following activities were designed as components of the 2009-2010 Fistula First quality improvement project and were completed in March 2010.

1. **Decreasing Catheters** - 51 dialysis facilities in Network 9 and 28 dialysis facilities in Network 10 with high catheter rates and low AV fistula rates participated in an initiative designed to decrease catheters. This project was part of the 2009-2010 Quality Improvement Work Plan (QIWP) for the Fistula First initiative.

In July 2009 facilities were asked to complete a root cause analysis identifying the reasons for a high catheter rate:

- a) High percentage of new patients starting with catheter only
- b) High percentage of catheter only >90 days
- c) High percentage of catheters with maturing AVF (AVF utilization/maintenance)

OR
The facilities were advised to initiate a process change that would address the barriers to decreased catheters/increased fistula in their facility. Network staff provided specific tools and resources to assist in process change and plan development.

The project was conducted over a seven month period with monthly activities that included:

- Intervention-specific conference calls for participant networking and technical assistance from Network staff
- Evaluation of facilities’ monthly prevalent fistula rate increase (goal 0.33 percentage point/month) and reports to facilities
- Evaluation of project progress through the assessment of the facility vascular access management QAPI minutes

Additionally, the following educational activities were included as part of the interventions:

- Month 2 - Facilities attend QAPI and Vascular Access Management I WebEx
- Month 3 - Facilities attend “Networking for Solutions” Learning Session
- Month 5 - Facilities attend QAPI and Vascular Access Management II WebEx

Goals and timeline for the Decreasing Catheters project were:

- To increase by 1 percentage point each quarter to attain a four percentage point increase by March 2010.

**Results:** The Decrease Catheter project was successful in both Networks 9 and 10. Both Networks met the goal that was set for March 2010 and continued to improve at the quarterly rate or better through September 2010.

Figure 45 and Figure 46 display the results of this project at the end of the project, March 2010 and for six months after (September 2010) for Network 9 and Network 10.
2. Changing Patient Culture - 16 dialysis facilities in Network 9 and 12 dialysis facilities in Network 10 were identified as having a patient culture that contributed to low AV fistula rates. Their barriers were identified as patient refusal due to poor staff/patient communication skills, patient lack of knowledge, and/or facility culture. They participated in an initiative designed to improve patient/staff communications and patient culture. This project was part of the 2009-2010 Quality Improvement Work Plan (QIWP) for the Fistula First initiative.

The Network developed and provided two products for use by the participating facilities:

a) “Helping Patients Make Healthy Fistula Choices” is a program designed to educate staff on techniques to help identify a patient’s readiness to have a fistula placed or used and techniques in listening and empathy. Utilizing this teaching module will assist staff in discussing best care options with the patients. It will also identify patient fears and patient barriers to fistula placement and usage in order to assist staff in addressing those issues.

b) The Fistula Coaching Program is designed to promote the best vascular access choice among patients through peer-to-peer education, communication, planning and problem solving. The program is provided through a trained, facility-based, patient volunteer program. Utilizing this teaching module will identify a patient champion that will be able to have a dialogue with the patient opposed to a fistula to help that patient make a best care decision.

The project was conducted over a seven month period with monthly activities that included:

- Intervention-specific conference calls for participant networking and technical assistance from Network staff
- Evaluation of facilities’ monthly prevalent fistula rate increase (goal 0.33 percentage point/month) and reports to facilities
- Evaluation of project progress through the assessment of the facility vascular access management QAPI minutes

Additionally, the following educational activities were included as part of the interventions:

- Month 2 - Facilities attend QAPI and Vascular Access Management I WebEx
- Month 3 - Facilities attend “Networking for Solutions” Learning Session
- Month 5 - Facilities attend QAPI and Vascular Access Management II WebEx
Goals and timeline for the Decreasing Catheters project were:
  - To increase by 1 percentage point each quarter to attain a four percentage point increase by March 2010.

Results: The Changing Patient Culture project was successful in both Networks 9 and 10. Both Networks met the goal that was set for March 2010 and continued to improve through September 2010.

Figure 47 and Figure 48 display the results of this project at the end of the project, March 2010 and for six months after (September 2010) for Network 9 and Network 10.
3. Community Partnerships - 18 dialysis facilities in Network 9 and 12 dialysis facilities in Network 10 were identified as having a lack of communication between dialysis facility staff and surgeons and hospitals. This lack of communication contributed to low AV fistula rates. They participated in an initiative designed to improve communications with their identified key partners. This project was part of the 2009-2010 Quality Improvement Work Plan (QIWP) for the Fistula First initiative.

Facility staff completed a root cause analysis identifying the external ESRD stakeholder(s) who were hindering fistula rate improvements which could include:

   a. Vascular surgeon(s)
   b. Nephrology office staff
   c. Primary care physician
   d. Hospital discharge planner
   e. Acute dialysis staff
   f. Other identified stakeholder

The facility staff developed plans to build a mutually rewarding relationship with their identified stakeholders. Network staff suggested techniques to begin the partnering process and provided specific tools and resources to assist in the project.
The project was conducted over a seven month period with monthly activities that included:

- Intervention-specific conference calls for participant networking and technical assistance from Network staff
- Evaluation of facilities’ monthly prevalent fistula rate increase (goal 0.33 percentage point) and reports to facilities
- Evaluation of project progress through the assessment of the facility vascular access management QAPI minutes

Additionally, each intervention included the following educational activities:

- Month 2 - Facilities attend QAPI and Vascular Access Management I WebEx
- Month 3 - Facilities attend “Networking for Solutions” Learning Session
- Month 5 - Facilities attend QAPI and Vascular Access Management II WebEx

Goals and timeline for the Community Partnerships project were:

- To increase by 1 percentage point each quarter to attain a four percentage point increase by March 2010.

