NATIONAL QUALITY FORUM
Driving measurable health improvements together

Memo

May 26, 2021

To: Renal Standing Committee

From: NQF staff

Re: Post-comment web meeting to discuss public comments received and NQF member expression of support

Introduction

NQF closed the public commenting period on the measures submitted for endorsement consideration to the Fall 2020 measure review cycle on April 23, 2021.

Purpose of the Call

The Renal Standing Committee will meet via web meeting on May 26, 2021 from 1:00 - 3:00 pm EST. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period.
- Provide input on proposed responses to the post-evaluation comments.
- Review and discuss NQF members' expression of support of the measures under consideration; and
- Determine whether reconsideration of any measures or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see comment table and additional documents included with the call materials).
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Web link: https://nqf.webex.com/nqf/j.php?MTID=m6e1428eb2d3823b8f7d2358c3c2fefd2
Meeting ID: 173 389 6954
Password: RenalFall2020!

Or Join by Phone:
Speaker dial-in #:1-844-621-3956 and enter **Meeting ID:** 173 389 6954

Background

Renal disease is a leading cause of morbidity and mortality in the United States. More than 20 million adults in the United States (10 percent of the population) have chronic kidney disease (CKD), which is associated with premature mortality, decreased quality of life, and increased healthcare costs. Risk factors for CKD include cardiovascular disease, diabetes, hypertension, and obesity. Untreated CKD can result in end-stage renal disease (ESRD).

Currently, over half a million people in the United States have received a diagnosis of ESRD. This project sought to identify and endorse performance measures for accountability and quality improvement that address conditions, treatments, interventions, or procedures relating to kidney disease.

On February 8, 2021 and February 11, 2021, NQF convened a multistakeholder Standing Committee composed of 25 individuals to evaluate one new measure and one measure undergoing maintenance review. The Committee recommended one measure for continued endorsement and did recommend the other measure.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF solicits comments prior to the evaluation of the measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from December 15, 2020 to January 15, 2021 for the measures under review. All of these pre-evaluation comments were provided to the Committee prior to the measure evaluation meeting.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment on March 25, 2021 for 30 calendar days. During this commenting period, NQF received six comments from three member organizations:

Member Council	# of Member Organizations Who Commented
Health Professional	1
Provider Organization	1
QMRI	1

We have included all comments that we received (both pre- and post-evaluation) in the comment table (excel spreadsheet) posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation

comments—draft responses (including measure steward/developer responses) for the Committee's consideration. Please review this table in advance of the meeting and consider the individual comments received and the proposed responses to each.

Although all comments are subject to discussion, the intent is not to discuss each individual comment on the May 26, 2021 post-comment call. Instead, we will spend the majority of the time considering the set of comments as a whole. Additionally, please note measure stewards/developers were asked to respond where appropriate. Where possible, NQF staff has proposed draft responses for the Committee to consider.

Comments and Their Disposition

Measure-Specific Comments

2701: Avoidance of Utilization of High Ultrafiltration Rate (>13 ml/kg/hour) (Kidney Care Quality Alliance (KCQA))

KCP believes fluid management is a critical area to address through performance measurement and supports the Standing Committee's recommendation for continued endorsement of this measure.

Measure Steward/Developer Response:

No response required.

Proposed Committee Response:

Thank you for your comments. The Committee will review and discuss them during the Post-Comment Meeting.

Action Item:

No action required.

3567: Hemodialysis Vascular Access—Practitioner-Level Long-Term Catheter Rate (Centers for Medicare & Medicaid Services (CMS)/ University of Michigan Kidney Epidemiology and Cost Center (UMKECC))

Four comments were submitted for this measure. Commenters questioned the measure's ability to distinguish whether the care received is based on patient preferences or if treatment decisions are based on clinical appropriateness. They raised concerns about the opportunity for improvement in the performance gap, discussing what defines an acceptable standard. Commenters mentioned unintended consequences of dialysis units preferentially accepting only patients with established AV access, suggested the expansion of denominator exclusions and stated that the measure does not account for patients for whom a catheter is the only or most appropriate choice.

Comment #1:

Vascular access may be the most important performance metric for patients making decisions about dialysis facilities, and KCP has consistently supported the facility-level Long-Term Catheter Rate (LTCR) measure, NQF 2978. Nevertheless, we support the Standing Committee's recommendation against endorsement of the clinician-level LTCR measure because of little room for continued improvement in this aspect of care. As noted by the Committee, the median performance identified during measure testing—8.3 percent—is likely close to the appropriate level of catheter use in clinical practice and thus does not support the addition of a clinician-level measure for which a corollary facility-level metric is already in use. We also share the Committee's concerns that the measure does not account for patients for whom a catheter is the only or most appropriate choice, such as patients with exhausted vascular access or those on the transplant waitlist whose waiting time is expected to be brief (e.g., with a living related donor transplant). This omission is in direct conflict with the updated 2019 NKF KDOQI Clinical

Practice Guidelines for Vascular Access, cited to support the measure, which instead emphasize a patient-focused approach to vascular access and list a number of circumstances where short- or long-term use of tunneled CVCs may be clinically appropriate.

Measure Steward/Developer Response:

The performance gap is an assessment to determine if there are opportunities for improvement in the measure outcome. While the median performance of 8.3% long-term catheter (LTC) use may be considered clinically appropriate, we note that 25% of providers have catheter rates above 13%, indicating that there is in fact substantial opportunity for improvement among a sizable number of providers. In addition, the width of the actual performance gap between high and low performing providers is larger in measure #3567 than the performance gap for the recently NQF endorsed facility level metric #2978: Hemodialysis Vascular Access: Long-term Catheter Rate. Perhaps even more important is the opportunity to align incentives between physician provider groups and the dialysis facilities in which they see patients by having a similar outcome measures for LTC use.

We understand that there are certain clinical situations where the use of a LTC is an appropriate option and this measure serves to identify provider groups whose performance is substantially different from that of their peers. The 2015 TEP that developed the facility level version of this measure considered multiple prior failed vascular access attempts as an exclusion criterion for vascular access measures, however consensus was not reached within the TEP on how best to implement this exclusion. Specifically, there was not consensus as to who was the most appropriate provider to make this assessment (e.g. nephrologist, vascular surgeon, or interventional radiologist/nephrologist) or on what bases (ultrasound, venography, number of prior failed accesses). In addition, we have evaluated historical vascular access data in CROWNWeb to determine if a patient's prior vascular access history could be used to identify multiple failed vascular accesses, and in turn whether this information could define potential exclusion criteria for exhausting all potential options for AVF placement. Unfortunately, the reliability of prior vascular access data in CROWNWeb was not sufficient to use this as an exclusion criteria.

We support a patient focused approach to vascular access and believe that this measure is in fact supported by the 2019 NKF KDOQI guidelines. Guideline 2.3 indicates that "KDOQI suggests an AV access (AVF or AVG) in preference to a CVC in most incident and prevalent HD patients due to the lower infection risk associated with AV access use".

Proposed Committee Response:

Thank you for your comments. The Committee will review and discuss them during the Post-Comment Meeting.

Action Item:

No action required.

Comment #2

The American Medical Association (AMA) supports the Standing Committee's recommendation to not continue endorsement of this measure. Specifically, we agree with the concerns around the inability of the measure to distinguish whether the care received is based on patient preferences or if treatment decisions are based on clinical appropriateness. Additional refinement or new measure development is needed to create a measure that adequately assesses whether appropriate treatment decisions were made based on patient choice and through shared decision-making.

Measure Steward/Developer Response:
We recognize the importance of patient choice when determining a vascular access plan, however at this time there are no standard criteria for how to validate an informed decision. A check-box attestation may not be sufficient for determining whether an informed and express choice was made by a patient, and this is especially true for vulnerable patients.

Proposed Committee Response:
Thank you for your comments. The Committee will review and discuss them during the Post-Comment Meeting.

Action Item:
No action required.

