



## 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 subcriterion 1b).

### Brief Measure Information

**NQF #:** 0257

**De.2. Measure Title:** Maximizing Placement of Arterial Venous Fistula (AVF)

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

**De.3. Brief Description of Measure:** Percentage of patient months for patients on maintenance hemodialysis during the last HD treatment of month using an autogenous AV fistula.

**1b.1. Developer Rationale:** The NKF K/DOQI guidelines state the following: 1) AV fistulas have the lowest rate of thrombosis and require the fewest interventions, 2) cost of AV fistula use and maintenance is the lowest, 3) fistulas have the lowest rates of infection, and 4) Fistulas are associated with the highest survival and lowest hospitalization rates. Indeed, a number of epidemiologic studies consistently demonstrate the reduced morbidity and mortality associated with greater use of AV fistulas for vascular access in maintenance hemodialysis.

**S.4. Numerator Statement:** Number of patient months in the denominator who were using an autogenous AV fistula at the last HD treatment of month.

**S.7. Denominator Statement:** 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.10. 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 ESRDS for less than 91 days). There are no additional exclusions for this measure.

**De.1. Measure Type:** Outcome

**S.23. Data Source:** Administrative claims, Electronic Clinical Data

**S.26. 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?** 0256: Minimizing Use of Catheters as Chronic Dialysis Access

### 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 subcriteria to pass this criterion and be evaluated against the remaining criteria.**

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

[0257\\_NQF\\_Evidence\\_Fistula\\_revised.docx](#)

**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., the benefits or improvements in quality envisioned by use of this measure)

The NKF K/DOQI guidelines state the following: 1) AV fistulas have the lowest rate of thrombosis and require the fewest interventions, 2) cost of AV fistula use and maintenance is the lowest, 3) fistulas have the lowest rates of infection, and 4) Fistulas are associated with the highest survival and lowest hospitalization rates. Indeed, a number of epidemiologic studies consistently demonstrate the reduced morbidity and mortality associated with greater use of AV fistulas for vascular access in maintenance hemodialysis.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** (This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Analysis of CROWNWeb data from January 2013 to December 2013 indicated the mean percentage of patient months with AV Fistula was 67% (SD=12%). Distribution: Min=0%, Max=100%, 1st quartile=60%, median=68%, 3rd quartile=75%. These results indicate that on average, 67% of patients at facilities are dialyzing with AV Fistulas.

**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 endorsement maintenance. 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 subcriterion on improvement (4b.1) 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 primary 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 ( $p < 0.0001$ ), 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 fistula in each quintile, by demographic group, are presented below. Males, non-Black, non-White, 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=69.4%; Q2=67.8%; Q3=67.2%; Q4=65.8%; Q5=64.0%;  $P < 0.0001$ )

Black (Q1=71.3%; Q2=70.9%; Q3=67.8%; Q4=65.3%; Q5=60.8%;  $P < 0.0001$ )

White (Q1=61.5%; Q2=65.7%; Q3=67.9%; Q4=70.2%; Q5=71.2%;  $P < 0.0001$ )

Hispanic (Q1=65.0%; Q2=64.5%; Q3=66.6%; Q4=68.1%; Q5=68.8%;  $P < 0.0001$ )

Diabetes as primary cause of ESRD (Q1=64.7%; Q2=66.5%; Q3=66.7%; Q4=67.7%; Q5=68.3%;  $P < 0.0001$ )

Age  $\geq 75$  (Q1=65.1%; Q2=65.8%; Q3=66.3%; Q4=68.3%; Q5=69.2%;  $P < 0.0001$ )

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 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**

N/A

**1c. High Priority** (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

**1c.1. Demonstrated high priority aspect of healthcare**

Affects large numbers, A leading cause of morbidity/mortality

**1c.2. If Other:**

**1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.**

List citations in 1c.4.

