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 #:** 1438 **NQF Project:** End Stage Renal Disease
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Periodic Assessment of Post-Dialysis Weight by Nephrologists
De.2 **Brief description of measure***:* The proportion of patients who have documentation of receiving a new post-dialysis weight prescription from a nephrologist in the reporting month, irrespective of whether or not a change in post dialysis weight prescription was made.
1.1-2 **Type of Measure:** Process De.3 **If included in a composite or paired with another measure, please identify composite or paired measure** N/A
De.4 **National Priority Partners Priority Area:** Population health De.5 **IOM Quality Domain**: Effectiveness De.6 **Consumer Care Need:** Living with illness

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
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:**	**A** **Y**☐ **N**☐
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and	**B**

update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	Y☐ N☐
C. The intended use of the measure includes both public reporting and quality improvement. ►**Purpose:** Public reporting, Internal quality improvement	C Y☐ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1**Testing:** No, testing will be completed within 12 months D.2 **Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	D Y☐ N☐
(for NQF staff use**)** **Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** Y☐ N☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
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**	**Eval Rating**
(for NQF staff use) **Specific NPP goal**:	
1a.1 **Demonstrated High Impact Aspect of Healthcare:** Leading cause of morbidity/mortality 1a.2 1a.3 **Summary of Evidence of High Impact:** Formal requirement for periodic assessment of post dialysis weight is likely to raise awareness of this measure in the dialysis community and focus the attention of the treating nephrologist as well as other personnel in the dialysis units to the regular documentation of this field. Currently, while nephrologists realize its clinical importance, there is the likelihood of significant variation in the rigor with which they seek to optimize their post dialysis weight prescription on a periodic basis. It is ultimately this diligence that is likely to pay dividends in terms of improving the achievement of optimal state of hydration that is crucial to improving patient outcomes. 1a.4 **Citations for Evidence of High Impact:** Charra B, Laurent G, Chazot C, et al. "Clinical assessment of dry weight." Nephrology, dialysis, transplantation: official publication of the European Dialysis and Transplant Association - European Renal Association. 1996; 11 Suppl 2:16-9.	**1a** C☐ P☐ M☐ N☐
1b. Opportunity for Improvement 1b.1 **Benefits (improvements in quality) envisioned by use of this measure:** While many nephrologists realize the clinical importance of post-dialysis weight assessment, there is the likelihood of significant variation in the rigor with which they seek to optimize their post dialysis weight prescription on a periodic basis. This measure stresses the importance of diligent re-assessment and is likely to pay dividends in terms	**1b** C☐ P☐ M☐ N☐

of improving the achievement of optimal state of hydration that is crucial to improving patient outcomes. If better fluid weight management results from more frequent re-assessments of post-dialysis weight, it will likely decrease hospitalization associated with volume excess thus saving costs. Greater attention to post dialysis weight also leads to greater attention to blood pressure. Therefore superior blood pressure control is also likely to be an added benefit. These benefits could save lives and reduce health care utilization for this high risk population.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Post-dialysis weight assessment practices likely vary considerably across dialysis facilities. Currently there are no published studies describing national practice patterns in this regard. However, frequent assessment of post dialysis weight vis a vis prescribed dry weight is thought to be good clinical practice that has the potential to improve achievement of prescribed dry weight. A quality measure that requires facilities to document the formal assessment of prescribed post dialysis weight is likely to encourage better fluid weight management at those facilities.

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

1b.4 Summary of Data on disparities by population group:
Disparities for periodic assessment of post-dialysis weight 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*)**:** Better fluid weight management resulting from more frequent re-assessments of post-dialysis weight will likely decrease hospitalization associated with volume excess and will lead to greater attention to blood pressure control.

1c.2-3. Type of Evidence: Cohort study, Observational study, Evidence-based guideline, Randomized controlled trial, 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*)**:**
Periodic assessment and challenging of the patient's post-dialysis weight is a widely practiced clinical approach for achieving optimal hydration status in HD. The practice has been recommended by observations principally from France (see, e.g., Charra 1996) that also emphasize strict dietary salt restriction and prolongation of length of the dialysis session, and more recently in the form of a randomized clinical trial that utilized frequent clinical probing of the target weight versus usual management with progressive post dialysis weight and blood pressure reduction (Agarwal 2009). In general, the approach is a method designed to slowly achieve euvolemia. The technique can be implemented in clinical practice with or without supplementary techniques such as blood volume monitoring (using online hematocrit monitoring), or by monitoring patients' hydration status using bioelectrical impedance analysis. The latter two techniques are still being assessed in clinical studies and their clinical value remains to be established for routine practice. Adequate and regular assessment of post dialysis weight by the facility nephrologist is key to the successful achievement of euvolemia in dialysis patients. To that extent, this measure is very important toward improving health care quality. However, there are no large randomized trials yet in this regard.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom***):**
Observational studies, particularly from France and one small randomized trial. Level B evidence, as rated by the Fluid Weight Management Clinical Technical Expert Panel using an assessment scale similar to KDOQI.

