**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**: 2604 (New Measure)**

**Measure Title**: **Medical Attention to Nephropathy for People with Serious Mental Illness and Diabetes**

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 7/25/2014

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| **Instructions**  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * Respond to all questions as instructed with answers immediately following the question. All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Maximum of 10 pages (*incudes questions/instructions*; minimum font size 11 pt; do not change margins). ***Contact NQF staff if more pages are needed.*** * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Steering Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Health outcome: [**3**](#Note3) a rationale supports the relationship of the health outcome to processes or structures of care. Applies to patient-reported outcomes (PRO), including health-related quality of life/functional status, symptom/symptom burden, experience with care, health-related behavior. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) [grading definitions](http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm) and [methods](http://www.uspreventiveservicestaskforce.org/methods.htm), or Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org/publications/index.htm).  **5.** 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 multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Health outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: **Patients receiving a nephropathy screening test or having evidence of nephropathy during the measurement year**

Structure: Click here to name the structure

Other: Click here to name what is being measured

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**HEALTH OUTCOME/PRO PERFORMANCE MEASURE**  *If not a health outcome or PRO, skip to* [*1a.3*](#Section1a3)

**1a.2.** **Briefly state or diagram the path between the health outcome (or PRO) and the healthcare structures, processes, interventions, or services that influence it.**

**Not applicable.**

**1a.2.1.** **State the rationale supporting the relationship between the health outcome (or PRO) to at least one healthcare structure, process, intervention, or service (*i.e., influence on outcome/PRO*).**

*Note: For health outcome/PRO performance measures, no further information is required; however, you may provide evidence for any of the structures, processes, interventions, or service identified above.*

**Not applicable.**

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**intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measure**

**1a.3.****Briefly state or diagram the path between structure, process, intermediate outcome, and health outcomes**. Include all the steps between the measure focus and the health outcome.

**The rate in this measure relates to the desired outcome in the following way: Patients with serious mental illness (schizophrenia, bipolar disorder, or depression) and diabetes 🡪 Nephropathy screening is performed or evidence of nephropathy is documented 🡪 Screening results are evaluated 🡪 Results indicate nephropathy 🡪 Health provider determines treatment to delay onset or progression of diabetic nephropathy🡪 Improvement in diabetes complications and quality of life (desired outcome).**

**1a.3.1.** **What is the source of the systematic review of the body of evidence that supports the performance measure?**

Clinical Practice Guideline recommendation – ***complete sections*** [***1a.4***](#Section1a4)***, and*** [***1a.7***](#Section1a7)

US Preventive Services Task Force Recommendation – ***complete sections*** [***1a.5***](#Section1a5) ***and*** [***1a.7***](#Section1a7)

Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)

Other – ***complete section*** [***1a.8***](#Section1a8)

*Please complete the sections indicated above for the source of evidence. You may skip the sections that do not apply.*

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**1a.4. CLINICAL PRACTICE GUIDELINE RECOMMENDATION**

**1a.4.1.** **Guideline citation** (*including date*) and **URL for guideline** (*if available online*):

**Association Guidelines**

**Diabetes Care (American Diabetes Association)**

**American Diabetes Association. (2013) Standards of Medical Care in Diabetes. Diabetes Care. 36:S1-e4; doi: 10.2337/dc13-S001**

**URL:** [**http://mcintranet.musc.edu/agingq3/calculationswesbite/ADA%20Guidelines/ADA%20Binder.pdf**](http://mcintranet.musc.edu/agingq3/calculationswesbite/ADA%20Guidelines/ADA%20Binder.pdf)

**American Association of Clinical Endocrinologists (AACE)**

**AACE Diabetes Care Plan Guidelines. (2011) Endocrine Practice. 17(Suppl 2); 1-53 URL:** [**https://www.aace.com/files/dm-guidelines-ccp.pdf**](https://www.aace.com/files/dm-guidelines-ccp.pdf)

**American Geriatrics Society (AGS)**

**Guidelines for Improving the Care of the Older Person with Diabetes Mellitus.**

**California Healthcare Foundation/American Geriatrics Society Panel on Improving Care for Elders with Diabetes. (2003) American Geriatrics Society. 51(Suppl 5) JAGS. URL:** [**http://www.medicine.emory.edu/ger/bibliographies/geriatrics/bibliography87\_files/Guidelines\_for\_Improving\_the\_Care\_of\_the\_Older\_Person\_with\_Diabetes\_Mellitus.pdf**](http://www.medicine.emory.edu/ger/bibliographies/geriatrics/bibliography87_files/Guidelines_for_Improving_the_Care_of_the_Older_Person_with_Diabetes_Mellitus.pdf)

**1a.4.2.** **Identify guideline recommendation number and/or page number** and **quote verbatim, the specific guideline recommendation**.

