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 2011, 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.

**2011 Primary objectives:**

- To increase the prevalence rate of AV fistula in Network 9 from 54.2 percent in March 2011 to 56.6 percent in March 2012 (an increase of 2.4 percentage points) and to increase Network 10 from 57.2 percent in March 2011 to 59.0 percent in March 2012 (an increase of 1.8 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 2011 is detailed in Figure 44:

**Figure 44.**
**Network 9/10**
**Fistula First Percentages**
**Fistula Prevalence as of December 2011**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Mar’11</td>
<td>Dec’11</td>
<td>Mar’11</td>
<td>Dec’11</td>
</tr>
<tr>
<td>Fistula Prevalence</td>
<td>54.2%</td>
<td>57.1%</td>
<td>57.2%</td>
<td>59.4%</td>
</tr>
</tbody>
</table>

**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.
- **Strategy 7: FFBI Change Concepts** - Expand and endorse the current Change Concepts for education and promotion throughout the renal, surgical, and interventional communities.

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 continued to market the vascular access management resources handbook that was developed in 2010. 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 many of the tools provided on the FFBI Web site. 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. A 3Ps Toolkit was posted on The Renal Network, Inc. Web site, www.therenalnetwork.org, providing all available tools electronically that addresses Prevent Catheter, Place and Use Fistula, and Preserve Fistula.

Nationally, Network 9/10 participated on the FFBI conference calls for Network Quality Improvement Directors (QIDs) on February 9, March 9, April 13, May 18, June 8, July 13, August 10, October 12, November 9, and December 21, 2011.

**Vascular Access Advisory Panel Coalition.** A panel of experts oversees the Fistula First Initiatives, under the direction of the MRB. This Vascular Access Advisory Panel Coalition (VAAPC) was organized at the beginning of the Fistula First Initiative in 2004. The VAAPC continued its activities during 2011.

Members of the panel include:

<table>
<thead>
<tr>
<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>Stephen Adley, R.N.</td>
<td>FMC</td>
<td>North Olmstead</td>
<td>Ohio</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>
</tr>
<tr>
<td>Deepa Chand, M.D.</td>
<td>Akron Children’s Medical</td>
<td>Akron</td>
<td>Ohio</td>
</tr>
<tr>
<td>Name</td>
<td>Center</td>
<td>City</td>
<td>State</td>
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</tr>
<tr>
<td>Catherine Colombo, R.N.</td>
<td>Chicago</td>
<td>Illinois</td>
<td></td>
</tr>
<tr>
<td>Peter DeOreo, M.D.</td>
<td>Centers for Dialysis Care</td>
<td>Cleveland</td>
<td>Ohio</td>
</tr>
<tr>
<td>Mary Hammes, D.O.</td>
<td>Woodlawn Dialysis</td>
<td>Chicago</td>
<td>Illinois</td>
</tr>
<tr>
<td>Richard Hellman, M.D.</td>
<td>DCI Indianapolis</td>
<td>Indianapolis</td>
<td>Indiana</td>
</tr>
<tr>
<td>Mike Kraus, M.D.</td>
<td>IU Medical Center</td>
<td>Indianapolis</td>
<td>Indiana</td>
</tr>
<tr>
<td>Gordon McLennan, M.D.</td>
<td>Cleveland Clinic</td>
<td>Cleveland</td>
<td>Ohio</td>
</tr>
<tr>
<td>Prabir Roy-Chaudhury, M.D.</td>
<td>University of Cincinnati</td>
<td>Cincinnati</td>
<td>Ohio</td>
</tr>
<tr>
<td>Marcia Silver, M.D.</td>
<td>Metro Health Medical Center</td>
<td>Cleveland</td>
<td>Ohio</td>
</tr>
<tr>
<td>Louis Thibodeaux, M.D.</td>
<td>General &amp; Vascular Surgical Specialists</td>
<td>Cincinnati</td>
<td>Ohio</td>
</tr>
<tr>
<td>Jay B. Wish, M.D.</td>
<td>University Hospitals of Cleveland</td>
<td>Cleveland</td>
<td>Ohio</td>
</tr>
</tbody>
</table>

