National Quality Forum

Renal Post-comment Standing Committee Meeting

Spring 2022 Cycle

Thursday

October 6, 2022

The Committee met via Videoconference, at 2:00 p.m. EDT, Lorien Dalrymple and Renee Garrick, Co-Chairs, presiding.

Present:

Lorien Dalrymple, MD, MPH, Fresenius Medical Care North America, Chair
Renee Garrick, MD, FACP, Westchester Medical Center, New York Medical College, Chair
Andrew Chin, MD, University of California, Davis
Medical Center
Annabelle Chua, MD, Duke University
Gail Dewald, BS, RN, CNN, Gail Dewald & Associates, LLC
Stuart Greenstein, MD, Montefiore Medical Center
Lori Hartwell, Patient/Caregiver Perspective, Renal Support Network
Frederick Kaskel, MD, PhD, Children's Hospital at Montefiore
Alan Kliger, MD, Yale University School of Medicine, Yale New Haven Health System
Mahesh Krishnan, MD, MPH, MBA, FASN, DaVita,
Inc.
Karilynne Lenning, MHA, LBSW, Telligen
Precious Mccowan, ESRD Network
Andrew Narva, MD, FASN, University of the District of Columbia
Jessie Pavlinac, MS, RDN-AP, CSR, LD, FAND, Oregon Health & Science University

Jeffrey Silberzweig, MD, The Rogosin Institute
(New York Presbyterian)
Michael Somers, MD, American Society of Pediatric Nephrology, Harvard Medical School, Boston Children's Hospital
Jennifer Vavrinchik, MSN, RN, CNN, National Dialysis Accreditation Commission
John Wagner, MD, MBA, Kings County Hospital Center
Gail Wick, MHSA, BSN RN, CNNe, Consultant, GWA

NQF Staff:

Peter Amico, PhD, Consultant
Poonam Bal
Erica Brown, MHA, PMP, Project Manager
Paula Farrell, MSHQS, Director
Gabby Kyle-lion, MPH, Analyst
Isabella Rivero, Associate

Also Present:

Dr. Joseph Messano

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(2:01 p.m.)

Welcome and Review of Meeting Objectives

Ms. Farrell: All right, thank you, everyone. Say good afternoon and thank you for joining us for our spring 2022 Renal post-comment meeting. My name is Paula Farrell, and I'm the Director of the project, and I'll be helping shepherd us through our post-comment call today.

So today the standing committee is going to be reviewing comments submitted for the measures that were evaluated in the Spring 2022 cycle. And the committee will also discuss and review two reconsideration requests that were submitted.

So now I'm going to turn the meeting over to our co-chairs, Lorien and Renee, to provide their welcoming remarks.

Co-Chair Garrick: Hi, it's Renee, I'll kick off. It's great to have everybody here, thank you. So this is a opportunity to take a look at things today.

And I wanted to take a special second to thank all of our patient participants. We really appreciate your being here. It adds enormously to the meeting. So thanks again for your time and attendance.

And Lorien.

Co-Chair Dalrymple: And I'll just also say a brief welcome and thank you to everyone for joining this afternoon as we reconsider two of the measures we previously evaluated and also respond to a comment we received in the comment period. So looking forward to our call and discussion today.

Ms. Farrell: All right, great, thank you. Next slide, please.

So we're going to review a few housekeeping

reminders. We are on a Zoom meeting with audio and video capabilities, so we do ask that if you are able to, you please turn on your video.

Also queries, please remember to always put yourself on mute when you're not speaking. And there are some specific features in Zoom that you can use. There is a chat box, where you can either message us, the NQF staff, individually, or you can message all of the meeting attendees, if you would like.

We also ask that you please use the raise hand function in Zoom to be called upon by the co-chairs instead of just speaking up, because this will allow us to ensure that everyone who would like to speak has an opportunity to do so.

And finally, any issues or questions, please feel free to reach out to the NQF project team at renal@qualityforum.org. Next slide, please.

So as I mentioned, we are on a Zoom call, and I wanted to point out some additional items when using Zoom. You'll find a mute button when you click the lower part of your screen.

And to find the chat box, you'll click on the participant or chat button. And you'll also find a raise hand function under the reactions tab. Next slide, please.

So this slide provides instructions on the Zoom functionality if you have happened to join on the phone. And when you're using your phone, you can find in the chat box and the raise hand function under the more button. Next slide, please.

As a reminder, as with all of our meetings, we do have some meeting ground rules to go over. We do ask that everyone is respectful and allows -- allow others to contribute to the discussion. And we ask that you do please remain engaged and actively participate during the meeting.

Also ensure as Standing Committee members that

you are basing your evaluation and recommendation on NQF measures based on the NQF measure evaluation criteria.

And finally, please keep your comments concise and focused so that we are able to have a real discussion. Next slide, please.

All right, so at our meeting today, we're going to be discussing some of the submitted reconsideration requests. And then we are going to review and discuss comments received on the other measures. And then we'll allow time for member and public comment. We'll discuss next steps, and then we'll adjourn the meeting. Next slide, please.

So this was their team, the project team that has worked hard to set up the meeting for you. I do want to mention that we have one additional new team member, Isabella Rivero, who is on our team. She joined in September as an Associate, and we're happy to have her, Isabella, on board. Next slide, please.

All right, so with that, I'm going to turn the call over to Gabi, and she is going to perform roll call.

Gabi.

Ms. Kyle-Lion: Thanks, Paula. When I call your name, if you could just let us know if you're here, that's be great.

We'll start off with Lorien Dalrymple.

Co-Chair Dalrymple: Here.

Ms. Kyle-Lion: Thank you. Renee Garrick.

Co-Chair Garrick: I'm here.

Ms. Kyle-Lion: Stuart Mark Greenstein.

Member Greenstein: I'm here.

Ms. Kyle-Lion: Thank you. Frederick Jeffrey Kaskel.

Member Kaskel: Here.

Ms. Kyle-Lion: Thank you. Myra Kleinpeter.

Okay, we'll circle back in just a moment. Alan Kliger.

Member Kliger: Here.

Ms. Kyle-Lion: Mahash Krishan.

Member Krishnan: Present.

Ms. Kyle-Lion: Thank you. Karilynne Anne Lenning.

Member Lenning: I'm here.

Ms. Kyle-Lion: Thank you. Jessie Pavlinac.

Member Pavlinac: Here.

Ms. Kyle-Lion: Jeffrey Silberzweig.

Member Silberzweig: I'm here.

Ms. Kyle-Lion: Thank you. Michael Somers.

Member Somers: I'm here.

Ms. Kyle-Lion: Thank you. Jennifer Vavrinchik.

Member Vavrinchik: I'm here.

Ms. Kyle-Lion: John Wagner.

Member Wagner: Good afternoon, here.

Ms. Kyle-Lion: Thank you. James Michael Guffey. Okay, we'll circle back.

Andrew Chin.

Member Chin: I'm here.

Ms. Kyle-Lion: Thank you. Annabelle Chua.

Member Chua: Here.

Ms. Kyle-Lion: Thank you. Rajesh Davda. I believe

Dr. Davda said they were not able to join. But I'll just give it a minute just in case things change.

Okay, Gail Dewald. Gail, if you're talking, we aren't able to hear you. I think I see you on the call. You may be double muted. If you could just send us a chat to let us know you're there, that would be great if you aren't able to unmute.

We're circle back to Gail Dewald and move to Gail Wick.

Member Wick: Here.

Ms. Kyle-Lion: Thank you. Lori Hartwell.

Member Hartwell: I'm here.

Ms. Kyle-Lion: Thank you. Precious McCowan.

Member McCowan: Present.

Ms. Kyle-Lion: Thank you. Cher Thomas. Okay.

Member Hartwell: Cher Thomas just said she had an emergency and she'll be in shortly.

Ms. Kyle-Lion: Okay, thank you so much for letting us know, Lori.

Roberta Louise Wager. Okay, we'll move on and come back.

