



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0256

Corresponding Measures:

De.2. Measure Title: Minimizing Use of Catheters as Chronic Dialysis Access

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services

De.3. Brief Description of Measure: Percentage of patient months on maintenance hemodialysis during the last HD treatment of month with a chronic catheter continuously for 90 days or longer prior to the last hemodialysis session.

1b.1. Developer Rationale: Based upon data from the CMS Fistula First Breakthrough Initiative (FFBI), a gradual trend towards lower catheter use has been observed among prevalent maintenance HD patients in the US, declining from approximately 28% in 2006 to approximately 24% by May 2007. Furthermore, the percentage of maintenance HD patients using a catheter for ≥ 90 days has declined as well over this time period from nearly 12% to 9.5-10%. Continued monitoring of chronic catheter use is needed to sustain this trend.

S.4. Numerator Statement: Number of patient months in the denominator who were continuously using a chronic catheter as hemodialysis access for 90 days or longer prior to the last hemodialysis session during the month.

S.6. Denominator Statement: Adult hemodialysis patients who have had ESRD for greater than 90 days as of the first day of the reporting month.

S.8. Denominator Exclusions: Exclusions that are implicit in the denominator definition include pediatric patients (<18 years old), and acute hemodialysis patients (hemodialysis patients who have had ESRD for less than 91 days). There are no additional exclusions for this measure.

De.1. Measure Type: Outcome

S.17. Data Source: Claims (Only), Electronic Health Record (Only)

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Nov 15, 2007 **Most Recent Endorsement Date:** Oct 01, 2015

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Maximizing Placement of Arterial Venous Fistula (AVF), NQF# 0257

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0256_NQF_Evidence_Catheter_revised.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

IF a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

Based upon data from the CMS Fistula First Breakthrough Initiative (FFBI), a gradual trend towards lower catheter use has been observed among prevalent maintenance HD patients in the US, declining from approximately 28% in 2006 to approximately 24% by May 2007. Furthermore, the percentage of maintenance HD patients using a catheter for ≥ 90 days has declined as well over this time period from nearly 12% to 9.5-10%. Continued monitoring of chronic catheter use is needed to sustain this trend.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (*This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.*) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

Analysis of CROWNWeb data from January 2013- December 2013 indicated the facility level mean percentage of patient-months dialyzing with a catheter ≥ 90 days was 9% (SD=7%). Distribution: Min=0%, Max=100%, 1st quartile=4%, median=8%, 3rd quartile=13%.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

Disparity analyses were performed among the entire eligible adult population (n=4,226,245) to examine the difference in performance scores by sex, race, ethnicity, age and diabetes as cause of ESRD.

In particular, for each facility, the percent of patient-months by demographic group (sex, race, ethnicity, age and diabetes) was calculated. Then the facilities were divided into quintiles (Q1-Q5) based on the percentage of patient-months in the particular demographic category (i.e., a facility with percentage of females similar to the national median will be included in quintile 3). The top 20% of facilities in terms of rank, based on the percentages of females, were classified as Q5, while the bottom 20% of facilities were classified as Q1. Average (mean) performance for the measure was calculated for each quintile, and the means were examined for trend across quintiles (Q1-Q5). The Cochran-Armitage test for trend was performed to assess disparities in performance scores. Trend test results for each group across quintiles were statistically significant ($p < 0.001$), which imply that there are statistically significant changes in performance scores depending on sex, race, ethnicity, age, and diabetes as primary cause of ESRD. In the absence of biological effects explaining these differences, risk adjustment for these factors would potentially mask disparities in care.

The mean performance scores for percent of patient-months with a catheter ≥ 90 days in each quintile, by demographic group, is presented below. Males, non-Black, non-White, non-Native American, non-Asian, non-Hispanic, Age 18-74, and no diabetes as

primary cause are the respective reference categories.

Mean Performance Scores for Quintiles by Population Group (Q1-Q5), p-values for trend tests:

Female: (Q1=9.5%; Q2=9.7%; Q3=9.8%; Q4=9.5%; Q5=9.2%; P<0.0001)

White: Q1=9.2%; Q2=9.5%; Q3=9.8%; Q4=9.7%; Q5=9.6%; P<0.0001)

Hispanic: (Q1=9.2%; Q2=9.3%; Q3=9.9%; Q4=9.9%; Q5=9.3%; P<0.0001)

Diabetes as primary cause of ESRD: Q1=10.0%; Q2=9.4%; Q3=9.4%; Q4=9.7%; Q5=9.1%; P<0.0001)

Age>=75: Q1=9.1%; Q2=9.0%; Q3=9.5%; Q4=9.7%; Q5=10.7%; P<0.0001)

Note: Scores for Native American and Asian populations could not be reported, as these quintiles could not be calculated given that approximately 75% of facilities have zero Native American patients and approximately 50% facilities have zero Asian patients in their facilities.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

N/A

2. Reliability and Validity—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. ***Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Renal, Renal : End Stage Renal Disease (ESRD)

De.6. Non-Condition Specific(check all the areas that apply):

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Minor revisions have been made to the specifications for this measure. We have included calculation details for using either Medicare claims and CROWNWeb as the data source.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Number of patient months in the denominator who were continuously using a chronic catheter as hemodialysis access for 90 days or longer prior to the last hemodialysis session during the month.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The numerator will be determined by counting the patient-months in the denominator who were on maintenance hemodialysis with a chronic catheter continuously for 90 days or longer prior to the last hemodialysis session of the month.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

Adult hemodialysis patients who have had ESRD for greater than 90 days as of the first day of the reporting month.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The patient's age will be determined by subtracting the patient's date of birth from the first day of the reporting month.