The VAAPC is charged with developing and implementing strategies to achieve Fistula First goals, under the direction of the MRB. The VAAPC met twice during 2011, once in May and once in October. Conference calls were scheduled during interim times to continue the work of this advisory body. Reports of VAAPC activities were made continuously to the MRB. Network staff participates on the national FFBI coalition, so ideas between these two groups are shared routinely.

**Data Distribution.** Fistula First Facility Specific Reports were sent to all hemodialysis programs in February 2011 to show fourth quarter 2010 data, June 2011 to show first quarter 2011 data, September 2011 to show second quarter 2011 data, and December 2011 to show third quarter 2011 data. Fourth quarter 2011 data will be sent in February 2012.

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, mentoring, and demonstrating best practices.

**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.

• February 7, 2011: Emailed nurse managers, vascular access coordinators, and medical directors marketing the Network’s AVF Assessment and Cannulation Resources page on the Web site.

• February 8 and 10, 2011: A Vascular Access Success Stories webinar was held; 547 participants attended.

• March 2011: A poster was created, entitled “Are You Using the Gold Standard,” with input from the PLC and MRB. This poster was sent to facilities, along with patient stories about their fistula journeys to assist them when helping patients identify the AVF as the best access.

• March 3, 2011: Emailed announcement concerning 2010 Fistula First Comprehensive Fistula Construction and Management Program for Surgeons: “How to Make Fistulas that Work” that was held in Chicago, Illinois in November 2010 was available on HDCN website and linked to from the FFBI website to medical directors, nurse managers, vascular access coordinators, nurse practitioners, and surgeons.

• May 23, 2011: A Cannulation Camp was held in northern Indiana/Chicago, Illinois area. The agenda consisted of vascular access assessment, cannulation, and QAPI principles. 168 participants attended this educational offering.

• June 7, 2011- A Cannulation Camp was held in Cincinnati, Ohio. The agenda consisted of vascular access assessment, cannulation, and QAPI principles. 160 participants attended this educational offering.

• August 9 and 11, 2011: An “Improving Incident Vascular Access Outcomes Through Physician Group Practice QAPI” webinar was held. Discussion surrounded areas to consider for improving vascular access outcomes regarding AVF placement, maintenance, and monitoring. A total of 70 facility representatives from Network 9 and 27 facility representatives from Network 10 attended the webinar over the two days. There were 27 physicians that attended this webinar.

• August 16, 2011: A save the date flyer regarding the Fistula First Comprehensive Fistula Construction and Management Program for Surgeons was emailed to surgeons and medical directors in the Network 9/10 area. This program was presented by Network 5 and Network 6 on December 2, 2011 in Atlanta, GA.

• September 13, 2011: A learning session entitled “Saving Lives-One Dialysis Treatment at a Time” was held in Indianapolis, IN. One of the presentations focused on AVF assessment and monitoring. There were a total of 230 attendees at the learning session; 170 participants represented Network 9 and 60 participants represented Network 10.
October 4 and 5, 2011: The “66% AVF rates-Attainable & Sustainable” webinar was held. There were two presentations regarding best practices in the areas of AVF placement, maintenance, and monitoring. There were 81 participants from Network 9 and 39 participants from Network 10.

October 6, 2011: Emails were sent to nephrologists, administrators, nurse managers, and vascular access coordinators in Networks 9 and 10. This email announced changes to the FFBI Change Concept #7. There was a clarification to the statement that nephrologists should not admit “catheter only” patients.

October 27, 2011: A Vascular Access Informational Webinar for non-intervention small facilities was held. Discussion surrounded areas to consider for small facilities to improve vascular access outcomes regarding AVF placement, maintenance, and monitoring.