Comment #3

Summary: Our nephrologist colleagues within the Johns Hopkins Health System had a number of comments about the measure. They believe that the concept of this measure has the opportunity to ensure optimal care and could result in long-term healthcare savings with fewer interventions. They do have some concerns, though, with the measure as currently specified. They recommended the denominator exclusions be expanded to include AKI patients, live donor transplant recipients, patients who have exhausted AV access options, and those who cannot hemodynamically tolerate AV access. They also have the concern that this measure could have the unintended consequence of dialysis units preferentially accepting only patients with established AV access. It should be recognized that the numerator, as currently defined, potentially includes those patients who, due to limited insurance coverage options (e.g., Veterans, undocumented) may have restricted opportunities for AV access placement.

Measure Steward/Developer Response:
This measure excludes AKI patients from the denominator since those patients are not included in CROWNWeb which is the primary data source for identifying patients in the measure. Patients who receive a living-donor kidney transplant within 3 months of starting dialysis would also be excluded from the measure, allowing for expedited care for those with patients where dialysis is intended to be short term. In the above mentioned 2015 TEP discussion about exclusion criteria for this measure, other clinical conditions such as severe congestive heart failure were also discussed, but a data source does not exist to capture these potential considerations.

Given that the NQF endorsed facility level metric #2978: Hemodialysis Vascular Access: Long-term Catheter Rate is already in use by CMS, we do not believe that adding the current provider level quality measure would exacerbate any potential unintended consequences of preferentially accepting dialysis patients with established AV access.

Since we rely on Physician Medicare claims to identify patient-provider months with a long-term catheter, patients with limited insurance coverage, such as undocumented patients, are not included in this measure.

Proposed Committee Response:
Thank you for your comments. The Committee will review and discuss them during the Post-Comment Meeting.

Action Item:
No action required.

Comment #4

We appreciate the thoughtful review that was recently completed by the Renal Standing Committee for quality measure #3567 Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate. This measure did not pass the Performance Gap requirement and the Standing Committee expressed that "the median performance of 8.3 percent is likely close to the appropriate level of catheter use in clinical practice, and there is little opportunity for improvement". However, 25% of providers have catheter rates above 13%, indicating that there is in fact substantial opportunity for improvement among a sizable number of providers. Our understanding is that the performance gap represents the magnitude of variation in provider performance, and not whether the mean level of performance is clinically appropriate. In addition, the width of the actual performance gap between high and low performing providers is larger in measure #3567 than the performance gap for the recently NQF endorsed facility level metric #2978: Hemodialysis Vascular Access: Long-term Catheter Rate. Given this discrepancy, it is not clear why the provider level metric failed after demonstrating a larger performance gap than the currently endorsed facility level metric. While we are not requesting reconsideration of this measure, we did want to draw attention to the discrepancy in the application of the performance gap criteria in hopes of improving the consistency of committee review.

Measure Steward/Developer Response:

No response required.

Proposed Committee Response:

Thank you for your comments. The Committee will review and discuss them during the Post-Comment Meeting.

Action Item:

No action required.

NQF Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Committee's recommendations. NQF members provided their expressions of support: See Appendix A.

Appendix A: NQF Member Expression of Support Results

NQF members provided their expressions of support/nonsupport. 1 of 2 measures under consideration received support from NQF members. Results for each measure are provided below.

2701: Avoidance of Utilization of High Ultrafiltration Rate (>13 ml/kg/hour) (Kidney Care Quality Alliance (KCQA))

Member Council	Support	Do Not Support	Total
Consumer			
Health Plan			
Health Professional			
Provider Organization			
Public/Community Health Agency			
Purchaser			
QMRI	1		1
Supplier/Industry			

3567: Hemodialysis Vascular Access—Practitioner-Level Long-Term Catheter Rate (Centers for Medicare & Medicaid Services (CMS)/ University of Michigan Kidney Epidemiology and Cost Center (UMKECC))

Member Council	Support	Do Not Support	Total
Consumer			
Health Plan			
Health Professional		1	1
Provider Organization			
Public/Community Health Agency			
Purchaser			
QMRI		1	1
Supplier/Industry			