Hemodialysis patients are defined as follows: "Admit Date" to the specified facility is prior or equal to the first day of the study period, 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 study period AND "Treatment Dialysis Broad Start Date" is prior or equal to the first day of the study period, AND "Dialysis Broad Type of Treatment" = 'HD', AND "Primary Dialysis Setting" = 'Dialysis Facility/Center' or 'Home' on the last day of the study period, AND "Date Regular Chronic Dialysis Began" is prior to the first day of the study period.

For both CROWNWeb and Claims data, the denominator will include all hemodialysis patients who are at least 18 years old and have had ESRD for greater than 90 days as of the first day of the reporting month.

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Exclusions that are implicit in the denominator definition include pediatric patients (<18 years old), and acute hemodialysis patients (hemodialysis patients who have had ESRD for less than 91 days). There are no additional exclusions for this measure.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

See above denominator details.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

N/A

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Lower score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

For this measure calculation, the numerator will be divided by the denominator. Calculation of the numerator and denominator is described below.

The denominator will include all patients at least 18 years old who are determined to be maintenance hemodialysis patients.

The patient's age will be determined by subtracting the patient's date of birth from the first day of the reporting month.

Hemodialysis patients are defined as follows: "Admit Date" to the specified facility is prior or equal to the first day of the study period, 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 study period AND "Treatment Dialysis Broad Start Date" is prior or equal to the first day of the study period, AND "Dialysis Broad Type of Treatment" = 'HD', AND "Primary Dialysis Setting" = 'Dialysis Facility/Center' or 'Home' on the last day of the study period, AND "Date Regular Chronic Dialysis Began" is prior to the first day of the study period.

The numerator will be determined by counting the patient months in the denominator who were on maintenance hemodialysis with a chronic catheter continuously for 90 days or longer prior to the last hemodialysis session of the month.

For CROWNWeb data, the numerator is defined as "Access_Type_id" in (19,20) while "19" means Catheter only and "20" means Port access only AND "Date Access Type for Dialysis Changed" is blank or, if populated, is more than 90 days prior to the last hemodialysis session of the month.

For Claims data, we use data prior to reporting period, a 90 day lookback period (e.g. October – December 2012 for January 2013 reporting period) to determine catheter history AND vascular access type should satisfy (vas_cat='Y' and art_graft=' ' and art_fistula=' ')).

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims (Only), Electronic Health Record (Only)

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data is collected.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

CROWNWeb is the primary data source. However, this measure can be collected through Medicare claims data (since July 2010) and Fistula First Breakthrough Initiative data (though the definition of the measure is slightly different). The measure has been publically reported using claims data since 2013.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Dialysis Facility

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

2. Validity – See attached Measure Testing Submission Form

[0256_NQF_Testing_Catheter_revised.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in a combination of electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.

N/A

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

N/A

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting Dialysis Facility Compare (DFC) http://qa.medicare.gov/dialysisfacilitycompare/# Payment Program ESRD Quality Incentive Program http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/

4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

DFC:

Purpose: Dialysis Facility Compare helps patients find detailed information about Medicare-certified dialysis facilities. They can compare the services and the quality of care that facilities provide.

Geographic area: United States

Number of accountable entities: All Medicare-certified dialysis facilities who are eligible for the measure, and have at least 11 patients (due to public reporting requirements). For the most recent DFC report, that was 5722 facilities.

Patients included: All patients who meet the requirements to be included in the measure from included facilities.

QIP:

Purpose: The ESRD QIP will reduce payments to ESRD facilities that do not meet or exceed certain performance standards. The measure was added to the program for PY2014 and later years..

Geographic area: United States

Number of accountable entities: All Medicare-certified dialysis facilities who are eligible for the measure, and have at least 11 patients (due to public reporting requirements). For the most recent QIP report, this was 5562 facilities.

Patients included: All patients who meet the requirements to be included in the measure from included facilities.

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

N/A

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

N/A

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Strong improvement for this measure was not demonstrated. However, this measure can be related to NQF #0257, which demonstrated an increase in fistula performance. An increase in fistula placement accompanied by a steady catheter rate is a relatively positive outcome.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

N/A

4c.2. Please explain any unexpected benefits from implementation of this measure.

4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4d2.2. Summarize the feedback obtained from those being measured.

4d2.3. Summarize the feedback obtained from other users

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are

compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
[Yes](#)

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

[No appendix Attachment:](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [Centers for Medicare & Medicaid Services](#)

Co.2 Point of Contact: [Helen, Dollar-Maples, Helen.Dollar-Maples@cms.hhs.gov, 410-786-7214-](#)

Co.3 Measure Developer if different from Measure Steward: [University of Michigan Kidney Epidemiology and Cost Center](#)

Co.4 Point of Contact: [Casey, Parrotte, parrotte@med.umich.edu, 734-763-6611-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role

in measure development.

Clinical and data technical expert panels (TEP) were held in September and October 2006, respectively. Since 2006, no TEPs have been held in this area.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 02, 2015

Ad.4 What is your frequency for review/update of this measure? Annually

Ad.5 When is the next scheduled review/update for this measure? 02, 2016

Ad.6 Copyright statement:

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: