NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all yellow highlighted areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: If there is no TAP or workgroup, the SC also evaluates the subcriteria (yellow highlighted areas).

Steering Committee: Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) NQF Review #: 1432  NQF Project: End Stage Renal Disease

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTIVE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>De.1 Measure Title: Dietary Sodium Reduction Advice</td>
</tr>
<tr>
<td>De.2 Brief description of measure: The proportion of patients who have received formal advice on dietary sodium restriction by the renal dietician within the past 90 days</td>
</tr>
<tr>
<td>1.1-2 Type of Measure: Process</td>
</tr>
<tr>
<td>De.3 If included in a composite or paired with another measure, please identify composite or paired measure N/A</td>
</tr>
<tr>
<td>De.4 National Priority Partners Priority Area: Population health</td>
</tr>
<tr>
<td>De.5 IOM Quality Domain: Effectiveness</td>
</tr>
<tr>
<td>De.6 Consumer Care Need: Living with illness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONDITIONS FOR CONSIDERATION BY NQF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:</td>
</tr>
</tbody>
</table>

A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.
A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes
A.2 Indicate if Proprietary Measure (as defined in measure steward agreement):
A.3 Measure Steward Agreement: Government entity and in the public domain - no agreement necessary
A.4 Measure Steward Agreement attached: Y

B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least
B.1 Measure Owner/STeward verifies annually | N

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
1. IMPORTANCE TO MEASURE AND REPORT

The extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)

1a. High Impact

**(for NQF staff use) Specific NPP goal:**

<table>
<thead>
<tr>
<th>Demonstrated High Impact Aspect of Healthcare:</th>
<th>Affects large numbers, Frequently performed procedure, Patient/societal consequences of poor quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.1</td>
<td>Restriction of dietary sodium is widely recognized as a public health priority (Bibbins-Domingo 2010; Frieden &amp; Briss 2010; Smith-Spangler, et al. 2010) and is critical to the management of hypertension and improving the volume expanded state common among dialysis patients (Appel &amp; Anderson 2010; Kayikcioglu 2009; KDOQI 2006).</td>
</tr>
</tbody>
</table>

1a.4 Citations for Evidence of High Impact:

Overall, Level B evidence as rated by the Fluid Weight Management Clinical Technical Expert Panel using an 1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Excessive salt intake stimulates thirst that leads to a state of fluid overload or over hydration particularly in the ESRD population, where lack of renal function restricts the ability to excrete sodium and the body is almost entirely dependent on dialysis for providing this important function. Restriction of dietary sodium has been widely recognized in recent times as a public health priority and remains critical to the management of hypertension and improving the volume expanded state common among dialysis patients.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers: There have been no formal studies of how frequently dialysis facilities provide formal advice or counseling focused specifically on dietary sodium intake. Although sodium reduction is recognized as important, the extent of this practice is currently unknown as dietary sodium counseling has not been objectively assessed as a performance process measure.

1b.3 Citations for data on performance gap: N/A

1b.4 Summary of Data on disparities by population group: Disparities for dietary sodium reduction advice by population group have not been reported in the literature.

1b.5 Citations for data on Disparities: N/A

1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population): Excessive salt intake stimulates thirst that leads to excessive interdialytic weight gain thereby leading to a state of fluid overload or over hydration especially in the ESRD population, where lack of renal function restricts the ability to excrete sodium and the body is almost entirely dependent on dialysis for providing this important function.

1c.2-3. Type of Evidence: Observational study, Evidence-based guideline, Expert opinion

1c.4 Summary of Evidence (as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome): High interdialytic weight gain has been associated with adverse outcomes (Leggat 1998; Saran 2003; Kalantar-Zadeh 2009). The experience from Tassin, France supports the diligent use of dietary sodium restriction in the management of dialysis patients, in addition to slow ultrafiltration and longer treatment time (Charra & Chazot 2003). A retrospective cross-sectional comparative study of 2-centers reported that in the center practicing a strict low salt strategy and blood pressure control was significantly better and there was lower prevalence of left ventricular hypertrophy among patients who had been on HD for at least one year at the two centers (Kayikcioglu 2009). Expert opinion consistently emphasizes this strategy in preference to pure fluid restriction advice alone (Wright 2010; Ahmad 2004; Charra & Chazot 2003). Admittedly, there is lack of evidence based upon randomized trials in the area of dietary sodium restriction in dialysis patients, possibly because it is, to a large degree, taken for granted in this population and not considered a ‘state of the art’ intervention.

1c.5 Rating of strength/quality of evidence (also provide narrative description of the rating and by whom): Overall, Level B evidence as rated by the Fluid Weight Management Clinical Technical Expert Panel using an...
assessment scale similar to KDOQI. Predominantly from observational studies in dialysis. However, in the hypertensive population, there have been randomized clinical trials showing benefits of salt restriction for blood pressure control.

1c.6 Method for rating evidence: The clinical TEP followed similar methods of evidence assessment as that used by the KDOQI clinical practice guidelines.

1c.7 Summary of Controversy/Contradictory Evidence: There is no controversy over the importance of dietary sodium restriction in dialysis patients.


1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number): This measure is supported by the following 2006 KDOQI guidelines:

5.1 - The ultrafiltration component of the HD prescription should be optimized with a goal to render the patient euvolemic and normotensive. This includes counseling the patient on sodium and fluid restriction, adequate ultrafiltration, and the use of diuretics in patients with Residual Kidney Function. (Evidence Level A)

5.2 - Daily dietary sodium intake should be restricted to no more than 5 g of sodium chloride (2.0 g or 85 mmol of sodium). (Evidence Level A)


1c.11 National Guideline Clearinghouse or other URL: N/A

1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom): The 2006 KDOQI guidelines were based on Work Group consensus.

1c.13 Method for rating strength of recommendation (if different from USPSTF system, also describe rating and how it relates to USPSTF): N/A

1c.14 Rationale for using this guideline over others: There are no other known guidelines pertaining to dietary sodium restriction in dialysis patients.

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Importance to Measure and Report? 1

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
Steering Committee: Was the threshold criterion, Importance to Measure and Report, met?
Rationale:

<table>
<thead>
<tr>
<th>2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)</td>
</tr>
</tbody>
</table>

| S.1 Do you have a web page where current detailed measure specifications can be obtained? |
| S.2 If yes, provide web page URL: |

<table>
<thead>
<tr>
<th>2a. MEASURE SPECIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a. Precisely Specified</td>
</tr>
<tr>
<td>2a.1 Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome): Number of patients in the denominator who have received formal advice on dietary sodium restriction by the renal dietician within the past 90 days.</td>
</tr>
<tr>
<td>2a.2 Numerator Time Window (The time period in which cases are eligible for inclusion in the numerator): The 90 day period prior to the end of the reporting period.</td>
</tr>
<tr>
<td>2a.3 Numerator Details (All information required to collect/calculate the numerator, including all codes, logic, and definitions): A data element recording the date of the most recent &quot;patient education on sodium restriction&quot; will be included in the 2011 CROWNWeb national roll-out. Formal documentation of dietary advice/counseling regarding sodium restriction should be signed by the registered renal dietician at the facility.</td>
</tr>
<tr>
<td>2a.4 Denominator Statement (Brief, text description of the denominator - target population being measured): Number of patients in an outpatient dialysis facility undergoing chronic maintenance dialysis.</td>
</tr>
<tr>
<td>2a.5 Target population gender: Female, Male</td>
</tr>
<tr>
<td>2a.6 Target population age range: Adults 18 years or older.</td>
</tr>
<tr>
<td>2a.7 Denominator Time Window (The time period in which cases are eligible for inclusion in the denominator): The 90 day period prior to the end of the reporting period.</td>
</tr>
<tr>
<td>2a.8 Denominator Details (All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions): Denominator includes hemodialysis (HD) and peritoneal dialysis (PD) patients.</td>
</tr>
<tr>
<td>2a.9 Denominator Exclusions (Brief text description of exclusions from the target population): None.</td>
</tr>
<tr>
<td>2a.10 Denominator Exclusion Details (All information required to collect exclusions to the denominator, including all codes, logic, and definitions): N/A</td>
</tr>
<tr>
<td>2a.11 Stratification Details/Variables (All information required to stratify the measure including the stratification variables, all codes, logic, and definitions): No stratification is required for this measure.</td>
</tr>
<tr>
<td>2a.12-13 Risk Adjustment Type: No risk adjustment necessary</td>
</tr>
<tr>
<td>2a.14 Risk Adjustment Methodology/Variables (List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method): N/A</td>
</tr>
</tbody>
</table>

