NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Renal Standing Committee – Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the Renal Standing Committee for a web meeting on February 8, 2021, and February 11, 2021, to evaluate two Renal measures.

Welcome, Introductions, and Review of Meeting Objectives

Dr. Sam Stolpe welcomed the Standing Committee and participants to the web meeting and reviewed the meeting objectives. Standing Committee members each introduced themselves and disclosed any conflicts of interest. Lori Hartwell and Gail Wick recused themselves from NQF measure #2701 for directly collaborating with the measure developer on this measure. Gail Wick served as an active member of the Kidney Care Quality Assurance (KCQA) Quality Committee that developed NQF measure #2701. Lori Hartwell is a member of the Board of Directors for Kidney Care Partners and was involved with the measure on some of the KCQA calls.

Some Standing Committee members were unable to attend the meetings in their entirety due to early departures and late arrivals. The vote totals reflect members present and eligible to vote. Quorum was met and maintained for the entirety of the meetings. Quorum consisted of 17 out of 25 Standing Committee members for NQF #3567 and 16 out of 23 Standing Committee members for NQF #2701 due to two recusals as stated above.

Topic Area Introduction and Overview of Evaluation Process

NQF staff provided an overview of the topic area and the current NQF portfolio of endorsed measures. There are currently 21 measures in the Renal portfolio. Additionally, NQF reviewed the Consensus Development Process (CDP) and the measure evaluation criteria. The Standing Committee members did not provide any comments or feedback during this portion of the meeting.

Measure Evaluation

During the meeting, the Renal Standing Committee evaluated two measures, including one maintenance measure (NQF #2701) and one new measure (NQF #3567) for endorsement consideration. A detailed summary of the Standing Committee's deliberations will be compiled and provided in the draft technical report. NQF will post the draft technical report on March 22, 2021, for public comment on the NQF website. The draft technical report will be posted for 30 calendar days.

A measure is recommended for endorsement by the Standing Committee when the vote margin on all must-pass criteria (i.e., Importance, Scientific Acceptability, and Use), and overall, is greater than 60 percent of voting members in favor of endorsement. A measure is not recommended for endorsement when the vote margin on any must-pass criterion, or overall, is less than 40 percent of voting members in favor of endorsement. The Standing Committee has not reached consensus if the vote margin on any must-pass criterion, or overall, is between 40 and 60 percent, inclusive, in favor of endorsement. When the Standing Committee has not reached consensus, all measures for which consensus was not reached will be released for NQF member and public comment. The Standing Committee will consider the

comments and re-vote on those measures during a webinar convened after the commenting period closes.

Rating Scale: H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable

#2701 Avoidance of Utilization of High Ultrafiltration Rate (>=13 ml/kg/hour)

Description: Percentage of adult in-center hemodialysis patients in the facility whose average ultrafiltration rate (UFR) is >=13 ml/kg/hour AND who receive an average of <240 minutes per treatment during the calculation period**; Measure Type:** Process**; Level of Analysis:** Facility**; Setting of Care:** Post-Acute Care; **Data Source:** Electronic Health Records

KCQA [Developer & Steward] Representatives at the Meeting

- Lisa J. McGonigal, MD, MPH
- George R. Aronoff, MD, MS

Standing Committee Votes

- Evidence: H-1; M-14; L-2; I-1
- Performance Gap: H-2; M-16; L-0; I-2
- Reliability: H-1; M-19; L-0; I-0
- Validity: H-0; M-19; L-1; I-0
- Feasibility: H-11; M-7; L-1; I-0
- Use: Pass-16; No Pass-3
- Usability: H-0; M-15; L-3; I-1

Standing Committee Recommendation for Endorsement: Yes-18; No-1

The Standing Committee recommended the measure for continued endorsement.