**Diabetes Care (American Diabetes Association)-2013**

**Pg. S7-S8**

**Screening**

* **Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of ≥5 years and in all type 2 diabetic patients starting at diagnosis. (Recommendation Grade: B)**
* **Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate glomerular filtration rate (GFR) and stage the level of chronic kidney disease (CKD), if present. (Recommendation Grade: E)**

**Treatment**

* **In the treatment of the nonpregnant patient with modestly elevated (30–299 mg/day) (Recommendation Grade: C) or higher levels (≥300 mg/day) of urinary albumin excretion (Recommendation Grade: A), either ACE inhibitors or ARBs are recommended.**
* **Reduction of protein intake to 0.8–1.0g/kg body wt per day in individuals with diabetes and the earlier stages of CKD and to 0.8 g/kg body wt per day in the later stages of CKD may improve measures of renal function (urine albumin excretion rate, GFR) and is recommended. (Recommendation Grade: C)**
* **When ACE inhibitors, ARBs, or diuretics are used, monitor serum creatinine and potassium levels for the development of increased creatinine or changes in potassium. (Recommendation Grade: E)**
* **Continued monitoring of urine albumin excretion to assess both response to therapy and progression of disease is reasonable. (Recommendation Grade: E)**
* **When eGFR is 60 mL/min/1.73 m2, evaluate and manage potential complications of CKD. (Recommendation Grade: E)**
* **Consider referral to a physician experienced in the care of kidney disease for uncertainty about the etiology of kidney disease, difficult management issues, or advanced kidney disease. (Recommendation Grade: B)”**

**American Geriatrics Society (AGS)-2003**

**Pg. 272**

**“A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 DM.**

**After the initial screening and in the absence of previously demonstrated macro- or microalbuminuria, a test for the presence of microalbumin should be performed annually. (Recommendation: IIIA)”**

**American Association of Clinical Endocrinologists (AACE)-2011**

**Pg. 11**

***“3.Q10.1. Diabetic Nephropathy***

**• R36. Beginning 5 years after diagnosis in patients with T1DM and at diagnosis in patients with T2DM, an annual assessment of serum creatinine to estimate the glomerular filtration rate (GFR) and urine albumin excretion should be performed to identify, stage, and monitor progression of diabetic nephropathy (Grade D; BEL 4). Patients with diabetic nephropathy should be counseled regarding the increased need for optimal glycemic control, blood pressure control, dyslipid­emia control, and smoking cessation (Grade A; BEL 1). When therapy with angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers is initi­ated, renal function and serum potassium levels must be closely monitored (Grade A; BEL 1).”**

**1a.4.3.** **Grade assigned to the quoted recommendation with definition of the grade:**

|  |  |
| --- | --- |
| **Diabetes Care (American Diabetes Association)** | |
| **Level** | **Definition** |
| **A** | **Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered, including:**   * **Evidence from a well-conducted multicenter trial** * **Evidence from a meta-analysis that incorporated quality ratings in the analysis**   **Compelling nonexperimental evidence (i.e., "all or none" rule developed by the Centre for Evidence-Based Medicine at Oxford)**  **Supportive evidence from well-conducted randomized clinical trials that are adequately powered, including:**   * **Evidence from a well-conducted trial at one or more institutions** * **Evidence from a meta-analysis that incorporated quality ratings in the analysis** |
| **B** | **Supportive evidence from well-conducted cohort studies, including:**   * **Evidence from a well-conducted prospective cohort study or registry** * **Evidence from a well-conducted meta-analysis of cohort studies**   **Supportive evidence from a well-conducted case-control study** |
| **C** | **Supportive evidence from poorly controlled or uncontrolled studies, including:**   * **Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results** * **Evidence from observational studies with high potential for bias (such as case series with comparison to historical controls)** * **Evidence from case series or case reports**   **Conflicting evidence with the weight of evidence supporting the recommendation** |
| **E** | **Expert consensus or clinical experience** |