Andrew Narva.

Member Narva: I'm here.

Ms. Kyle-Lion: Perfect, thank you so much. All right, we'll just circle and make sure we didn't miss anybody who may have joined while we've been doing attendance. Myra Kleinpeter. Okay. James Michael Guffey.

Gail Dewald, I did see your chat that you're here, thank you so much. If you want to try to get off mute, we can try that, see if it works.

All right, I'm still not hearing you, Gail, but we can work with you to see if we can get that audio fixated. And Cher said they would be joining later.

And Roberta Louise Wager. Okay, I am not seeing them.

All right, Paula, I'll go ahead and pass it back to you.

Ms. Farrell: Okay, thank you, Gabi, and we can move on to the next slide, please.

So as a reminder, we did review six measures during the Standing Committee's measure evaluation meeting for the spring 2022 cycle. And four measures were not recommended for endorsement during that meeting.

Two measures were recommended for endorsement. And we received reconsideration requests for two measures that were not recommended for endorsement. And those are NQF No. 3694 and No. 3696. Next slide, please.

I'm now going to turn it back over to Gabi to do a quick voting test for us. Gabi.

Voting Test

Ms. Kyle-Lion: Thanks again, Paula. Okay, so you all should have received a voting link this morning via email. If you did not, you can reach out to us via chat or email at renal@qualityforum.org.

But I'm going to go ahead and share the Poll Everywhere screen and pull up our test vote. Okay. Are you all seeing the Poll Everywhere? Perfect.

Member Hartwell: You know, I didn't get the email. Let me check my spam.

Member Greenstein: Yeah, I didn't get it either.

Ms. Kyle-Lion: Okay.

Member Kliger: I don't have one either.

Ms. Kyle-Lion: Okay, we'll go ahead and resend that to everyone again. And --

Member Kliger: You may not have my current email. So I will only get it if you send to the correct one. Can I give it to you?

Ms. Kyle-Lion: Yes, you can.

Member Kliger: Thank you. It's askliger@gmail.com. A-S as in Sam.

Ms. Kyle-Lion: Thank you.

Member Kliger: Thank you.

Ms. Kyle-Lion: Isabella, are you able to resend that email to the standing committee members, please?

MS. RIVERO: Yes, I can do that right now.

Ms. Kyle-Lion: Thank you.

Ms. Farrell: And once you get the email, standing committee members, if you could please go in and vote on whether or not you like Candy Corn so we can ensure that our voting is working correctly.

Member Krishnan: Just to clarify, this is conventional Candy Corn, right, like the yellow –-

Ms. Kyle-Lion: Yes.

Ms. Farrell: Is there any other kind of Candy Corn?

Ms. Kyle-Lion: They have the pumpkin.

Member Krishnan: Of course.

Ms. Farrell: Oh, okay.

Member Greenstein: Is the email coming from Isabella? Because I still haven't received it.

Ms. Kyle-Lion: It should be coming from the Renal inbox.

Member Greenstein: We'll be patient, haven't seen it yet.

Ms. Kyle-Lion: Okay.

Member Wick: I don't have it.

Ms. Kyle-Lion: It should be sending now.

Member Hartwell: Can I make a request to use a chocolate candy bar next time? Just for the record.

Ms. Kyle-Lion: We definitely can. I think Candy Corn's a little controversial, so the controversial candy, so.

Member Somers: I'm having trouble. I got the email, but I tried clicking onto the link and also copying the link into three different browsers, and it's not doing anything for me.

Ms. Kyle-Lion: You said you've tried different browsers, Michael?

Member Somers: Yeah, I've tried Chrome, I've tried Safari, I've tried something else.

Ms. Kyle-Lion: If it's still not working for you, feel free to send your vote privately via chat to me or the Renal inbox.

Member Hartwell: I'm having the same issue. I wonder if it has something to do with Microsoft Office.

Ms. Kyle-Lion: If you're -- I'm not sure. But if you're having issues voting, please do send me a private message with your vote, and we can count it that way.

Member Kliger: So again, with apology, I have not gotten an email from you yet.

Member Wick: This is Gail, I haven't either.

Ms. Rivero: Gail, do you mind confirming your email address? You can message me privately.

Member Narva: Maybe check you spam box.

Member Wick: I just did, and I got the other one this morning from you, Isabella.

Member Hartwell: Can you put the poll in the chat and I'll see if I can get it from here? Because I can't even copy and paste the link out of my email.

Ms. Kyle-Lion: Okay, Poonam said she'll send it. Just give us one second to get that link. Apologies for all the technical difficulties.

Member Silberzweig: What I found is that the link is -- it's looks like it doubled in the email. So you have to go in and carefully copy just the one part of it, and then it works.

Ms. Bal: Lori, I just sent a private chat with a link to you. Who else was having difficulty using the link, was it Alan?

Member Greenstein: I was able to vote, but I'm not sure if it went through, because I was able to get into the link.

Member Kliger: Yeah, and this is Alan, I also got into the link, thank you.

Member Hartwell: I'm trying to click on the link in the chat --

Member Dewald: This is Gail, I haven't gotten anything.

Member Greenstein: I'm sorry, you said you can check or you can't check?

Ms. Kyle-Lion: I can, you did. I got -- we have your vote.

Member Greenstein: Great, okay, thank you.

Member Hartwell: Let me just try to -- I'm going to try to key in the -- what you sent me in chat, because I don't know if --.

Ms. Kyle-Lion: We are at 16 votes, which is quorum. So we can -- we can move on from this for now. And then if people are still having issue when it is time to do live voting, if we get there you can go ahead and send me a private message via the Zoom platform.

So I'll go ahead and close the poll for now. Thank you to everyone who participated. The question was do you like Candy Corn. We had ten people say yes and six people say no. So it seems like there's -- there's quite a few Candy Corn lovers out there.

I'll go ahead and pass it back to you, Paula.

Ms. Farrell: All right, great. Thank you, Gabi.

Yeah, as Gabi mentioned, if you're still having issues with the voting, please go ahead and send a private chat to Gabi, and she can assist you through that as we're moving on with the call.

All right, we can go to the next slide, please. We're now going to go through the comments that were submitted. We did receive 22 comments from four organizations, which included one member organization and also individuals pertaining to the individual -- pertaining to the measures that were under review.

And as I mentioned, we did receive two reconsideration requests for Measures No. 3694 and 3696.

NQF reviewed all the comments that were submitted. And those of concern were sent to the -- to the developers. And they were provided an opportunity to respond to the comments on behalf of the measures.

NQF staff also determined which comments required a response from the standing committee. And staff had drafted proposed committee responses that we will review today.

And we will update the actual response after today's

discussion to better reflect the committee's conversation and then we will reply to the commenter.

I did want to mention that even though we're going to be only be discussing the comments that the standing committee wrote in responding to, any standing committee member can pull any comment for discussion during the meeting.

Reconsideration Requests NQF #3694 Percentage of Prevalent Patients Waitlisted in Active Status

All right, so first we're going to begin by discussing the reconsideration requests that were submitted. And we will begin with Measure No. 3694, which is the percentage of prevalent patients wait lists in active status.

And first I'd like to review the process that we're going to follow for the reconsideration request. So what I will do is first I'll review the concerns that the standing committee expressed during the measure evaluation meeting that was held in June regarding why the measure did not pass on validity.

I'll then summarize the comments that we received on this measure, and then I'll summarize the reconsideration request that was submitted by the developer.

Renee was our Co-Chair for this measure during the measure evaluation meeting, so she's going to be facilitating the committee's discussion today. But first the committee is going to be discussing the reconsideration request. And then the committee will vote to determine if the reconsideration request will be considered.

So the committee votes that they will not reconsider the reconsider the request, then we are done with 3694 and we will move on to the reconsideration for Measure 3696.

If the committee votes to accept the reconsideration request, we then will start the discussion with the validity criteria, which is the criteria that the measure did not pass on during the June meeting.

The lead discussants have been asked to review the validity testing that was submitted, and the standing committee will then be given an opportunity to discuss.

And after their discussion, the committee will then vote on validity. If the measure should not happen to pass on validity, we will be done with conversation on that measure.

If it does pass on validity, we will move on to the next criteria, which is feasibility. And then if the measure continues to pass the criteria, we will work all the way through the rest of the criteria, which is use and usability.

We will then also revote on evidence, because during our June meeting the standing committee voted consensus not reached on evidence. So we will have a discussion and vote on the evidence at that point.

The standing committee did pass the measure on performance gap and reliability during the June meeting, so if the standing committee does accept the reconsideration request, we will not be discussing performance gap and reliability during this call.

All right, so once these steps are complete for Measure 3694, we'll then move on to Measure 3696 and the same process will repeat itself.

So now I'm going to start by reviewing the standing committee's concerns that were expressed for Measure 3694. The percentage of prevalent patients waitlisted in active status.

And during the measure evaluation meeting, the

standing committee expressed concern that the evidence submitted for the measure did not demonstrate the nephrologists are the driver of a patient being waitlisted. Noting that the decision to waitlist is made by the transplant facility.

The standing committee also expressed concerns regarding the measure validity. And the committee noted that patients may be removed from a waitlist by the transplant team, which could then reflect poorly on the dialysis practitioner.

Additionally, during the standing committee meeting the committee expressed concern with the use of social determinants of health in the risk model and questioned if transplant center characteristics are accounted for in the model.

So for this measure, we did receive six comments, including the reconsideration request. Five comments were in support of the standing committee's recommendation to not recommend the measure for endorsement. And those commenters did agree on the committee of the concerns that the standing committee embraced.

Comments also cited concerns with attribution of the measure to the practitioner rather than the transplant facility. Variation in transplant center wait list criteria not being appropriately accounted for in the risk model. And the absence of reliability results stratified by provider size.

All right, now with that, I am going to go over the consideration request that we received from the developer on this measure. And the developer did submit a reconsideration request for Measure 3694 on the basis that NQF's measure evaluation criteria was not applied appropriately.

The developer advised that identical evidence and validity testing was submitted for Measure No. 3694 and Measure No. 3695. But the standing committee's voting on this criteria was inconsistent.

The standing committee voted consensus not reached on 3694 and passed NQF's 3695 on evidence. The standing committee did not pass NQF 3694 on validity, but did pass 3695 on validity.

And the developer noted in the reconsideration inconsistencies in the standing committee's application of the criteria and voting on the two measures. And if you'd like to see the whole verbiage of the reconsideration request that was submitted, you can find that in the comment brief that was attached to the invite.

Member Greenstein: Could you remind us what 3694 and 3695 were again?

Ms. Farrell: 3694 is the percentage of prevalent patients waitlisted in active status. And 3695 is percentage of prevalent patients waitlisted.

Member Greenstein: Okay.

Ms. Farrell: All right. All right, so next I'm going to turn the call over to our co-chair Renee to shepherd the committee through their discussion of a reconsideration request. Again, after the committee has completed its discussion on the request, we will then vote to determine if the committee wants to consider the request.

So Renee, I'm going to turn it over to you and to shepherd the discussion on the reconsideration.

Co-Chair Garrick: Thanks, Paula. So thanks for that background.

So as you've heard, we've been asked by the developer to first vote on whether we'd like to reconsider our prior deliberations regarding this measure, which is a measure regarding the active transplant list. So I think the task before us is that, and that's to vote yes or no o whether we'd like to reconsider the measure.

We actually won't discuss the measure right now. We

could have a brief conversation if there's any need to clarify anything regarding the task at hand, but we will not engage in a discussion of the measure right not until we first have a vote on whether we want to reconsider the measure.

That's my understanding. Paula, is that correct?

Ms. Farrell: Sorry, I couldn't get off mute. Yes, you are correct.

Co-Chair Garrick: Thanks. So if there is any questions about the task, we can certainly entertain them. So hearing none or seeing no hands -- oh, but --

Member Somers: Actually, yeah.

Co-Chair Garrick: I missed your hand, Michael.

Member Somers: Yeah, it's okay. I just wanted to clarify something. So the developer is asking for reconsideration on the basis that the same evidence was submitted to two separate measures. And we voted one way with one measure, and not the same way with this measure, is that correct?

Ms. Farrell: Yes, that's correct. They advised no reconsideration. The identical evidence and validity testing was submitted for 3694 and 3695. And the committee voted for evidence on 3694 that's consensus not reached. And then for 3695, evidence passed.

Member Somers: So I, you know, in terms of that request and that rationale, I just kind of think it's a bit specious to say that because you voted one way on one measure, you have to vote the same way on a different measure with the exact same evidence.

So I could think theoretically that the evidence could support one measure and not support a different measure.

Member Hartwell: I would agree with that, Michael. I'm a little confused. I --

Co-Chair Garrick: Right, so I think that's actually the question before us, is do we -- based on the facts that Michael just ran through, the task before us right now is to decide do we wish to reconsider our prior deliberation. And that is a yes-no vote.

And depending on how that vote goes, we either will or will not reconsider the measure of active waitlisting, having heard the comments from the developer. And the other comments that were submitted to -- back to us from the NQF staff.

So if there aren't other clarifying questions, I think we could take a vote to whether or not we wish to reconsider the measure, which is a yes/no vote.

And Paula, my understanding is that we have a quorum, and that we would vote on this measure. And to reconsider the measure, we would have to have a 60% vote in favor of reconsideration. Is that correct?

Ms. Farrell: It would need to be greater than 60%. So 61.

Co-Chair Garrick: Thank you.

Ms. Kyle-Lion: Okay, if we're ready to vote, I'll go ahead and pull up the screen. Just give me one minute.

Okay, voting is now open on the reconsideration request for NQF No. 3694, percentage of prevalent patients waitlisted in active status. The question is does the standing committee want to reconsider this measure.

Your options are A for yes and B for no. And I just want to reiterate that if you are having technical difficulties voting via the Poll Everywhere platform, please message me privately via the Zoom platform.

Okay, we are at 20 votes, which is quorum and the number that we were expecting, so I'm going to go ahead and close the poll. Okay, voting is now closed

on the reconsideration request for NQF No. 3694.

There were three votes for yes and 17 votes for no. Therefore, the measure will not be reconsidered.

All right, I will pass it back to Paula.

Ms. Farrell: Thank you. Well, since the standing committee has voted not to reconsider the measure, we will move on to the next reconsideration request.

And this is on Measure 3696, which is the standardized -- oh, I'm sorry, actually if we -- we were going to have a conversation with the standing committee to specify exactly why you were not reconsidering the measure. So I apologize for that, I skipped that step.

So Renee, if you could please shepherd the committee through that discussion, that would be great.

Co-Chair Garrick: Thanks, Paula. So because the developer asked us to reconsider the measure, we thought that it might be useful for the standing committee to have an opportunity to comment on the thoughts regarding why the committee has voted in the manner that we have regarding the reconsideration of validity.

And the reason for that is so that we could actually have this discussion so that when then move ahead to the CSAC committee we would better be able to comment on the thoughts of the standing committee since it will go next to that, to that body.

So we thought it might be to have an opportunity to clarify any questions that might arise or have the committee have an opportunity to give further comment.

Lorien, you want to add anything to that?

Co-Chair Dalrymple: Yeah, Renee, thank you, I'd be happy to. So for example, what we are proposing is

similar to what you stated, Michael.

So just because we vote differently on evidence between two measures, does that mean we're inconsistently applying NQF criteria, or do we have good logic as to why we think evidence supports one measure but not another measure that is a subset.

Similarly with validity, I think as was pointed and as the committee fully appreciated, the numerators differ between these two measures and the effect those numerators differences had on our decisions around validity.

This is an opportunity for the committee to specifically speak to their thoughts on why these two measures differ, and therefore one was endorsed and one was not.

Co-Chair Garrick: I don't see any hands. Are there any comments that the committee would like to make?

Member Somers: One -- one comment that I was just going to make along these lines is the idea that, you know, 3694, the measure we just considered, is actually waitlisting an active status.

And during, you know, our initial discussion, you know, there was lots of discussion about the role of the facility or the nephrologist in, you know, initially educating the patient, referring the patient, optimizing the patient's status so that if they do get waitlisted, they can maintain their status, you know, get on the waitlist, maintain their status on the waitlist.

But actually, you know, we had lots of discussion about how the facility and nephrologist has nothing to do with the activation component of things.

So I mean, a lot of the evidence that the measure developer had provided us about this measure, you know, had to do with how transplantation, you know,

was beneficial and that factors associated with -- there were factors associated with differences in waitlisting rates and transplant rates that facility or nephrologists could potentially affect.

But there really was very limited evidence for us to suggest that the facility or the nephrologist has a big role in the activation component.

So you know, I think that may be a rationale as to why we were more concerned about that and the validity of this measure versus the other measure, in my mind, at least.

Member Hartwell: Just to piggyback on Michael, and I agree with that. I mean, I have one friend right now who was not active on the waitlist because she needed a scan, a certain type to see a certain doctor to get back on the waitlist. And she had a four-month wait period to get that, that scan.

And so there's a lot of delays, and it's currently right now 40% of people are inactive on the list. And when we -- we're trying to help educate patients to get back on the list, but it's not always to do with a kidney issue. It's an outside issue. Or the recovering from an infection or whatever could be happening to them.

And sometimes it's just the bandwidth. And I just want to reiterate, I was -- I'm support of this measure, of the concept, but I mean, I -- people can't even get an appointment with the transplant doctor. You guys should just try, it's like, three, four months, they're not seeing anybody new because they're so overwhelmed.

And the impact this has is the current patients who are needing to see the transplant doctor. And so we have a huge problem of just we don't have enough transplant doctors.

And then you get into the rural areas as well. I mean, it's just, it's a good concept. I'm somebody who's had

four kidney transplants, I very appreciated this, but I agree with Michael.

Co-Chair Garrick: Thanks, Lori. I think Alan has his hand up. But Lori, just to comment on your comment. I think that's why the broader measure of the transplant waitlist is a different measure. And this measure is the active waitlist. So thanks for your comments, and I think Alan has his hand up.

Member Kliger: Yeah, I guess I want to say first of all that I understand why the developer asked us to reconsider. Because these measures as so similar that finding that the evidence would support one and not another would seem to sound confusing.

I think Michael really summarized this very well, and that these were different measures. And the judgments that were made were made because of those subtle differences in the definition of the three very similar measures, or four that I remember.

I personally would have raised the opposite issue. I would have asked us to reconsider the measure we passed because I'm concerned that there wasn't adequate evidence. But we're not asked to do that, we're asked rather to look at the ones that we didn't pass.

Member Wick: I agree.

Co-Chair Garrick: Lori, is your hand still up?

Member Hartwell: Well, I want to raise my hand instead of just speaking up. I want to be more polite about this scenario.

I just wanted to make sure I understand. So the new measure is to basically do the percentage of patients waitlisted. And what I -- what I have an issue with is that some patients don't even have access to a transplant center because they can't afford to get to it.

This -- this is what I wrap my brain around, or they

don't want a transplant. I mean, I find that hard to believe. But they're -- it's just a reality, because a lot of patients don't want it. And I'm just, I just wanted to make that clear, so I'll stop there.

Co-Chair Garrick: So that's a very important clarifying point. There were two measures. One was the broader measure of just transplant waitlisting, and as just pointed out, this was an active waitlist status.

So the question was should the ability for a patient to be on the active waitlist, is that clearly an indicator of the quality of the care provided by the nephrologist.

So there are two measures. One was the active waitlist, which is the measure we're discussing now, did not pass. And the broader measure, which did pass, was just waitlisting in general.

And there are some comments by -- that came into the group about perhaps that decision to pass that measure was not -- some of the commenters raised questions about why that measure was passed. But it was passed, and the active waitlist measure was not.

So the reconsideration request we've just voted on was solely, Lori, for this -- for this measure, the active waitlist measure.

Co-Chair Dalrymple: And I saw Stuart, then Andy.

Member Greenstein: Hello.

Co-Chair Garrick: Stuart, you want to go first?

Member Greenstein: Sure, so as an active transplant surgeon, the active waitlist is not a true indicator, I agree, of the nephrology practice because we do have differences in different programs.

And you know, until you can get active, you have to go through all the hoops that they would throw at the

patients, and sometimes it can take a long time.

But I think the better indicator of the nephrology is the referral of these patients to the -- to the transplant programs. And that is that if the patients don't get referred, you're right, they can't get on the waitlist.

So that's the -- that's the key for everybody, really. It's not the active waitlist, because it can take a while for a patient to get actively wait listed because they have to do an echo stress, all these other tests, and they're on dialysis three times a week and it's very hard for them to do their testing.

But if they don't ever get referred, that's the key. And that's probably the best measure of what's going in nephrology practice. I saw four patients today.

Two of them -- one of them started dialysis in 2015 and just got referred now. Another one's been on dialysis for two years and just got referred now. That's a long time to have wasted not being on a -- on a list or getting referred to you.

So that's the problem. It's not the active list as much as you're right, that is an indicator of individual transfer programs, and we all have differences in terms of risk adjustments and what we can take.

But to get referred first, we all want -- we want them to be referred. Let us decide who is and who's not a good candidate. And then we -- if we say they're not a good candidate, we always give the patient the option to go to another transfer program.

Co-Chair Garrick: Thanks for that comment, Stuart. And I think Andy has his hand up.

Member Narva: Sure. I don't find a significant difference in the logic between these two measures. And I do think that the nephrologist does have a big impact, even on facilitating evaluation, facilitating listing, at least in finding ways, creative ways to help

people who have decreased access to care get their workup.

And you know, I think that both of these measures, 94 and 95, support the idea that is promoted by nephrology societies that the nephrologist is the captain of the ESRD healthcare team.

And I think this -- voting this down sort of contradicts that. Because it just points out all the things that aren't under the control of the nephrologist.

Co-Chair Garrick: Thanks, thanks for your comment. I appreciate that. Lorien, was that -- is your hand up?

Co-Chair Dalrymple: Yes, I raised my hand. I'll speak as a committee member as opposed to a co-chair for a minute. Because I think it is helpful for us to have the opportunity to clarify why these two measures maybe differ.

And I probably, Michael, agree most with you that I view a difference in the active requirement because transplant centers, to our knowledge, do have variation in how they approach inactive and active transplant waitlisting.

Unfortunately, I believe the data that was provided with the measure, and Michael, maybe you'll correct me if I'm wrong, was pre-2014 OPTN policy revisions. So clearly, we all know prior to 2014 there was extreme variation in inactive and active transplant waitlisting that varied from center to center.

After 2014, I don't know that we were given new data to understand the extent that that variation exists today. And I think as a group we are hesitant to say that a quality of care provided by an nephrology or a nephrology group is measured when there's so much variation in transplant center practice.

So we did endorse a broader measure that overcame some of that transplant center practice. But to have a subset of active I think really required us to have

more confidence than we likely had about the consistency of how active and inactive is handled transplant center to transplant center.

And at least to my knowledge, we were not given any data to reassure us on that point.

Co-Chair Garrick: Right, and so I would only -- this is Renee, I would add just one comment, that is that was part of the concern, is that those -- those issues on the part of the transplant team are not publicly known, they're not reported, they're not transparent.

And so the transplant team, as others have already said, is the group that's responsible for the determination of someone's status on the waitlist. And that is the responsibility of the transplant team, as our transplanter pointed out a second ago.

Jeffrey, your hand is up.

Member Silberzweig: Thanks, Renee. So I think a point's been made that in many cases, if a patient is evaluated at one transplant center and turned down, that they have the option of going to another transplant center.

And I practice in New York City, and so certainly in New York City, there are plenty of transplant centers. But that's not true everywhere around the country.

I remember talking to a nephrologist some time ago in West Virginia, and the only, or the nearest center for her was in Pittsburgh, which was two or three hours away. And other centers are even further away.

So to say that getting a patient actively listed is within the purview of the nephrologist who can refer a patient to other centers, not in every case. And so I worry that this measure isn't valid in all -- for all practices.

Co-Chair Garrick: Right, I think that is one of the questions that came up in terms of risk to validity

when it was discussed last time. So thanks for reminding us of that, Jeffrey.

Are there other questions or comments? If not, our hope was to accomplish what we just did, which was to have an opportunity for the committee to express some of thinking around the vote so that we could be clear in our own minds and prepared for later conversations.

So if there aren't other comments on it, I think we'll go back to Paula for the next measure.

Ms. Farrell: All right, thank you, Renee.

Co-Chair Garrick: Thanks.

Ms. Farrell: We will move on to our next reconsideration, which is for Measure No. 3696, standardized modality switch ratios for incident dialysis patients.

We're going to follow the same process that we reviewed and we took with Measure 3694. So I'll start with reviewing the standing committee's concerns that were expressed during the measure evaluation meeting.

And the standing committee expressed concerns that the evidence supports dialysis modality switch as a marker of patient education and an unintended consequence could be encouraging practitioners to start patients on in-center dialysis and then switching them to home dialysis.

The standing committee also expressed concerns regarding the ethical comorbidities in the risk model influenced a patient's dialysis modality choice. And if the measure exclusions were appropriate.

All right, so now I'm -- summarize the measures that we -- comments that we received on this measure. And we received four comments on the measure, including the reconsideration request.

Two comments supported the standing committee's recommendation to not endorse the measure. And the commenters cited concerns that the measure could lead to practitioners being encouraged to initiate patients on in-center dialysis in order to gain credit for changing to home dialysis later.

That the credit for a switch should be longer than 30 days. And that it is unclear how the developer is using modality switch rates as a proxy for education as there's no mechanism for the measure to discern whether a decision to switch is because of education.

Two other comments that were received with a reconsideration request that was submitted by the developer, and I will summarize that request now. So the developer submitted a request for reconsideration for the measures on the basis that NQF's measure evaluation criteria was not applied appropriately.

The developer advised that the standing committee noted that clear evidence was not submitted to support modality switch as a marker of education and voted consensus not reached.

The developer noted that the measure submission cited several studies that demonstrated how educational interventions facilitate shared decisionmaking and greater home dialysis uptake, thus meeting NQF evidence criteria.

The developer also advises that the standing committee did not articulate why they overturned the scientific methods panel decision to pass the measure on validity.

In addition, the developer raised concerns with the standing committee's focus on measuring patient choice. And that the measure would encourage 100% performance. And the standing committee ultimately did not pass the measure on validity.

And so with that, I'll now turn the call over our co-

chair Lorien to shepherd the committee through the discussion on the reconsideration request.

Lorien.

Co-Chair Dalrymple: Thank you, Paula. So, similar to before, we will follow the same process where our first vote is to decide whether we would like to reconsider the measure. Similar to before, we will not have extensive discussion unless we decide to reconsider the measure, and then we will start at validity.

But does anyone have any questions or comments before we go to the reconsideration vote?

Member Hartwell: I would -- I would just -- because I like sharing the verbal -- and I mean, I appreciate the comment of by Karilynne about, you know, not being any perfect measures.

But I just wanted to say this measure reminds me a lot of the good -- the well-intentioned Fistula First, I mean, when they were trying to do the different things and patients are ending up with catheters longer.

And I think that that's what's concerning, is you think you're having a good policy, but the fact that, you know, a patient can't go straight home and they get a benefit from being in center, it's not really making the best choice for the patient.

So I just wanted to make that comment before we move on.

Co-Chair Dalrymple: Thank you, Lori. I don't see any hands, but I do want to give a moment before we go to voting just in case anyone -- John, thank you, I see your hand. Please go ahead.

Member Wagner: Yeah, so thanks. So I just have a question about the arguments that the developer has raised. If the committee believes that the evidence is there but the validity is not, and/or the opposite,

does that mean that we believe that one of their arguments is correct, namely that the evidence is there and/or that the validity is there but not both?

Is that -- does that oblige us to rediscuss this measure?

Co-Chair Dalrymple: So Paula, I'm probably going to have NQF staff answer that question as to when we're asked to reconsider measures what is really being asked. I think Paula, do you want to answer that, and then Renee and I can fill in any.

Ms. Farrell: Sure. So for evidence, the committee voted consensus not reached. But for validity, the committee did not pass the measure on validity.

So ultimately the reconsideration will be on the validity. And if the standing committee would like to accept the reconsideration, then we would jump into discussing validity, because that is the criteria that did not pass.

Co-Chair Dalrymple: And I think -- I think, Paula, John might be asking a question that Renee and I asked on -- as well. So I think he's -- I think, John, they're asking, well, when should we say yes to reconsideration? What would prompt us to vote yes? Is it that we understand the developer's concerns, and because we see your concerns, we will rediscuss this?

And the outcome may or may not be the same, John. So I think -- I think that's what's being asked, Paula. Under what circumstances should the committee reconsider, even if they feel perhaps validity didn't land in the right place. But we appreciate the concerns you're raising and therefore are willing to rediscuss it.

I think that's the kind of guidance being asked for.

Ms. Farrell: Poonam, could you assist here with this question?

Ms. Bal: Yeah, of course. So yes, I think Lorien explained it pretty well, which is that the question really is do you think that there is merit to the developer's request. You know, they have done their duty to present a case for why they think the measure should be reconsidered.

And then it's up to the standing committee to decide if they think that there could be merit here. Or that even if there could be -- more discussion could be warranted.

Accepting a reconsideration does not indicate that you think that they are correct or that the measure will now pass or that you think it should now pass. It's simply saying that you think that there is enough doubt that the criteria was not properly applied to at least re-have the discussion again and determine if you made the right decision.

Does that help?

Co-Chair Garrick: So could -- it's Renee. Poonam, I think that's perfect, and I think that's the correct issue, is where the correct criteria applied. And so on the validity question of this measure which did not pass, I think there was an issue.

And again, now I'm speaking not as a co-chair but as a committee member, that the question at hand is does a switch of modality, is that a reflection of the quality of the care rendered by the dialysis facility. Or as was suggested by others, are there many issues that go into that, and some patients may choose not to go home at all.

So the question I think is were the correct criteria applied on the validity vote that -- by this committee. And I understand that the developer's asking for reconsideration, and our opportunity now is to say are we -- do we want to have a reconsideration. So that's the yes/no vote.

But the issue on the first go-around did not pass on

the issue of the validity of this as a quality measure of -- for the dialysis facility.

Co-Chair Dalrymple: And Lori, go ahead.

Member Hartwell: Yeah, I just have a -- I'm just trying to like understand how this impacts, sorry -- impacts, let me just mute my phone. How this impacts. So if, and I've been on all treatment options, so I'm just trying to understand some of my own scenarios as well.

So if a patient starts out and they go on a home and then for whatever reason I'm not able to do home, I go on in center, I have to move in center. Which has happened, you get hospitalized, you don't feel good. So that is actually a patient choice a lot of times if they want to go back in center because they can't do it.

And then I think the other way is I'm thinking, well, here's a patient on home and -- on in center, and they want to try home. But then for whatever reason, they can't figure -- they just don't feel comfortable with it, or something happens or whatever, or, and they want to go back in center.

And I don't know we can make that a reflection because one of the things is patients want choice. And I think it's finding the right -- right treatment for patient. And sometimes people start off on one and then end up on another. So it's just part of the process.

So, and do I have that correctly stated?