Comment [KP8]: 2a. The measure is well defined and precisely specified so that it can be implemented consistently within and across organizations and allow for comparability. The required data elements are of high quality as defined by NQF's Health Information Technology Expert Panel (HITEP). |

Comment [k9]: 11 Risk factors that influence outcomes should not be specified as exclusions. 12 Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.
2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Better quality = Higher score

2a.20 Interpretation of Score: Better quality = Higher score

2a.21 Calculation Algorithm (Describe the calculation of the measure as a flowchart or series of steps): A patient’s age is determined as of the date 90 days prior to the end of the reporting month. Patients are counted as being in the facility for the entire 90 day period if “Admit Date” to the specified facility is prior or equal to the first day of the study period (90 days prior to the end of the reporting month), AND the patient has not been discharged (“Discharge Date” is null or blank), OR “Discharge Date” from the facility is greater than or equal to the last day of the reporting period. Patients are included in the denominator if they are at least 18 years old and were continuously enrolled in the dialysis facility for the previous 90 days. Patients are included in the numerator if they are in the denominator and the facility has documentation that the patient has received formal advice on dietary sodium restriction by the renal dietician within the most recent formal sodium advice (as indicated by the corresponding CROWNWeb data element- see numerator details) is less than or equal to 90. The measure is calculated by dividing the numerator by the denominator.

2a.22 Describe the method for discriminating performance (e.g., significance testing): The performance of the facility will be compared to state, Network and national performance.

2a.23 Sampling (Survey) Methodology If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate): N/A

2a.24 Data Source (Check the source(s) for which the measure is specified and tested) Electronic clinical data

2a.25 Data source/data collection instrument (Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.): CROWNWeb


2a.32-35 Level of Measurement/Analysis (Check the level(s) for which the measure is specified and tested) Facility/Agency

2a.36-37 Care Settings (Check the setting(s) for which the measure is specified and tested) Dialysis Facility

2a.38-41 Clinical Services (Healthcare services being measured, check all that apply) Dialysis

2b. Reliability testing

2b.1 Data/sample (description of data/sample and size): The measure has not been tested for reliability.

2b.2 Analytic Method (type of reliability & rationale, method for testing): N/A; see above.

2b.3 Testing Results (reliability statistics, assessment of adequacy in the context of norms for the test conducted):

Comment [KP10]: 2b. Reliability testing demonstrates the measure results are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period.

Comment [K11]: 8 Examples of reliability testing include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing may address the data items or final measure score.
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Rating</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2c.1</td>
<td>Data/sample (description of data/sample and size): Data are not available to test the validity of the measure; however, a clinical technical expert panel (C-TEP) evaluated the measure.</td>
<td>N/A</td>
<td>see above.</td>
</tr>
<tr>
<td>2c.2</td>
<td>Analytic Method (type of validity &amp; rationale, method for testing): Face validity is the only validity assessed. The validity was assessed by a vote by the C-TEP.</td>
<td>C</td>
<td>Comment [KP12]: 2c. Validity testing demonstrates that the measure reflects the quality of care provided, adequately distinguishing good and poor quality. If face validity is the only validity addressed, it is systematically assessed.</td>
</tr>
<tr>
<td>2c.3</td>
<td>Testing Results (statistical results, assessment of adequacy in the context of norms for the test conducted): The measure was unanimously ratified by the C-TEP as a valid measure.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2d.1</td>
<td>Summary of Evidence supporting exclusion(s): There are no exclusions.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2d.2</td>
<td>Citations for Evidence:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2d.3</td>
<td>Data/sample (description of data/sample and size):</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2d.4</td>
<td>Analytic Method (type analysis &amp; rationale):</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2d.5</td>
<td>Testing Results (e.g., frequency, variability, sensitivity analyses):</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2e.1</td>
<td>Data/sample (description of data/sample and size): Risk adjustment is not necessary for this measure.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2e.2</td>
<td>Analytic Method (type of risk adjustment, analysis, &amp; rationale):</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2e.3</td>
<td>Testing Results (risk model performance metrics):</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2e.4</td>
<td>If outcome or resource use measure is not risk adjusted, provide rationale:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2f.1</td>
<td>Data/sample from Testing or Current Use (description of data/sample and size): The measure is not currently in use; no data were available for testing.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2f.2</td>
<td>Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis &amp; rationale):</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2f.3</td>
<td>Provide Measure Scores from Testing or Current Use (description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2g.1</td>
<td>Data/sample (description of data/sample and size): Multiple data sources are not allowed for this measure and therefore testing is not applicable.</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

Comment [KP13]: 9 Examples of validity testing include, but are not limited to: determining if measure scores can predict scores on some other related valid measure; content validity for multi-item scales/tests. Face validity is a subjective assessment of whether the measure reflects the quality of care (e.g., whether the proportion of patients with BP < 140/90 is a marker of quality). If face validity is the only validity addressed, it is systematically assessed (e.g., ratings by relevant stakeholders) and the measure is judged to represent quality care for the specific topic and that the measure is determined to be face valid for the specific topic. Therefore, testing is not applicable.