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| **American Geriatrics Society (AGS): Quality of Evidence** | |
| **Level** | **Definition** |
| **III** | **Evidence from respected authorities, based on clinical experience, descriptive studies, or reports of expert committee** |

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| --- | --- |
| **American Geriatrics Society (AGS): Strength of Evidence** | |
| **Grade** | **Definition** |
| **A** | **Good evidence to support the use of a recommendation; clinicians “should do this all the time”** |

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| **American Association of Clinical Endocrinologists (AACE)** | | | | |
| **Best evidence level** | **Subjective factor impact** | **Two-thirds consensus** | **Mapping** | **Recommendation grade** |
| **1** | **None** | **Yes** | **Direct** | **A** |
| **4** | **Negative** | **Yes** | **Adjust Down** | **D** |

**Starting with the left column, best evidence levels (BELs), subjective factors, and con­sensus map to recommendation grades in the right column. When subjective factors have little or no impact (“none”), then the BEL is directly mapped to recommendation grades. When subjective factors have a strong impact, then recommendation grades may be adjusted up (“positive” impact) or down (“negative” impact). If a two-thirds consensus cannot be reached, then the recommendation grade is D. NA, not applicable (regardless of the presence or absence of strong subjective factors, the absence of a two-thirds con­sensus mandates a recommendation grade D).**

**Reprinted from reference 1: *Endocr Pract*. 2010;16:270-283.**

**1a.4.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: If separate grades for the strength of the evidence, report them in section 1a.7.*)

|  |  |
| --- | --- |
| **American Geriatrics Society (AGS): Quality of Evidence** | |
| **Level** | **Definition** |
| **I** | **Evidence from at least one properly randomized controlled trial** |
| **II** | **Evidence from one well-designed clinical rail without randomization, from cohort or case-controlled analytical studies, from multiple time-series studies, or from dramatic results in uncontrolled experiments** |

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| --- | --- |
| **American Geriatrics Society (AGS): Strength of Evidence** | |
| **Level** | **Definition** |
| **B** | **Moderate evidence to support the use of a recommendation; clinicians “should do this most of the time”** |
| **C** | **Poor evidence to support the use of a recommendation; clinicians “may or may not follow the recommendation”** |
| **D** | **Moderate evidence against the use of a recommendation; clinicians “should not do this”** |
| **E** | **Good evidence against the use of a recommendation; clinicians “should not do this”** |

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| --- | --- | --- | --- | --- |
| **American Association of Clinical Endocrinologists (AACE)** | | | | |
| **Best evidence level** | **Subjective factor impact** | **Two-thirds consensus** | **Mapping** | **Recommendation grade** |
| **2** | **Positive** | **Yes** | **Adjust** | **A** |
| **3** | **None** | **Yes** | **Direct** | **D** |
| **1, 2, 3, 4** | **NA** | **No** | **Adjust Down** | **D** |

**1a.4.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.4.1*)**:**

**Not Applicable**

**1a.4.6. If guideline is evidence-based (rather than expert opinion), are the details of the quantity, quality, and consistency of the body of evidence available (e.g., evidence tables)?**

Yes **→ *complete section*** [***1a.7***](#Section1a7)

No **→ *report on another systematic review of the evidence in sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)***; if another review does not exist, provide what is known from the guideline review of evidence in*** [***1a.7***](#Section1a7)

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**1a.5.** **UNITED STATES PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

**1a.5.1.** **Recommendation citation** (*including date*) and **URL for recommendation** (*if available online*):

**Not Applicable**

**1a.5.2.** **Identify recommendation number and/or page number** and **quote verbatim, the specific recommendation**.

**Not Applicable**

**1a.5.3.** **Grade assigned to the quoted recommendation with definition of the grade**:

**Not Applicable**

**1a.5.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: the* *grading system for the evidence should be reported in section 1a.7.*)

**Not Applicable**

**1a.5.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.5.1*)**:**

**Not Applicable**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.6. OTHER SYSTEMATIC REVIEW OF THE BODY OF EVIDENCE**