Numerous studies demonstrate that the use of AV fistulas have the best 5-year patency rates and require the fewest interventions compared with other access types. Finally, the advantages of AV fistula over other accesses are clearly delineated in the NKF K/DOQI guidelines, summarized as follows: 1) AV fistulas have the lowest rate of thrombosis and require the fewest interventions, 2) cost of AV fistula use and maintenance is the lowest, 3) fistulas have the lowest rates of infection, and 4) Fistulas are associated with the highest survival and lowest hospitalization rates. Indeed, a number of epidemiologic studies consistently demonstrate the reduced morbidity and mortality associated with greater use of AV fistulas for vascular access in maintenance hemodialysis.

**1c.4. Citations for data demonstrating high priority provided in 1a.3**

1. National Kidney Foundation: DOQI Clinical Practice Guidelines for Vascular Access.

[http://www.kidney.org/Professionals/kdoqi/guideline\\_upHD\\_PD\\_VA/index.htm](http://www.kidney.org/Professionals/kdoqi/guideline_upHD_PD_VA/index.htm)

**1c.5. 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.)**

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 subcriteria 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. Cross Cutting Areas** (check all the areas that apply):

**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. For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

[Minor revisions have been made to the specifications for this measure. We have included calculation details for using both 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)

[If an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.](#)

[Number of patient months in the denominator who were using an autogenous AV fistula at the last HD treatment of month.](#)

**S.5. Time Period for Data** (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

[One month](#)

**S.6. 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, 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.](#)

[The numerator will be determined by counting the patient months in the denominator who were using an AV fistula as the means of access.](#)

**S.7. Denominator Statement** (Brief, narrative description of the target population being measured)

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

[Populations at Risk](#)

**S.9. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, 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)

[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 at least 90 days as of the first day of the reporting month.](#)

**S.10. 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 \(hemodialysis patients who have had ESRDS for less than 91 days\). There are no additional exclusions for this measure.](#)

**S.11. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, 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)

[N/A](#)

**S.12. Stratification Details/Variables** (All information required to stratify the measure results including the stratification variables,

definitions, 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 with at S.2b)

N/A

**S.13. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

**S.14. Identify the statistical risk model method and variables** (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

N/A

**S.15. Detailed risk model specifications** (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

**S.15a. Detailed risk model specifications** (if not provided in excel or csv file at S.2b)

N/A

**S.16. Type of score:**

Rate/proportion

If other:

**S.17. 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 = Higher score

**S.18. Calculation Algorithm/Measure Logic** (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; 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 denominator will include all patients greater than or equal to 18 years old who are determined to be in-center hemodialysis, or home hemodialysis patients.

The numerator will be determined by counting the patient months in the denominator who were on maintenance hemodialysis using an AV fistula as the means of access.

In CROWNWeb, a patient is counted in the numerator if "Access\_type\_id" in (14,16) at the last treatment of the month where "14" represents AV fistula only (with 2 needles) and "16" represents AV Fistula combined with a Catheter; while in Medical Claims data, a patient is included if (vas\_cat=' ' and art\_graft=' ' and art\_fistula='Y') OR (vas\_cat='Y' and art\_graft=' ' and art\_fistula='Y') at the last treatment of the month.

<p><b>S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment</b> <i>(You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</i>  <a href="#">No diagram provided</a></p>
<p><b>S.20. Sampling</b> <i>(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)</i>  <u>IF a PRO-PM</u>, identify whether (and how) proxy responses are allowed.  <a href="#">N/A</a></p> <p><b>S.21. Survey/Patient-reported data</b> <i>(If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)</i>  <u>IF a PRO-PM</u>, specify calculation of response rates to be reported with performance measure results.  <a href="#">N/A</a></p> <p><b>S.22. Missing data</b> (specify how missing data are handled, e.g., imputation, delete case.)  <u>Required for Composites and PRO-PMs.</u>  <a href="#">N/A</a></p>
<p><b>S.23. Data Source</b> <i>(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).</i>  <i>If other, please describe in S.24.</i>  <a href="#">Administrative claims, Electronic Clinical Data</a></p> <p><b>S.24. Data Source or Collection Instrument</b> <i>(Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)</i>  <u>IF a PRO-PM</u>, identify the specific PROM(s); and standard methods, modes, and languages of administration.  <a href="#">This measure is primarily designed for collection in CROWNWeb but can also be calculated from Fistula First and Medicare claims data. The measure has been publically reported using Medicare claims data since 2013.</a></p> <p><b>S.25. Data Source or Collection Instrument</b> <i>(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</i>  <a href="#">No data collection instrument provided</a></p> <p><b>S.26. Level of Analysis</b> <i>(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)</i>  <a href="#">Facility</a></p> <p><b>S.27. Care Setting</b> <i>(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)</i>  <a href="#">Dialysis Facility</a>          If other:</p>
<p><b>S.28. COMPOSITE Performance Measure</b> - Additional Specifications <i>(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</i>  <a href="#">N/A</a></p>
<p><b>2a. Reliability</b> – See attached Measure Testing Submission Form  <b>2b. Validity</b> – See attached Measure Testing Submission Form  <a href="#">0257_NQF_Testing_Fistula_revised.docx</a></p>