October 27, 2011: A Vascular Access Informational Webinar for non-intervention facilities that have not made improvement was held. Discussion surrounded areas to consider for facilities to improve vascular access outcomes regarding AVF placement, maintenance, and monitoring.

November 30, 2011: Surgeon reports were sent to surgeons in Networks 9 and 10. These reports utilized 2007 and 2009 Medicare Part B claims data from CMS and made available to Networks through FFBI.

December 2, 2011: An announcement was emailed regarding new videos on the FFBI website illustrating AV Fistula physical exam. The announcement was sent to nephrologists, administrators, nurse managers, and vascular access coordinators in Networks 9 and 10.

Physician specific incident CKD patient vascular access data reports were sent to nephrologists in July 2011 (January 2, 2011 – June 30, 2011 incident data) and February 2012 (July 1, 2011 – December 31, 2011 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.

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 twice in 2011 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 also conducted some site visits in 2011. Staff also partnered with LDOs to present at physician meetings and quality meetings.

- March 17, 2011: A DaVita Medical Director Summit was held in Cincinnati, Ohio. The Network Executive Director partnered with DaVita management to present medical director responsibilities regarding vascular access management and AV fistula improvement to DaVita facility medical directors.
- March 22, 2011: The Executive Director presented to the Central Indiana nephrology group practices as a follow-up from June 2010. The agenda focused on barriers to fistula placement and use, and medical director responsibilities.
- April 4, 2011: A DaVita Medical Director Summit was held in Indianapolis, Indiana. The Network Executive Director partnered with DaVita management and presented medical director responsibilities regarding vascular access management and AV fistula improvement to DaVita facility medical directors.
- July through September 2011: The quality improvement staff worked one-on-one with 30 QIP facility nurse managers in Network 9, and 11 QIP facility nurse managers in Network 10, providing technical assistance in QAPI processes and requested materials to improve vascular access management outcomes.
- August 11, 2011: The Executive Director, the Vascular Access Advisory Panel Coalition Chair, and the Quality Improvement Director conducted a meeting with two medical directors from FMC facilities in Indianapolis, IN with high catheter and low fistula rates. Discussion surrounded physician office and dialysis facility processes, barriers to improvement, and suggestions on how to improve vascular access management outcomes.
- August 25, 2011: The Executive Director, the Vascular Access Advisory Panel Coalition Chair, and the Quality Improvement Director conducted a meeting with two additional medical directors from FMC facilities in Indianapolis, IN with high catheter and low fistula rates. Discussion surrounded physician office and dialysis facility processes, vascular access center processes, barriers to improvement, and suggestions on how to improve vascular access management outcomes.
October through December 2011: The quality improvement staff worked, one-on-one, via telephone with 45 QIP facility nurse managers in Network 9 and 43 QIP facility nurse managers in Network 10 providing technical assistance in QAPI processes and requested materials to improve vascular access management outcomes.

November 3, 2011: The Vascular Access Advisory Panel Coalition Chair presented at a FMC Summit in Indianapolis, IN focused on nephrologists and medical directors. Discussion surrounded areas to consider for improvement in vascular access outcomes regarding AVF placement, maintenance, and monitoring.

**2010-2011 Fistula First Completed Projects**

The following activities were designed as components of the 2010-2011 Fistula First quality improvement project and were completed in March 2011.

There were two intervention groups that were part of the 2010-2011 Fistula First quality improvement project:

1. **Placement and Assessment of Fistula Intervention -** facilities with at least 30 patients and fistula rates below 55% (poor performing facilities) submitted to the Network a facility-specific root cause analysis and an action plan that was updated quarterly. Network 9 had 63 facilities participating and Network 10 had 23 facilities participating in this intervention group.

2. **Promising Stars Focus Group -** facilities with at least 30 patients and fistula rates between 55-62% (early adopters) received the *3Ps Vascular Access Management Handbook*. These facilities were asked to utilize at least one new tool and/or process from the handbook and report to the Network quarterly on the improvements made through the use of the handbook. Network 9 had 71 facilities participating and Network 10 had 46 facilities participating in this intervention group.

There is a third group that is discussed in the Facility Specific Quality Assessment and Improvement Project area (Catheter Reduction QIP). This project, Catheter Out/Fistula In: Targeting Catheter Reduction to Increase AV Fistula Rate (Catheter Reduction QIP), while not in the Fistula First QIP specifically, does contribute to the increase of Network-wide AV fistula rates and is tracked for fistula improvement as well as catheter reduction.
Network 9 had 132 facilities participating and Network 10 had 60 facilities participating in this intervention group.

This AV fistula rate improvement project incorporated an eight-step project model in the two interventions, Placement and Assessment of Fistula and Promising Stars Focus Group. The eight steps include:

1. Statistical analysis to identify facilities in need of intervention (facilities with outcomes that were below 55% prevalent fistulas) and facilities that need extra attention to continue improving fistula rates (facilities with outcomes between 55-62% prevalent fistulas).
2. Conducting root cause analysis with targeted facilities to discover barriers to improvement at the facility level.
3. Requiring action plans that align with facility QAPI projects addressing barriers from each facility targeted for intervention.
4. Providing conference calls for QIP participants and learning sessions for targeted facilities on topics identified through the RCA.
5. Collecting facility specific data through the fistula first dashboard and providing participating facilities with data feedback reports monthly.
6. Identifying benchmark facilities (defined as those facilities with either a fistula rate at goal or increasing by at least one percentage point per quarter) and sharing tools and resources with participating facilities.
7. Increasing the number of facility site visits and individual facility conference calls for poor performers.
8. Analysis of facility specific data monthly to determine which facilities are successfully achieving QIP goals and which facilities are in need of additional intervention.

These interventions combined with an aggressive approach to data feedback in the non-intervention facilities was used as the project design for this QIP. The following interventions conducted:

**Placement and Assessment of Fistula Intervention (<55%):**

Tasks that were conducted for the place and monitor fistula intervention:

- Facility medical directors, nurse managers, and administrators received an introductory letter outlining their poor performance and an overview of the project.
- Facility staff submitted to the Network a RCA to identify barriers to improving fistula rates in their facility.
• Facility staff submitted to the Network an action plan detailing the steps to be taken to improve fistula rates in their facility.
• Facility staff submitted to the Network updated action plans at least quarterly.
• Network staff evaluated the RCA and action plan and provided technical support as needed on an individual facility basis.

The project was conducted over a nine month period with activities that included:
• Evaluation of facilities’ monthly prevalent fistula rate increase (goal 0.33 percentage point) and feedback reports to facilities.
• Facility site visits or conference calls for participants that did not meet the monthly/quarterly goals.
• Evaluation of project progress through the assessment of the facility vascular access management action plan.

Additionally, the intervention included the following educational activities:
• Month 2 – Facilities attend a QAPI/Vascular Access Management Best Practice WebEx.
• Month 3/5 -Facilities attend Vascular Access Management Learning Session based on preventing catheters, placing and using fistula, and preserving fistula.
• Month 7 - Facilities attend Vascular Access Management WebEx describing best practice.

**Promising Stars Focus Group Intervention (55-62%):**
Tasks that were conducted for the Promising Stars intervention:
• Facility medical directors, nurse managers, and administrators received an introductory letter outlining their participation in this project and an overview of the project.
• Facility staff attended a “kickoff” WebEx describing the intervention project.
• Facility staff chose at least one new tool and/or process from the 3Ps Vascular Access Management Handbook.
• Facility staff reported to the Network which tool they were using and reported quarterly on the improvements made through the use of the handbook.
• Network staff evaluated the tools selected with improvements made and provided technical support as needed.