**1a.6.1.** **Citation** (*including date*) and **URL** (*if available online*):

**AACE Diabetes Care Plan Guidelines. Endocrine Practice. 2011. Vol 17, Suppl 2: 1-53 URL:** [**https://www.aace.com/files/dm-guidelines-ccp.pdf**](https://www.aace.com/files/dm-guidelines-ccp.pdf)

**Li R, Zhang P, Barker LE, Chowdhury FM, Zhang X. Cost-effectiveness of interventions to prevent and control diabetes mellitus: a systematic review. Diabetes Care. 2010. 33(8):1872-1894.**

**1a.6.2.** **Citation and** **URL for methodology for evidence review and grading** (*if different from 1a.6.1*)**:**

**Not Applicable**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.7. FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE supporting the measure**

*If more than one systematic review of the evidence is identified above, you may choose to summarize the one (or more) for which the best information is available to provide a summary of the quantity, quality, and consistency of the body of evidence. Be sure to identify which review is the basis of the responses in this section and if more than one, provide a separate response for each review.*

**1a.7.1.** **What was the specific structure, treatment, intervention, service, or intermediate outcome addressed in the evidence review?**

**This measure assesses whether diabetic patients were screened for nephropathy if they did not already have evidence of nephropathy during the measurement year. The measure is based on clinical guidelines. Evidence provides support for the timing of screenings, specific screening tests, and treatment based on screening results. Screening tests recommended by the guideline include microalbumin and serum creatinine. Treatment recommendations from the guidelines include medications, counseling, nephrologist referral, close monitoring of urine albumin excretions, and close monitoring of nephropathy progression.**

**1a.7.2.** **Grade assigned for the quality of the quoted evidence with definition of the grade**:

**Table 1: 2010 American Association of Clinical Endocrinologists Protocol for Production of Clinical Practice Guidelines—Step I: Evidence Rating**

|  |  |
| --- | --- |
| **Numerical descriptor (evidence level)** | **Semantic descriptor (reference methodology)** |
| **1** | **Randomized controlled trials (RCT)** |
| **2** | **Meta-analysis of nonrandomized prospective or case-controlled trials (MNRCT)** |
| **2** | **Nonrandomized controlled trial (NRCT)** |
| **2** | **Prospective cohort study (PCS)** |
|  |  |
| **3** | **Cross-sectional study (CSS)** |
| **3** | **Surveillance study (registries, surveys, epidemiologic study, retrospective chart**  **review, mathematical modeling of database) (SS)** |
| **4** | **No evidence (theory, opinion, consensus, review, or preclinical study) (NE)** |

**1=strong evidence; 2=intermediate evidence; 3=weak evidence; and 4=no evidence.**

**ADA did not grade the evidence using a separate system from the overall grading of the clinical practice recommendations.**

**1a.7.3. Provide all other grades and associated definitions for strength of the evidence in the grading system.**

**1 Meta-analysis of randomized controlled trials (MRCT)**

**2 Retrospective case-control study (RCCS)**

**3 Single case reports (SCR)**

**3 Consecutive case series (CCS)**

**1a.7.4.** **What is the time period covered by the body of evidence? (*provide the date range, e.g., 1990-2010*). Date range**:

**AACE: 1993-2008**

**ADA: 1993-2007**

**QUANTITY AND QUALITY OF BODY OF EVIDENCE**

**1a.7.5.****How many and what type of study designs are included in the body of evidence**? (*e.g., 3 randomized controlled trials and 1 observational study*)

**The listing below provides an overview of two evidence reviews that were conducted. The first review was conducted by the AACE. The 2nd review was conducted by the ADA. The evidence helped construct the guidelines for nephropathy screenings and treatment in patients with diabetes. The evidence provided is only a portion of research conducted for this area in diabetes health care.**

**AACE**

**Screening**

**Measurement of albumin to creatinine ratio: Clinical Practice Guideline No Evidence**

**Use of glomerular filtration rate (GFR) in screening for nephropathy: 1 Cross-sectional study**

**Estimation of GFR: 1 surveillance study**

**Treatment**

**Medication treatment to prevent onset or delay progression of diabetic nephropathy: 4 randomized controlled trials, 1 Prospective cohort study, 2 Review/no evidence**