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

1c
C☐
P☐
M☐
N☐

1c.7 Summary of Controversy/Contradictory Evidence: The measure as defined may still not ensure thorough assessment and prescription of post-dialysis weight. There is no controversy regarding the importance of frequent assessment and documentation of post-dialysis weight prescription. **1c.8 Citations for Evidence (***other than guidelines***):** Agarwal R, Satyan S, Alborzi P, et al. "Home blood pressure measurements for managing hypertension in hemodialysis patients." American journal of nephrology. 2009; 30:126-34. Charra B, Laurent G, Chazot C, et al. "Clinical assessment of dry weight." Nephrology, dialysis, transplantation: official publication of the European Dialysis and Transplant Association - European Renal Association. 1996; 11 Suppl 2:16-9. **1c.9 Quote the Specific guideline recommendation (***including guideline number and/or page number***):** This measure is related to the following 2006 KDOQI volume and blood pressure guideline: 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 RKF. (Evidence Level A) The KDOQI panel noted that, "For a fluid-overloaded dialysis patient, this step-by-step process of identifying, or 'probing,' for the true dry weight through ultrafiltration—but without inducing hypotension—should be accomplished gradually over a number of dialysis treatments (usually over 4 to 12 weeks, but it may require as long as 6 to 12 months) until evidence of fluid overload is in abeyance." **1c.10 Clinical Practice Guideline Citation:** KDOQI. Clinical practice guidelines for HD adequacy. Am J Kidney Dis. 2006; Jul;48 (1 Suppl 1): S13-97. **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 periodic re-assessment of post-dialysis weight in dialysis patients.	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report*?	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report***, met?** **Rationale:**	**1** **Y☐** **N☐**
2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES	
Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	**Eval Rating**
2a. MEASURE SPECIFICATIONS	
S.1 Do you have a web page where current detailed measure specifications can be obtained? **S.2 If yes, provide web page URL:** **2a. Precisely Specified**	**2a-specs** **C☐** **P☐** **M☐**
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 denominator who have documentation of receiving a new post-dialysis weight prescription from a nephrologist in the reporting month, irrespective of whether or not a change in post dialysis weight prescription was made. **2a.2 Numerator Time Window (***The time period in which cases are eligible for inclusion in the numerator*)**:** The entire reporting calendar month. **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 hemodialysis patient´s last formal post-dialysis weight assessment by a nephrologist" will be included in the 2011 CROWNWeb national roll-out. Note that it is not necessary for the post-dialysis weight prescription to be changed monthly; however, a new prescription must be written monthly for compliance with the measure.	**N**☐
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 hemodialysis (HD). **2a.5 Target population gender:** Female, Male **2a.6 Target population age range:** Adult and pediatric patients **2a.7 Denominator Time Window (***The time period in which cases are eligible for inclusion in the denominator*)**:** The entire reporting calendar month. **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 only in-center HD patients.	
2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population*)**:** None. **2a.10 Denominator Exclusion Details (***All information required to collect exclusions to the denominator, including all codes, logic, and definitions*)**:** N/A	
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. However, the measure could be displayed for all patients or stratified to show results separately for pediatric and adult patients.	
2a.12-13 Risk Adjustment Type: No risk adjustment necessary **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 **2a.15-17 Detailed risk model available Web page URL or attachment:**	
2a.18-19 Type of Score: Rate/proportion **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*)**:** Patients are counted as being in the facility for the entire reporting month if “Admit Date” to the specified facility is prior or equal to the first day 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 month. Patients are counted as in-center HD patients if their in-center HD start date is less than or equal to the first day of the reporting month and their in-center HD end date is greater than or equal to the last day of the reporting month (or blank/null in the case the patient has not ended in-center HD). Patients are included in the denominator if they were continuously enrolled in the dialysis facility as an in-center HD patient for the entire reporting month.	