NQF staff provided a brief overview of the measure, including the measure description above. Lisa McGonigal and George Aronoff from KCQA represented the measure developer. The developers provided an overview of the measure, highlighting the measure specifications, rationale, evidence provided, and testing approach. The lead discussants, Andrew Narva and Renee Garrick, in the review of the evidence provided by the developer, noted that the specific requirements of the measure were not addressed directly by some of the guidelines. The cutoffs for the measure were noted to have been selected on a pragmatic basis. The Standing Committee noted that the developer provided some evidence of disparities from the literature but not from direct testing. The Standing Committee noted that the documentation of the measure suggested the following point: while the data are not perfect, significant performance variation remains between dialysis facilities. In the discussion of scientific acceptability, the Standing Committee noted that the reliability of the measure was moderate based on the intraclass correlation coefficients from the developer's analysis. The Standing Committee noted that the tests provided by the developer for the validity of the measure were appropriately conducted and the results were directionally expected. The measure was noted by the Standing Committee to draw on readily available data sources and was passed on feasibility with little discussion. The measure was noted to have recently been incorporated into the End-Stage Renal Disease (ESRD) Quality Improvement Program (QIP) during the discussion on use. The Standing Committee expressed concerns related to the measure's implementation considering the ultrahigh filtration rate is reporting only for ESRD QIP. The Standing Committee noted that the QIP reporting measure includes the patient's dry weight and

delivered dialysis time; therefore, the elements are available to see which one affects the ultrafiltration rate (UFR). The Committee passed the measure on both the use and usability criteria. The Standing Committee will discuss related and competing measures during the post-comment web meeting on May 26, 2021.

#3567: Hemodialysis Vascular Access: Practitioner Level Long-Term Catheter Rate

University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) [Developer]/Centers for Medicare & Medicaid (CMS) [Steward] Representatives at the Meeting

- Jon Segal, MD
- Joe Messana, MD

Standing Committee Votes

- Evidence: H-0; M-12; L-5; I-1
- Performance Gap: H-0; M-7; L-10; I-2
- Reliability: Vote Not Taken
- Validity: Vote Not Taken
- Feasibility: Vote Not Taken
- Use: Vote Not Taken
- Usability: Vote Not Taken

Standing Committee Recommendation for Endorsement: Vote Not Taken

The Standing Committee did not vote on the recommendation for endorsement because they did not pass the measure on performance gap—a must-pass criterion.

At the onset of the discussion, NQF staff provided a brief overview of the measure, including the measure description above. Jon Segal from UM-KECC introduced the measure, which consisted of highlights from the specifications, while noting the measure's relationship to a comparable facility-level measure that was reviewed by the Committee during the previous cycle. The Standing Committee asked the developer how the measure can appropriately account for patients who have a catheter since no other access point is considered appropriate, or for patients who plan on being transplanted and do not want permanent access. The developer noted that this discussion occurred in the consideration of the NQF-endorsed facility measure with the same focus, with the issue being that no data source is available at this time to inform exclusions related to exhaustion of vascular access options, patient choice, and similar issues. The Standing Committee expressed concern that patients who do not have options other than catheters may experience stinting of care if this measure is included in an accountability program. The Committee noted that facilities were referenced throughout the developer's specifications.. The developer responded, stating that this was done in error and that they will correct the measure specification. The Standing Committee reviewed the evidence provided, noting that it is based on the 2016 and 2020 Kidney Disease Outcomes Quality Initiative (KDOQI) guidelines, especially noting that the mortality evidence was not as strong but that persistent evidence remains for increased bloodstream infections with catheter use, which is a highly undesirable outcome.

The Standing Committee noted that in group practices, two or more providers can share a common practice identification number. Hence, although multiple providers are seeing the patient regularly, they can be counted together under one practice identification number within the measure. The developer

noted that if this is calculated at the individual provider level, the providers would share the total number of patient months, though individual providers are not seeing the patient in consecutive months. The Standing Committee questioned if the evidence provided was specific to practitioner level actions, to which it was noted that the general body of evidence focuses on patient outcomes rather than provider actions. The Standing Committee was concerned that older CrownWeb data from 2016 was used for the analysis. The Committee further noted that the gap was larger for younger patients, and perhaps appropriately, given that many younger patients may be waiting for a transplant. The Standing Committee also added that there is no risk adjustment for things such as vintage, to which the developer emphasized that the measure is harmonized with the facility measure. The Standing Committee did not pass the measure on performance gap, a must-pass criterion. Therefore, the measure was not recommended for endorsement.