**Normalization of albumin excretion to decrease nephropathy progression: 2 randomized controlled trials**

**Restricting protein intake in patients nephropathy: 1 meta-analysis of nonrandomized prospective or case-controlled trials**

**Referral of stage 4 chronic kidney disease patients to nephrologist: opinion/no evidence**

**ADA**

**The ADA included a systematic review of interventions to control diabetes mellitus when developing the guidelines. Seventeen studies for interventions end stage renal disease or nephropathy were identified. The interventions included screenings for microalbuminuria and treatment options to delay the progression of nephropathy. The studies included RCTs, cohort studies, observational studies, and clinical trials.**

**1a.7.6.** **What is the overall quality of evidence across studies in the body of evidence**? (*discuss the certainty or confidence in the estimates of effect particularly in relation to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population*)

**The overall quality of evidence for the measure focus is high. Guidelines supporting the measure include recommendations for the screening and treatment of nephropathy.**

**Evidence for treatment options to prevent nephropathy onset and delay the progression of nephropathy have the strongest evidence with the most RCTs.**

**The evidence supporting screenings for nephropathy is weaker in comparison to the nephropathy treatment evidence. This evidence includes clinical trials, cross sectional studies, surveillance studies, and large cohorts studies as opposed to RCTs. Evidence for nephropathy screenings also include literature reviews. Despite this weaker evidence for nephropathy screenings, the linkage to improved nephropathy outcomes through screening is high. Regular nephropathy screenings offer the opportunity for early detection of diabetic nephropathy and early treatment to delay progression of the disease.**

**ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE**

**1a.7.7.** **What are the estimates of benefit—magnitude and direction of effect on outcome(s) across studies in the body of evidence**? (*e.g., ranges of percentages or odds ratios for improvement/ decline across studies, results of meta-analysis, and statistical significance*)

**The evidence supporting this measure can be categorized into evidence for nephropathy screening and evidence for nephropathy treatments. Screening is a crucial step in delaying the onset or progression of nephropathy in diabetics. The results from one study cited that the average life expectancy increases from four to 14 years with nephropathy screening and interventions (Borch-Johnson, 1993). In addition, the study cited a decrease in the need for dialysis and kidney transplants by 21% to 63% (Borch-Johnson, 1993). The onset of nephropathy can also be delayed by six to 24 years and therefore, reduces the mortality rates of deaths due to nephropathy (Borch-Johnsen, 1993).**

**Guidelines supporting this measure also recommend referral to a nephrologist. An important aspect of referral includes timeliness. Data suggests that the early referral to a nephrologist can improve mortality rates and lifespan of patients on dialysis. Patients that begin treatment with a nephrologist over a year before starting dialysis live longer lives, on average, than patients that were referred within four months of starting dialysis. Screening for nephropathy is a necessary component of determining the stage of kidney disease. Therefore, the benefit of regular screenings will lead to earlier specialized treatment and improved outcomes for diabetic nephropathy.**

**Borch-Johnsen K, Wenzel H, Viberti GC, Mogensen CE. Is screening and intervention for microalbuminuria worthwhile in patients with insulin dependent diabetes? BMJ. 1993; 306: 1722-1725.**

**Levinsky, NG. Specialist evaluation in chronic kidney disease: too little, too late. 2002. Annals of Internal Medicine. 137 (6): 542-543.**

**1a.7.8.** **What harms were studied and how do they affect the net benefit (benefits over harms)?**

**The harms associated with the screening and treatment of nephropathy stem from adverse effects that are associated with pharmacotherapy and other treatment options (dialysis and kidney transplant). One study suggested higher risks to patients when using combined medication therapies as opposed to monotherapy (Halimi et al., 2009).**

**Halimi JM, Asmar R, Ribstein J. Optimal nephroprotection: Use, misuse and misconceptions about blockade of the renin-angiotensin system. Lessons from the ONTARGET and other recent trials. Diabetes Metab. 2009; 35:425-430.**

**UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE**

**1a.7.9.** **If new studies have been conducted since the systematic review of the body of evidence, provide for each new study: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review**.

**There are no new published studies that contradict the current guidelines.**

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**1a.8 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**Not Applicable**

**1a.8.1** **What process was used to identify the evidence?**

**Not Applicable**

**1a.8.2.** **Provide the citation and summary for each piece of evidence.**

**Not Applicable**