**Results:** The Community Partnerships project was successful in Network 10 but fell short in Network 9. Network 10 met the goal that was set for March 2010 and continued to improve through September 2010. Network 9 improved but not at the quarterly rate that was set as goal.

Figure 49 and Figure 50 display the results of this project at the end of the project, March 2010 and for six months after (September 2010) for Network 9 and Network 10.
4. 2009 – 2010 Performance Improvement Plan (PIP) - Because CMS imposed a performance improvement plan (PIP) for failure to achieve 2009 vascular access goals,
the MRB worked during the second and third quarter of 2009 to strengthen quality improvement projects for improving fistula rates. Poor performers originally classified as a “comparison group” and not in a specific QIP were targeted for stronger intervention through Root Cause Analysis (RCA). A fourth QIP based on RCA was added in November 2009 to the 2009-2010 QIWP.

Network 9 had 61 newly targeted facilities and Network 10 had 18 newly targeted facilities in this RCA group. Facility staff was given an RCA tool designed to analyze their vascular access data and determine the cause of poor vascular access outcomes in their facility. They submitted the completed RCA tools to the Network for review and comment during November and December 2009. These facilities participated in the same interventions as the participants of the three original QIPs:

- Intervention-specific conference calls for participant networking and technical assistance from Network staff
- Evaluation of facilities’ monthly prevalent fistula rate increase (goal 0.33 percentage point) and reports to facilities
- Evaluation of project progress through the assessment of the facility vascular access management QAPI minutes

This intervention also included the following educational activities:

- Facilities attend “Networking for Solutions” Learning Session
- Facilities attend QAPI and Vascular Access Management II WebEx

The addition of the RCA facilities increased QIP participation numbers. Participating facilities increased in October 2009 to 216 or approximately 38% of all the facilities in Network 9/10.

Goals and timeline for the RCA project were:

- To increase by 1 percentage point each quarter to attain a four percentage point increase by March 2010. However, this group began the RCA process in November 2009.

**Results:** The RCA project was successful in Network 10 but fell short in Network 9. Network 10 met the goal that was set for March 2010 and continued to improve through September 2010. Even though Network 9 was unsuccessful in reaching the goal set for March 2010 it improved by 1 percentage point each quarter since the project start in November 2009 and continued to improve at the quarterly rate or better through September 2010.
Figure 51 and Figure 52 display the results of this project at the end of the project, March 2010 and for six months after (September 2010) for Network 9 and Network 10.
The PIP was closed for Network 10 in January 2010 because it was projected that the March 2010 goal would be achieved and it was in December 2009. The PIP was closed for Network 9 in October 2010 because we provided comprehensive monthly updates regarding the FF initiatives to CMS, the Network 9 AV fistula rate met the March 2010 goal in May 2010, and was well ahead of interim measures for the March 2011 goal.

5. Fistula First Quality Award: In 2005, The Renal Network established an award designed to recognize leaders of the Fistula First Initiative and provide them with a platform from which they can share their knowledge as mentors to other dialysis providers. Application for this award is voluntary and is viewed as a way for any group or individual to be recognized by providing performance processes and results in the area of placement and usage of AVF.

The goal of this award is to demonstrate performance outcomes above standards in the area of promoting AV fistula and vascular access management related to the FF Initiative. The award criteria were developed using the 11 Change Concepts of the CMS National Fistula First Initiative along with the K-DOQI guidelines.

Fistula First 11 Change Concepts
1. Routine CQI review of vascular access.
2. Timely referral to nephrologist
3. Early referral to surgeon for “AVF only” evaluation and timely placement.
4. Surgeon selection based on best outcomes, willingness, and ability to provide access services.
5. Full range of appropriate surgical approaches to AVF evaluation and placement.
7. AVF placement in patients with catheters where indicated.
8. Cannulation training for AV fistulas.
9. Monitoring and maintenance to ensure adequate access function.
10. Education for care givers and patients.
11. Outcomes feedback to guide practice.

This performance award is defined by criteria that demonstrate rapid, sustainable improvement defined by a time-specific aim, and quantitative measures to display improvement and identification of process changes that lead to project advancement. Winners are selected based on a voluntary application that describes their processes to
place and maintain fistula and decrease catheters, as well as program outcomes. Winners are announced at the annual meeting of the Network Council and are used as mentors for educational activities.

In 2008, in memory of Dr. Richard Breitenfield, a quality champion in Network 9, the title of the award was changed to the “Dr. Richard Breitenfield Quality Award.” In 2010 facilities could apply and be considered for this award if they had a prevalent AV fistula rate of 66% or higher.

Eight facilities filed applications for the 2010 Dr. Richard Breitenfield Quality Award. A volunteer panel consisting of members of the MRB and VAAP reviewed the applications. Four of the award applicants had outcomes greater than their Network prevalent fistula rate and had put processes into place that helped them achieve superior results. All four award winners could extensively describe each process that assisted in their great outcomes.