Co-Chair Dalrymple: Well, and I could ask, you know, Annabelle, if you wanted to recap it. I think the simple way I think about this measure, Lori, and I'll look to Annabelle to make sure I summarize it correctly is it's a measure looking at all dialysis facilities in the U.S. and incidence in-center patients. And looking at what proportion of those patients go home compared to what would be expected for a case

mix of that facility.

So this is one of those observed-over-expected measures. And the premise is the more patients you have switched to home in their first year of dialysis, that that is a valid measure of the quality of care provided in that facility.

Annabelle, do you think that was fair enough snapshot of this measure?

Member Chua: Yes, and I think their argument was a quality -- like the education that they received that led to the choice of home dialysis.

Member Hartwell: Well, and then, I'm just trying to think of that, because I was on PD and home hemo. And there was a situation when I was on home hemo I did not feel comfortable doing it by myself.

So let's say I did not feel comfortable doing it by myself I -- because my care partner can't help me. And I have to go back in center because I don't feel comfortable. I do not think that reflects the quality at all. That's lack of resources for the patients to be able to do it.

The other -- the other way is that there is a big push to put patients on home, which I'm in total support of. But you know, sometimes patients just don't feel comfortable or their housing situation changes or something happens where they're not able to do it anymore.

And I know it's not a perfect measure, but I do want people to not be reluctant or push people on a, you know, a modality that they know may not do well. But I appreciate the spirit of it, because --.

And then the other point is is some patients still in this country are, you know, the home, you know, I love nephrologists, everybody, please, you know, you're my favorite people, because I'm here because of it. But a lot of -- there's not a lot of centers around

in some of the places that patients have easy access to to be able.

And I know that right now there's like a list of people being trained, but as we all know, there's a staffing shortage. So I'll stop there, but I mean, I get -- I get the spirit of it, I'm just -- I just don't want it to ever get in the way of the right choice that the patient wants to make because they're trying to get a measure.

Co-Chair Dalrymple: Yeah, and Lori, what I would say, because others may have commented, if we vote to reconsider the measure, then we will go into a full discussion of validity, feasibility, usability. We will even go back to evidence because of the consensus not reached.

But before we go into those broader discussions, it will be important for us to vote on whether we want to reconsider the measure and go through all of the criteria again.

Okay, Michael, I see your hand up.

Member Somers: Yes, I just wanted to say the developer in their comments said that we didn't articulate why we overturned the scientific method panel's decision to pass the measure on validity and we turned it down on validity.

But I went back to, you know, my notes during the meeting, and you know, when we were discussing validity, there was a lot of discussion about the evidence that the developer had provided us in terms of their testing of their measure and comparing it to things like the standardized mortality rate, the first year SMR, the standardized hospitalization ratio.

And you know, my notes say that we discussed that and people were really concerned about the very weak association that they found. So I just wanted to say I take exception to that because I did think we articulated during out meeting in our discussion why

we voted the way we did. We just didn't vote the way we did without discussion.

Co-Chair Dalrymple: Thank you, Michael, because I think you're say -- you say for example, if you did not believe that to be true, then you would perhaps say, you know what, we should reconsider just so we can, you know, state clearly what our thinking was.

But I think your position is, and I will say Renee and I did review all of the transcripts from our meetings, your thought is that validity was discussed at length and there was a good understanding.

Dr. Messano, I see your hand up. I'm probably going to have to ask the NQF staff about procedure here. Paula, and Poonam, do we take comments from developers prior to voting on reconsideration?

Ms. Farrell: Yes, we can do that.

Co-Chair Dalrymple: Okay, so Dr. Messano, you're next.

DR. MESSANO: Yeah, I'd just like to make a brief point of clarification. In response to Ms. Hartwell's well-earned anecdotes from her experience, we agree, Lori, with I think most everything you said, that patient choice has to be involved in this stuff and people should not stay on if they don't want to.

But I just want to clarify so that you all are voting on the right thing. This measure is a measure that evaluates a subset of incident dialysis patients: the 80% of new dialysis patients who start on in-center hemodialysis, from which something on the order of five or six percent go on to home dialysis in the first year.

And based on the literature and based on our TEP, a patient center TEP, the decision to try home dialysis is not always clear to patients before they start dialysis or is better considered after, you know, they've had uremic toxins reduced after initiating

dialysis, or for whatever reasons they take time to get around to it.

Education was discussed extensively by this group when you were talking about validity and people questioned whether this was an appropriate measure of patient education. Patient education was used as an argument for evidence. That is one particular process that a dialysis facility can utilize that will lead to increased uptake of home dialysis.

From a validity point of view, I just want to be clear. This measure is a measure of switches. The numerator is switches in this subpopulation, and it's observed over expected. The expected is risk-adjusted. And it's not a measure of education, it's not a proxy for education. Education's one component.

Supporting patients, facilitating, you know, referring them to a surgeon for a PD catheter placement, whatever. This is a measure of successful switches defined by at least 30 days on a home dialysis modality when you started out with in-center. Just wanted to clarify that.

Co-Chair Dalrymple: Thank you. Renee, you're next.

Co-Chair Garrick: Thanks. Thank you so much, and I think that's a very important clarification. I think that's actually was -- and again, we have to have -- we don't want to get too deep into the measure.

But just to comment again as a committee member, that is the important question here, is is a switch from one dialysis modality to the other. If units have that switch, does that mean that that's a higher quality facility than a unit where patients may be educated and choose not to go home?

So the question here is is dialysis switch a marker of the quality of care being rendered by a facility. And I think that's is -- and I thank you, I think that is the question.

Co-Chair Dalrymple: I do not see any other hands, and I would favor, if the committee is in agreement, that we move to the vote on reconsideration to vote yes or no to reconsider the measure. I don't see any hands coming up, so I will assume that people are comfortable with that.

And then depending on the vote, we will take next steps.

Ms. Kyle-Lion: Okay, I'll go ahead and pull up that vote for everyone. Okay, voting is now open for Measure -- or NQF No. 3696, standardized modality switch ratio for incident dialysis patients on whether the standing committee would like to reconsider it.

Your options are A for yes or B for no. And just as a reminder for anybody experiencing technical difficulties with the Poll Everywhere platform, you may send me a message via the Zoom platform with your vote.

We are at 18 votes right now, I believe we're expecting 20. So we'll just hold for a little bit longer to see if we get those last two votes.

Okay, it looks like we're holding at 19, which is above quorum, so I will go ahead and close the poll. Voting is now closed on whether the standing committee would like to reconsider NQF No. 3696.

Okay, there was one vote for yes and 18 votes for no. Therefore, the standing committee will not reconsider this measure.

I will pass it back to Paula.

Discussion of Comments NQF #3695 Percentage of Prevalent Patients Waitlisted

Ms. Farrell: All right, thank you, Gabi.

So with that, we will move on to the comments that we received on 3695. Actually, I'm sorry again, I forgot (simultaneous speaking). Yeah, if we could

have a discussion so typically on why we didn't reconsider the request, that would be great.

Co-Chair Dalrymple: Thanks, Paula. So I think this is similar to our last opportunity. And I think, Michael, you have already done this to some extent. I think it is important the committee address developers' concerns and that we have this opportunity to clarify what perhaps did not feel clear during the discussion to the developers.

And so if people would like to add more specific comments on their thoughts. Around validity, quite honestly, is where I would start if people want to talk about evidence, that is an option. But this measure did ultimately fail on validity, so I think that's probably where it would be most important.

And as a reminder, so if there were concerns about exclusions, risk, adjustment, other things that relate to the validity is this so the measure of quality of care for a dialysis facility.

And Jeff, I see your hand, so please go ahead.

Member Silberzweig: Thanks, Lori. So I think that, as has been outlined and as you said before, and as Lori has touched on, there are many factors that go into whether a patient chooses to do dialysis at home and is able to maintain that for a month or more. Be that infections, which, you know, certainly the nephrologist has some influence over. Or be it home circumstances which they don't.

And so I think that to say that this is a measure of -- a valid measure to assess nephrologists' or providers' practice doesn't -- doesn't work for me.

Co-Chair Dalrymple: Thank you, Jeff. Do others have comments they would like to offer? Alan?

Member Kliger: Only that I think that the developer's concerns were not well-founded in the actual process that we carried out. I think that Lori and Michael very

nicely summarized I think two major aspects that we considered at length in deciding that it did not pass in validity.

Co-Chair Dalrymple: Thank you, Alan. Anyone else that would like to offer a comment?

Okay, so Paula, I think we can move on.

Ms. Farrell: All right, great, thank you.

So lastly we will review, like I said, the comments that we received for Measure 3695, which is the percentage of prevalent patients waitlisted.

Two commenters submitted comments that disagreed with the standing committee's recommendation to endorse the measure. And one commenter noted that they had several issues with the measure, including the attribution of the measure to individual clinicians and practitioner groups, and that the model did not -- does not validly account for variation in transplant center eligibility criteria.

And that the developer did not provide stratification of reliability scores by provider size for the measure.

Thus, it made it impossible to discern how widely reliable -- reliably -- how widely reliability varies across practices -- practice sizes.

The second commenter also noted a concern on how the measure could have a negative impact on smaller transplant centers.

The comments were, these two comments were submitted to the developer, and I will summarize their response that they provided back.

The developer did respond that being waitlisted for a kidney transplant is the cumulation of a variety of preceding preparatory activities, including education of patients about the option of transplantation, referral of patients to the transplant center for evaluation, completion of the evaluation process, and

optimizing the health of the patient while on dialysis.

And while most efforts are dependent on the dialysis -- and that most efforts are dependent on the dialysis practitioner groups.

Aspects that are not entirely dependent on the dialysis practitioner groups, such as actual waitlisting decision by transplant center or patient's choice about transplantation option can be influenced by the dialysis practitioner groups.

The developer did agree that measures directed at referral and transplant education would potentially be valuable, but there are limitations in the national data available on referral and appropriate tools to capture quality of transplant education.

That poses a practical hurdle to the development of such a measure. And they agreed that referral is an important metric to report at the dialysis facility level, but there is currently no mechanism to capture data on referrals on a national scale.

Additionally, to address ongoing disparities in access to transplantation, the developer advised that all dialysis patients should be included in the measure.

And the developer agreed that there is a variation across transplant centers and eligibility criteria, and that underlying patient co-morbidities may affect their candidacy.

However, the waitlisting measures adjust for a wide range of co-morbidities and transplant center characteristics, such as random effects and center waitlist mortality.

So staff also identified these comments as something that the standing committee should respond to. And you will see on your screen now that staff proposed the following the standing committee response to these comments.

So our proposed draft response reads, thanking the

commenter for their comments and advising that the standing committee considers measures independently of others that have been recently implemented. And the standing committee determined that this measure met all NQF criteria for endorsement, and therefore recommended the measure for endorsement.

So now I'll turn the call back over to our co-chairs, Lorien and Renee, and they can shepherd the standing committee through a discussion on this drafted response. And if the committee would like to provide any revisions to the response.

Co-Chair Dalrymple: So is the committee comfortable with the response that has been drafted, or would you like to add additional thoughts and comments? And Andy, I see your hand. And Andy, you're muted.

Member Narva: I just want to say I think the response from the developer is very well-crafted.

Co-Chair Dalrymple: And Andy, are you comfortable with the response that NQF has drafted on our behalf for the standing committee response?

Member Narva: Yeah, I -- it doesn't -- it says thank you for your -- thank you for your comments.

Co-Chair Dalrymple: It's succinct, Andy. It says we followed NQF criteria and feel comfortable with our decision.

Member Narva: I know, it's a -- you know, it's fine.

Co-Chair Dalrymple: Are there -- and Alan, I see your hand.

Member Kliger: Yeah, just quickly. First, I agree that this is an appropriate comment, and I would endorse it.

But I can't let the moment go by without remembering the anecdote everyone knows of the man under a street lamp at night who is searching

around on the ground, and somebody comes over and says what are you looking for.

He says, "Well, I'm looking for my keys. He said, "Well, did you lose your keys here?" He said, "No, no, I lost my keys over there." "But why aren't you looking over there?" "Well, because the light is over here."

When we believe that it's important to record referrals to the transplant center as the major effort that nephrologists and their teams can make to promote transplantation, saying that adequate data on referrals is not available and that's the reason why we try to craft other measures skirts the major issue.

Because I believer, as I think many have said on this committee, that if we had indeed some way to adequately measure referrals, that that would really be a far better metric of quality.

And that perhaps we need to encourage the developer and others to help us devise ways that we can adequately and appropriately capture referrals and referral rates so that we can use them.

Co-Chair Dalrymple: So Stuart, I see your hand, but Alan, I do feel like I should respond to that.

Our committee did endorse this measure. So the committee as majority at least decided this measure is a valid measure of quality. And I recognize there are different perspectives on that. We've certainly heard it throughout the committee. And that is what makes our committee so great, we do not all agree, we have different opinions.

But as a committee, we did endorse this measure and we're being asked to explain that decision. And so that's really the purpose of this discussion, have we adequately explained why the committee ultimately endorsed this measure.

And I know that, you know, obviously like most

measures it was not unanimous. But I think it is important that we speak to the measure itself, not other potential measures.

Member Kliger: Lorien, I -- again, I apologize. I added it as a, you know, sort of a postscript. I agree that our statement should be as it stands and nothing more. I'm simply pointing out -- and I endorse the fact that we approved this measure, I'm not challenging that.

I'm simply saying that we need to recognize what the real issue that has been discussed before is that perhaps a better measure might provide.

Co-Chair Dalrymple: Thank you, Alan. Stuart, and then Renee.

Member Greenstein: So I have to agree 200% with Alan that, I mean, I agree, we should endorse this measure, but I think we are missing the point that the real measure that has to be looked at is the referral to the transplant programs. And there are ways that that can be measured.

The transplant programs can sign off on a record saying that patient has been referred and that can be adequately looked at. So there are ways. But until that is put into action, we have to do something to measure this.

Co-Chair Dalrymple: Renee, and then Lori.

Co-Chair Garrick: Thanks, I just wanted to respond. I think this is an example of a group that had -- did a great job having a conversation about these measures. And remember, we heard three transplant measures that day.

And I think that there's no question that if we could get a tighter measure that really reflects the role of the nephrologist, that would be a measure that we'd all like to hear.

I think this is -- the point of having perfect not being

the enemy of the good. And I think we do endorse the concept of what was done by the committee when we -- when we first heard this measure. And I think that we did uphold the standards of the NQF in terms of the vote for endorsement.

And I think most of us agree with the comments that were just made that there's probably a better measure out there than this measure.

But this was endorsed under the notion that it's a broader member -- sorry, a broader measure than some of the other measures that were heard that day. And was one that would at least help support this concept of transplantation.

And hopefully we'll have a better measure in the future that would be more in line with the role of the nephrologist.

Co-Chair Dalrymple: Lori, you're next.

Member Hartwell: Yeah, I'm just -- and I appreciate what you said, because it is -- it is like, you know is this -- is this the appropriate, you know, thing until something's better. And I'm just wondering how it really reflects just a patient being referred.

And I've heard from my patients that are members of mine that the center keeps bugging me to go get waitlisted, I don't want a transplant. That's what I've heard.

And I'm just -- I'm just perplexed. It -- you know, we're all about educating patients to make the right choice but there's so many barriers to it that now have become more exposed since, you know, this has been out there for a while.

And I'm just wondering if anybody on the group could say how this is helping, you know, other -- you know, is it really helping the patient get transplanted. I mean, because that's ultimately the goal, not to get waitlisted, to get transplanted, I believe at the end of

the day. Is that really happening?

Co-Chair Dalrymple: So Lori, would you like some of the committee members to give their thoughts on those questions, or are you just posing them --

Member Hartwell: Well, I was just, yeah, I was kind of curious because I mean, you know, you don't know what you don't know. And but I just -- I mean, just hearing that there's -- we all want patients to get transplanted, everything like that. And what I'm hearing from the conversation is we need a better measure.