Patients are included in the numerator if they are in the denominator and the facility reports that the patient received a new post-dialysis weight prescription in the reporting month, as indicated by the CROWNWeb data element recording the date of the last formal post-dialysis weight assessment by a nephrologist (see numerator details). The weight assessment occurred within the reporting month if the weight assessment date is less than or equal to the last day of the reporting month and the weight assessment date is also greater than or equal to the first day of the reporting month. 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.26-28 **Data source/data collection instrument reference web page URL or attachment:** URL http://www.projectcrownweb.org/crown/index.php 2a.29-31 **Data dictionary/code table web page URL or attachment:** URL http://www.projectcrownweb.org/crown/index.php?page=Public_Documents&subPage=Release_Documents 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	
TESTING/ANALYSIS	
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)*: N/A; see above.	**2b** **C**☐ **P**☐ **M**☐ **N**☐
2c. Validity testing 2c.1 **Data/sample** *(description of data/sample and size)*: Data are not available to test the validity of the measure; however, a C-TEP evaluated the measure. 2c.2 **Analytic Method** *(type of validity & rationale, method for testing)*: Face validity is the only validity assessed. The validity was assessed by a vote by the C-TEP. 2c.3 **Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:	**2c** **C**☐ **P**☐ **M**☐ **N**☐

The measure was unanimously ratified by the C-TEP as a valid measure.	
2d. Exclusions Justified **2d.1 Summary of Evidence supporting exclusion(s):** There are no exclusions. **2d.2 Citations for Evidence:** N/A **2d.3 Data/sample** *(description of data/sample and size)*: N/A **2d.4 Analytic Method** *(type analysis & rationale)*: N/A **2d.5 Testing Results** *(e.g., frequency, variability, sensitivity analyses)*: N/A	**2d** C☐ P☐ M☐ N☐ NA☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1 Data/sample** *(description of data/sample and size)*: Risk adjustment is not necessary for this measure. **2e.2 Analytic Method** *(type of risk adjustment, analysis, & rationale)*: N/A **2e.3 Testing Results** *(risk model performance metrics)*: N/A **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:** N/A	**2e** C☐ P☐ M☐ N☐ NA☐
2f. Identification of Meaningful Differences in Performance **2f.1 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. **2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: N/A **2f.3 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)*: N/A	**2f** C☐ P☐ M☐ N☐
2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** *(description of data/sample and size)*: Multiple data sources are not allowed for this measure and therefore testing is not applicable. **2g.2 Analytic Method** *(type of analysis & rationale)*: N/A **2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings)*: N/A	**2g** C☐ P☐ M☐ N☐ NA☐
2h. 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:**	**2h** C☐ P☐ M☐ N☐ NA☐

N/A	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties?*	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, **met?** **Rationale:**	*2* **C☐** **P☐** **M☐** **N☐**
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	**Eval Rating**
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 publically 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	**3a** **C☐** **P☐** **M☐** **N☐**
3b/3c. Relation to other NQF-endorsed measures 3b.1 **NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): 3b.2 **Are the measure specifications harmonized? If not, why?**	**3b** **C☐** **P☐** **M☐** **N☐** **NA☐**
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	**3c** **C☐** **P☐** **M☐** **N☐** **NA☐**

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability*?	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** **C☐** **P☐** **M☐** **N☐**
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	**Eval Rating**
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)	**4a** **C☐** **P☐** **M☐** **N☐**
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.**	**4b** **C☐** **P☐** **M☐** **N☐**
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.**	**4c** **C☐** **P☐** **M☐** **N☐** **NA☐**
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 easily auditable as the post-dialysis weight prescription is recorded in the patient's treatment record.	**4d** **C☐** **P☐** **M☐** **N☐**
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 Data Technical Expert Panel (D-TEP) and C-TEP noted the high feasibility of this measure. Although re-assessment is part of the dialysis treatment standard of care, the requirement of a new prescription is a simple way to emphasize the fact that the post-dialysis weight assessment was in fact carried out monthly by a nephrologist. **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** **C☐** **P☐** **M☐** **N☐**

4e.3 Evidence for costs: See above reference to Federal Register. **4e.4 Business case documentation:** If better fluid weight management results from more frequent re-assessments of post-dialysis weight, it will likely decrease hospitalization associated with volume excess thus saving costs. Greater attention to post dialysis weight also leads to greater attention to blood pressure. Therefore superior blood pressure control is also likely to be an added benefit. These benefits could save lives and reduce health care utilization for this high risk population.	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility*?	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met? **Rationale:**	**4** **C☐** **P☐** **M☐** **N☐**
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	**Time-limited ☐**
Steering Committee: Do you recommend for endorsement? **Comments:**	**Y☐** **N☐** **A☐**

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*)**:** 03/03/2011