Portfolio Measure Gaps

In the discussion of measure gaps, the Standing Committee called for home dialysis measures, especially a more inclusive Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey that captures home dialysis. The Standing Committee emphasized that patient-reported outcomes related to dialysis care represent an especially important measure gap. The Standing Committee also recognized a gap related to incorporating telemedicine quality and access metrics into renal care, particularly for rural populations. The Standing Committee also emphasized care problems in transitions in care for dialysis and other kidney care and called for outcome measures in care transitions. Further emphasis was placed on addressing transitions in care through care coordination measures. Gaps were also recognized in measures for pediatric patients. The Standing Committee noted that transitions in care and care coordination measures would be well suited this population.. The Standing Committee also noted that issues associated with housing Advanced healthcare planning metrics were discussed, ensuring that clear, documented planning has taken place. The Standing Committee emphasized the role that housing insufficiencies, food insecurity, and other social determinants of health have in kidney care. The Standing Committee emphasized supportive and palliative care and how an integrated care model may benefit patients, especially for behavioral health.

Public Comment

No public or NQF member comments were provided during the measure evaluation meeting.

Next Steps

NQF will post the draft technical report on March 22, 2021, for public comment for 30 calendar days. The continuous public comment with member support will close on April 20, 2021. NQF will reconvene the Standing Committee for the post-comment web meeting on May 26, 2021.

Pre-Evaluation Comments

Comments received as of January 15, 2021:

Topic	Commenter	Comment
3567: Hemodialysis Vascular Access: Practitioner Level	Submitted by Kidney Care Partners	NQF 3567: Hemodialysis Vascular Access—Practitioner-Level Long-Term Catheter Rate (CMS)

Topic	Commenter	Comment
Long-term Catheter Rate		KCP believes vascular access may be the most important performance metric for patients making decisions about dialysis facilities and has consistently supported the facility-level Long-Term Catheter Rate (LTCR) measure, NQF 2978. Nevertheless, in reviewing the clinician-level LTCR measure we have identified a number of issues that warrant consideration and offer the following substantive and technical comments: · Meaningful Differences in Performance. An essential component of NQF's evaluation of validity is a demonstration of meaningful differences in performance, allowing end-users of public reporting or value-based purchasing programs to make informed decisions about the quality of care delivered by various providers. For the practitioner-level LTCR measure, CMS testing data indicate that approximately 90% of all clinicians and clinician groups perform "as expected." We disagree with CMS's conclusion that these data demonstrate the measure identifies practical differences in performance. A performance measure in which 90% of all measured entities are reported as performing "as expected" provides little meaningful, actionable information to patients, and we do not find the above statistics sufficiently compelling to support the measure's intended use in public reporting. · Permanent Access Maturation. KCP believes catheter reduction is paramount, but we again note arteriovenous fistulas frequently require two to three months to reach maturity. We thus believe an exclusion for patients on ESRD treatment <90 days as of the first day of the reporting month would strengthen the measure considerably. This revision would minimize the risk of penalizing providers for physiological circumstances beyond their control and would also align NQF 3567 with the numerous CMS NQF-endorsed facility-level measures containing this exclusion. · Patients on Transplant Waitlists. Given the burden associated with arteriovenous fistula placement on both patients and health resources, nephrologists may determine short-term vascular access options may be more appropriate for new dialysis patients already on the transplant waitlist whose waiting time is expected to be brief, such as with a living related donor transplant. Here again, an exclusion for patients on ESRD treatment <90

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		days as of the first day of the reporting month would largely effectively address this issue. · Patients with Exhausted Vascular Access Options. CMS notes in its measure submission materials that a Vascular Access TEP it convened in 2015 had favored a measure exclusion for patients who have exhausted their anatomic vascular access options, verified by documentation of a second opinion from a qualified vascular access surgeon, but was unable to reach consensus on how best to incorporate it. While operationalizing this exclusion may indeed prove challenging, we agree with the TEP that the continued pursuit of permanent access in patients for whom this is no longer a viable option is a considerable risk in its absence. We urge the developer to revisit the TEP's recommendation to assess for a reliable, valid means of capturing of this important clinical data point. An alternative approach would be to establish an "expected percentage" or threshold to allow for a certain anticipated number of patients with truly exhausted access. · Profile Inter-Unit Reliability (PIUR). KCP has consistently opposed CMS's use of the PIUR for accountability metrics intended to distinguish performance between providers. CMS and UM-KECC crafted this novel metric of reliability to "assess more directly the value of performance measures in identifying facilities with extreme outcomes."[1] Per CMS: "The PIUR indicates the presence of outliers or heavier tails among the providers, which is not captured in the IUR itself. . . . [When] there are outlier providers, even measures with a low IUR can have a relatively high PIUR and can be very useful for identifying extreme providers." KCP strongly concurs, however, with NQF's Scientific Methods Panel (SMP) conclusion that the PIUR is not an appropriate reliability metric for measures in any accountability program intended to distinguish performance between providers falling in the middle of the curve, along a continuum. The ability to reliably distinguish outliers is inconsistent with the purpose of such programs, and the SMP concluded the IUR is and remains the appropriate reliability statistic for this purpose. While in this instance the measure's IURs are acceptable, KCP on principle reiterates its general opposition to use of the PIUR to demonstrate reliability

Topic	Commenter	Comment
		in accountability metrics used in programs intended to distinguish performance along a curve. · Attribution Rules Clarification. In the measure specifications CMS defines "long-term catheter use" as occurring under the care of the same practitioner or group practice for at least three consecutive months as of the last hemodialysis session of the reporting month. Measure submission materials further clarify that "counting" for the measure restarts if a patient transfers to a different practitioner/group, but this detail is not included in the formal measure specifications. KCP suggests the developer add an exclusion or revise the denominator to explicitly clarify this point. · Small Numbers Exclusion, Typographical Error. We note CMS indicates in the measure submission materials that when used for public reporting, measure calculation "will be restricted to facilities with at least 11 patients in the reporting month to ensure patients cannot be identified due to small cell size." As language elsewhere in the materials indicate the restriction applies to practitioners or practitioner groups, as is consistent with the focus of the measure, we believe the reference to facilities was a typographical error and request confirmation and correction from the developer. [1] Kalbfleisch JD, He K, Xia L, Li Y. Does the inter-unit reliability (IUR) measure reliability? Health Services and Outcomes Research Methodology. 2018;18(3):215-225. Doi: 10.1007/s10742-018-0185-4.
2701: Avoidance of Utilization of High Ultrafiltration Rate (>13 ml/kg/hour) (KCQA)	Submitted by Kidney Care Partners	KCP believes fluid management is a critical area to address through performance measurement and supports continued endorsement of this measure.
General	Submitted by Kidney Care Partners	Kidney Care Partners (KCP) appreciates the opportunity to submit early (pre-Standing Committee meeting) comments on the measures under consideration for endorsement in the National Quality Forum's Renal Project Fall 2020 Cycle. KCP is a coalition of members of the kidney care community that includes the full spectrum of stakeholders related to dialysis care—patient advocates, healthcare professionals, dialysis providers, researchers, and manufacturers and suppliers—organized to advance policies that improve

Topic	Commenter	Comment
		the quality of care for individuals with both chronic kidney disease and end stage renal disease. We commend NQF for undertaking this important work and offer comment on both measures under review.