Comment [K17]: 13 Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care such as race, socioeconomic status, gender (e.g., poorer treatment outcomes of African American men with prostate cancer, inequalities in tree...

Comment [K19]: 14 With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage...
### Analytic Method (type of analysis & rationale)

**2g.2**

| N/A |

### Testing Results (e.g., correlation statistics, comparison of rankings)

**2g.3**

| N/A |

### Disparities in Care

**2h.1** If measure is stratified, provide stratified results (scores by stratified categories/cohorts): N/A

**2h.2** If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans: N/A

**TAP/Workgroup:** What are the strengths and weaknesses in relation to the subcriteria for **Scientific Acceptability of Measure Properties**?

**Steering Committee:** Overall, to what extent was the criterion, **Scientific Acceptability of Measure Properties**, met?

| 2 |

### Usability

**3a. Meaningful, Understandable, and Useful Information**

**3a.1** Current Use: **Testing not yet completed**

**3a.2** Use in a public reporting initiative (disclosure of performance results to the public at large) (**If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years**);

This measure is currently not publicly reported. This measure could be considered for public reporting on Medicare’s Dialysis Facility Compare website in the future.

**3a.3** If used in other programs/initiatives (**If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years**):

None.

**Testing of Interpretability** (**Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement**)

**3a.4** Data/sample (**description of data/sample and size**):

Testing of interpretability has not been performed.

**3a.5** Methods (**e.g., focus group, survey, QI project**):

N/A

**3a.6** Results (**qualitative and/or quantitative results and conclusions**):

N/A

### Relation to other NQF-endorsed measures

**3b/3c.**

| N/A |

### Harmonization

**3b.**

| N/A |
4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

3a. Data Generated from An External Data Source

3a.1 How are the data elements that are needed to compute measure scores generated?

Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition)

3a.2 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?

No

3b. Electronic Sources

3b.1 Are all the data elements available electronically? (elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims)

Yes

3b.2 Are the measure specifications harmonized? If not, why?

3c. Distinctive or Additive Value

3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:

5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:

N/A

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Usability?

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

3

4a. Data Generated as a Byproduct of Care Processes

4a.1-2 How are the data elements that are needed to compute measure scores generated?

Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition)

4b. Electronic Sources

4b.1 Are all the data elements available electronically? (elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims)

Yes

4b.2 If not, specify the near-term path to achieve electronic capture by most providers.

4c. Exclusions

4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?

No

4c.2 If yes, provide justification.

4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences

4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.

The requested information should be available in patient medical records as standard practice guidelines require documentation of dietician contact with patients.

4e. Data Collection Strategy/Implementation

4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/implementation
Issues:
The measure was evaluated by a clinical technical expert panel (C-TEP) and data technical expert panel (D-TEP) with representatives from both large and small dialysis organizations. Both panels agreed that the data elements would be easy to collect.

4e.2 Costs to implement the measure (costs of data collection, fees associated with proprietary measures):
The estimated data collection burden and associated cost estimates for comparable measures are presented in Tables 1-3 in the Federal Register. Vol. 73, No. 73 page 20469. URL: http://www.cms.gov/CFCsAndCoPs/downloads/ESRDfinalrule0415.pdf

4e.3 Evidence for costs:
See above reference to Federal Register.

4e.4 Business case documentation: Reducing dietary sodium intake has been shown to be cost-effective for the general population. Sodium restrictions are likely to be even more cost-effective for end-stage renal disease patients where hypertension is nearly universal and restricting dietary sodium is recognized as important for both volume and blood pressure control. It should be relatively easy to implement a formal dietary sodium reduction strategy in dialysis facilities where renal dieticians are routinely available at the present time.

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Feasibility?

| Steering Committee: Overall, to what extent was the criterion, Feasibility, met? |
|---------------------------------------------------------------|-----------------|-----------------|------------------|
| Rationale:                                                   |                 |                 |                  |

RECOMMENDATION
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.

Steering Committee: Do you recommend for endorsement?

<table>
<thead>
<tr>
<th>Comments:</th>
<th></th>
</tr>
</thead>
</table>

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner)
Co.1 Organization
Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland, 21244

Co.2 Point of Contact
Thomas, Dudley, Thomas.Dudley@cms.hhs.gov, 410-786-1442-

Measure Developer if different from Measure Steward

Co.3 Organization
Arbor Research/UM-KECC, 315 W. Huron Street, Ann Arbor, Michigan, 48103

Co.4 Point of Contact
Adrienne, Janney, adrienne.janney@arborresearch.org, 734-665-4108-

Co.5 Submitter if different from Measure Steward POC
Thomas, Dudley, Thomas.Dudley@cms.hhs.gov, 410-786-1442-, Centers for Medicare & Medicaid Services

Co.6 Additional organizations that sponsored/participated in measure development

ADDITIONAL INFORMATION
**Workgroup/Expert Panel involved in measure development**

Ad.1 Provide a list of sponsoring organizations and workgroup/panel members’ names and organizations.

**Describe the members’ role in measure development.**
- Dr. Rajiv Agarwal, panel chair (University of Indiana, School of Medicine, Indianapolis, IN)
- Dr. Nathan Levin (Renal Research Institute, New York, NY)
- Dr. John Daugirdas (University of Chicago, Chicago, IL)
- William Peckham (http://www.billpeckham.com)
- Dr. Raymond Hakim (Fresenius Medical Care NA, Brentwood, TN)
- Dr. Thomas Parker III (Renal Ventures Management, Lakewood, CO)
- Dr. Allen Nissenson (DaVita, El Segundo, CA)
- Dr. Rajiv Saran, Moderator (University of Michigan - Kidney Epidemiology and Cost Center, Ann Arbor, MI)
- Brett Lantz, Analyst (Arbor Research Collaborative for Health, Ann Arbor, MI)

Ad.2 If adapted, provide name of original measure:

Ad.3-5 If adapted, provide original specifications URL or attachment

**Measure Developer/Steward Updates and Ongoing Maintenance**

Ad.6 Year the measure was first released:

Ad.7 Month and Year of most recent revision:

Ad.8 What is your frequency for review/update of this measure? Three years

Ad.9 When is the next scheduled review/update for this measure? 2013

Ad.10 Copyright statement/disclaimers:

Ad.11-13 Additional Information web page URL or attachment:

**Date of Submission (MM/DD/YY): 12/09/2010**
1c. The measure focus is:

- an outcome (e.g., morbidity, mortality, function, health-related quality of life) that is relevant to, or associated with, a national health goal/priority, the condition, population, and/or care being addressed;

OR

- if an intermediate outcome, process, structure, etc., there is evidence that supports the specific measure focus as follows:
  - Intermediate outcome - evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.
  - Process - evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s).
  - Structure - evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit.
  - Patient experience - evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public.
  - Access - evidence that an association exists between access to a health service and the outcomes of, or experience with, care.
  - Efficiency - demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality.

4 Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multi-step process, the step with the greatest effect on the desired outcome should be selected as the focus of measurement. For example, although assessment of immunization status and recommending immunization are necessary steps, they are not sufficient to achieve the desired impact on health status – patients must be vaccinated to achieve immunity. This does not preclude consideration of measures of preventive screening interventions where there is a strong link with desired outcomes (e.g., mammography) or measures for multiple care processes that affect a single outcome.
if patient preference (e.g., informed decision-making) is a basis for exclusion, there must be evidence that it strongly impacts performance on the measure and the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).

2e. For outcome measures and other measures (e.g., resource use) when indicated:
- an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified and is based on patient clinical factors that influence the measured outcome (but not disparities in care) and are present at start of care; or rationale/data support no risk adjustment.

13 Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care such as race, socioeconomic status, gender (e.g., poorer treatment outcomes of African American men with prostate cancer, inequalities in treatment for CVD risk factors between men and women). It is preferable to stratify measures by race and socioeconomic status rather than adjusting out differences.

14 With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74% v. 75%) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 v. $5,025) is practically meaningful. Measures with overall poor performance may not demonstrate much variability across providers.