### 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*)

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.**

**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.**

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. 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 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 PROM 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.*

Planned	Current Use (for current use provide URL)
	Public Reporting Dialysis Facility Compare (DFC)



<http://qa.medicare.gov/dialysisfacilitycompare/#>

Payment Program

ESRD QIP

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/>

**4a.1. For each CURRENT use, checked above, provide:**

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

**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.

**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.

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 5547 facilities.

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

**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

**4b. 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.1. Progress on Improvement. (Not required for initial endorsement unless available.)**

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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

January 2013: 5610 facilities, 66.8% national average

February 2013: 5601 facilities, 66.9% national average

March 2013: 5613 facilities, 66.9% national average

April 2013: 5613 facilities, 67.1% national average



May 2013: 5611 facilities, 67.1% national average  
 June 2013: 5601 facilities, 67.2% national average  
 July 2013: 5627 facilities, 67.3% national average  
 August 2013: 5621 facilities, 67.4% national average  
 September 2013: 5592 facilities, 67.7% national average  
 October 2013: 5670 facilities, 67.7% national average  
 November 2013: 5667 facilities, 67.8% national average  
 December 2013: 5652 facilities, 67.9% national average

The national average for this measure based on CROWNWeb data has increased from 66.8% to 67.9%. This suggests some improvement since the measure was implemented on DFC. Specifically, it suggests some improvement of facility level performance and increased use of fistula. These percentages are based on DFC data from January 2013 to December 2013.

**4b.2. 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.**

N/A

#### 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. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

N/A

### 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

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 completely harmonized?**

**5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on**

<b>interpretability and data collection burden.</b>
<b>5b. Competing Measures</b> The measure is superior to competing measures (e.g., is a more valid or efficient way to measure); <b>OR</b> Multiple measures are justified.  <b>5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):</b> <b>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.)</b>

<b>Appendix</b>
<b>A.1 Supplemental materials may be provided in an appendix.</b> 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. <a href="#">No appendix Attachment:</a>
<b>Contact Information</b>
<b>Co.1 Measure Steward (Intellectual Property Owner):</b> <a href="#">Centers for Medicare &amp; Medicaid Services</a> <b>Co.2 Point of Contact:</b> <a href="#">Corette, Byrd, Corette.Byrd@cms.hhs.gov</a> <b>Co.3 Measure Developer if different from Measure Steward:</b> <a href="#">University and Michigan Kidney and Epidemiology Cost Center</a> <b>Co.4 Point of Contact:</b> <a href="#">Casey, Parrotte, parrotte@med.umich.edu</a> , 734-763-6611-
<b>Additional Information</b>
<b>Ad.1 Workgroup/Expert Panel involved in measure development</b> <b>Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.</b> <a href="#">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.</a>
<b>Measure Developer/Steward Updates and Ongoing Maintenance</b> <b>Ad.2 Year the measure was first released:</b> <a href="#">2007</a> <b>Ad.3 Month and Year of most recent revision:</b> <a href="#">02, 2015</a> <b>Ad.4 What is your frequency for review/update of this measure?</b> <a href="#">Annually</a> <b>Ad.5 When is the next scheduled review/update for this measure?</b> <a href="#">02, 2015</a>
<b>Ad.6 Copyright statement:</b> <b>Ad.7 Disclaimers:</b>
<b>Ad.8 Additional Information/Comments:</b>