The project was conducted over a nine month period with activities that include:
• Evaluation of facilities’ monthly prevalent fistula rate increase (goal 0.33 percentage point) and feedback reports to facilities.
• Facility conference calls for participants that did not meet the monthly/quarterly goals.
• Evaluation of project progress through the reporting of the use of the handbook.

Additionally, the intervention includes the following educational activities:
• Month 2 – Facilities attend a QAPI/Vascular Access Management Best Practice WebEx.
• Month 3/5 - Facilities attend Vascular Access Management Learning Session based on preventing catheters, placing and using fistula, and preserving fistula.
• Month 7 - Facilities attend Vascular Access Management WebEx describing best practice.

This group was started in September 2010 giving it six months to achieve goal after the start of the interventions.

Catheter Out/Fistula In: Targeting Catheter Reduction to Increase AV Fistula Rate:
This project, Catheter Out/Fistula In: Targeting Catheter Reduction to Increase AV Fistula Rate (Catheter Reduction QIP), while not in the Fistula First QIP specifically, does increase the number of facilities that will be focusing on vascular access management and, in turn, will assist in increasing the Network-wide AV fistula rates.

See specific interventions discussed in the Facility Specific Quality Assessment and Improvement Project area (Catheter Reduction QIP).

Network Wide Intervention:
Network 9/10 provides education, tools, and resources to address the identified barriers to facility systems improving prevalent fistula rates.

There are 206 facilities in Network 9 and 73 facilities in Network 10 that are not participating in the previous described interventions. These facilities either have fistula rates >62% and/or have patient populations of less than 30. These facilities received the resources and tools listed below as part of the Network wide intervention.

Each facility medical director and vascular access coordinator in Networks 9 and 10 received during 2010-2011:
1. A monthly outcomes feedback report including:
   • Prevalent fistula rates compared to region, state, Network, and US
   • A facility fistula rate ranking
• Graphs displaying one year’s worth of prevalent fistula in use, catheter with fistula maturing, catheter <90 days, and catheter >90 days rates

2. Bi-monthly electronic newsletter including:
   • Information on tools for changing facility processes
   • Important aspects of a successful QAPI program

3. Notification/invitation to educational programs:
   • One QAPI/Vascular Access Management Best Practice WebEx
   • One Vascular Access Management Learning Session providing tools and resources on
     o preventing catheters,
     o placing and using fistula,
     o and preserving fistula
   • One Vascular Access Management WebEx describing best practice

4. The 3Ps Vascular Access Management Handbook housing resources, tools, and best practices regarding:
   • preventing catheters
   • placing and using fistula
   • preserving fistula

Figures 45 and 46 display the AV fistula percentage point improvement rate results for each intervention group by quarter until the end of the project on March 2011 for Network 9 & Network 10.

**Figure 45: Network 9**

*Quarterly Interim Outcomes (Percentage Point Improvement)*

<table>
<thead>
<tr>
<th>March 31, 2011 Goal</th>
<th>March 2010</th>
<th>March 2011</th>
<th>Variance from March 31, 2011 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>54.1%</td>
<td>51.1%</td>
<td>54.2%</td>
<td>+0.1 (Exceeded Goal)</td>
</tr>
</tbody>
</table>

| Placement & Assessment of Fistula | 1.53 | 1.85 | 1.56 | 2.08 |
| Catheter Reduction | 1.49 | 2.64 | 4.26 | 5.63 |
Goals and timeline for the Fistula First QIP were:

- Network 9: to increase the percentage of prevalent patients with a fistula by one percentage point each quarter for an increase of at least 3.0 percentage points to reach $54.1\%$ by March 2011. **Network 9 met this goal in March 2011.**

- Network 10: to increase the percentage of prevalent patients with a fistula by one percentage point each quarter for an increase of at least 2.4 percentage points to reach $56.6\%$ by March 2011. **Network 10 met this goal in December 2010.**