But this is what's out there until a better measure. And my question is is that does the group think that this measure is actually helping patients get the treatment option they want of a kidney transplant. That's what I -- I just thought I would put it out there.

Co-Chair Dalrymple: Yeah, Lori, I think what I should say, which may not be a direct answer to your question, is what the committee is asked to do in this moment is to respond to commenters that raised concerns about our endorsement of this measure. And we're required as a committee to provide a response.

The NQF staff has attempted to draft that on our behalf, but they are very specifically asking us to look at the standing committee response. But our response is to presumably explain why we endorsed the measure, because that is what the committee did as a whole.

And so I am concerned that we're starting to talk about other topics such as other measures, which during other periods of the meeting we certainly can. But the very specific task in front of us right now is do we feel this response represents the committee's position.

And I'll just say NQF criteria do not suggest, at least to me, that you vote to pass a measure because it's

the best one out there today. We should only ever pass measures that meet all NQF criteria. If we do not believe that to be true, we should not pass those measures.

So, I still would take the position that this measure passed because the standing committee believed it to meet NQF criteria as specified today.

And I'm pretty sure we discussed this during the meetings because it happened a couple times during the meeting that we don't evaluate measures compared to other potential measures. We evaluate that measure as it stands. And that is really our responsibility as a committee.

So I hope that helps a little bit, just because I know we need to complete this task first before we can move on to broader discussion.

And Andy, I see your hand up.

Member Chin: Yeah, thanks, Lorien. I agree with everything that's been said. But again, the -- we have passed the measure and the task at hand is to look at this committee response.

Do we think that perhaps adding a line saying, you know, that we basically endorsed it within the context of present available data or some line like that that really says or adds a little bit of yeah, we understand that this is, you know, maybe not the ideal thing.

Or do you think that's opening up a can of worms that we don't want to do?

Co-Chair Dalrymple: Well, my response, Andy, would be if we don't -- we -- I have to assume we believe this measure met NQF criteria. And therefore we endorsed it as it stood alone.

Is there always the potential for better measures? In everything we do, there is, yes, right. Whether it's a hospitalization measure, we all want better risk adjustment, we want different exclusions.

So I think alluding to the fact that there can always be a better measure with more data, richer data, I don't personally find that necessary because I think every quality measure in existence today we could all likely -- I bet Andy, you and I could think of like ten right off the top of our head where we're like, well, if we just had this one more element, it might be a little better.

But perfect measures rarely if ever exist in healthcare, and I think Karilynne brought that point up in the chat earlier today. So my only concerns is it seems to allude to something that is perhaps true of all of healthcare quality measurement.

Lori.

Member Hartwell: And I agree with you. I do remember the initial conversations of, you know, of this measure. And I think at the time, you know, we wanted to improve patients being referred.

But now we have some real-time information coming back, hearing from patients, different things like that. And I feel that that has put a lot of question and is this an appropriate, based on all the things I said before, I don't have to recap them.

I think we have been learn -- and my question is, is this measure improving patients' care. That's what the goal is of a measure, is to improve our care. And I'm not certain that it's improving our care at the moment, even though I believe that, you know, patients need to be referred.

And I have -- I have four or five support groups a month, and we constantly tell patients to go get on the transplant list. This is their thing.

And just the thing with kidney disease is you're so overwhelmed and you're so much in all the Kubler-Ross emotional stages that you just, you just don't want to do it, or you don't feel or your heard it or whatever the issue may be. I could give you -- I

actually have a whole list of reasons that patients gave us that they don't want to be transplanted.

But I feel that we've evolved and we've learned from what it happens. And my question goes back, is this, the way it stands, this measure, I don't believe it's improving the quality of care to just show that one center is doing. There are so many other factors involved.

So I'll just talk my decision up to evolving if -- of understanding how a measure works in real time. Because everything looks good on paper until it's thrown out on the streets.

Co-Chair Dalrymple: So Paula, I will probably ask the NQF staff to weigh in here. I do feel like the request has been clearly stated. You've now heard fairly extensive discussion. But I don't know that it changes the standing committee response for this report.

And Lori, I'm not clear if you would like a specific sentence or two added perhaps about unintended consequences or other things. I think that's what I'm struggling with is the proposed standing committee response as written, are you objecting to it and you would like it revised, recognizing the measure was endorsed by our committee?

Member Hartwell: I think, you know, we endorsed it, and I think that we want to recognize that. I know that we did, it's a fact, you can't take that away. But I think that we now have some real-time information involved.

And I mean, I want to ask the group, is it improving the patients' quality? Because as you know, there's a lot of measures that are out there right now and they're not perfect. But we shouldn't be spending our time on one that is not that will improve the quality and be tweaked.

And I don't know how that's going to happen, and we can't bring the discussion in of other measures that

we think are a better idea. So to just keep a measure that I believe is not helping is -- because I've evolved. You can put that in the quote, Lori evolved. And just understanding it.

And I, if I recall before the conversations is we were not in complete agreement of how this should. But everybody was excited about like let's move forward.

And I can tell you for certain that one thing this measure did is everybody's aware of, you know, of this topic. But I don't know if it's improving patient care. So that's my statement.

Co-Chair Dalrymple: Yeah, Lori, the only thing I would clarify, because we will have to move forward in the agenda, is this is a new measure that has not previously been implemented. Because this is not the facility measure, this is a new measure for physicians that has never previously been implemented.

Member Hartwell: But it's the same discussion, it's the discussion that, I mean, maybe I'm living in two different worlds, but it's the same discussion of -- of the problems with it.

So because I mean, and I love Dr. -- and I don't want to take up time. Because Dr. Kliger gave the best story, and I thought I have a great story too. But I'm going to hold it for another time due to time.

Co-Chair Dalrymple: So Paula, can you please advise on next steps?

Next Steps

Ms. Farrell: Well, from what I heard, there is no additions to the drafted response based on the discussion, that the committee is going with us for responding to the commenters with this response. And that is what we will move forward to do.

Okay. All right, so next we will jump into next steps. And so Gabi, if you can go back to the PowerPoint please.

And at this point, we'd like to give NQF members and the public an opportunity to comment. So if you're either an NQF member or a part of the public and you wish to comment on the discussion that was had today, please either raise your hand or put the comment in the chat.

We do ask that when it's your turn to comment that you please state your name and also the organization that you represent. And I'll just pause for a moment to give everybody a chance to do that.

All right, I'm not seeing any hand raises or comments in the chat. So next I'll be reviewing next steps. Gabi, if we can go to the next slide, please.

And we will incorporate the comments received and the responses to the comments in the meeting materials for our consensus standards approval committee meeting. And that meeting, the CSAC meeting for spring 2022 will be held on December 9 and December 12.

Also, the spring 2022 appeals period will be held for 30 days, from December 14 to January 13. Next slide, please.

And as always, if anyone has any questions, please feel free to reach out. And you can find the project team's contact information on this slide. The next slide, please.

And we are at the end of the meeting, so I would like to thank the standing committee, the measure developers, NQF members, and the public for their participation.

We were able to complete everything listed on the agenda during today's meeting, so we will be sending out a cancellation for the Renal day two meeting that is scheduled for October 12. So please look for that, that cancellation, to come to your inbox after this

meeting.

And I'd like to just turn it back over to our co-chairs, Lorien, and Renee, for their -- thank them for their work in leading the meeting. And then turn it back over to them to provide their closing remarks.

Adjourn

Co-Chair Garrick: Well I'll lead by just thanking everyone for attending and for all the great conversation and for all the pre-work that I'm sure everyone did to prepare for the meeting. So thanks, and looking forward to seeing everybody again in our next go-around.

Co-Chair Dalrymple: And I'll just echo Renee's comments of thanks for everyone's time and commitment and for the great discussion around these measures. And we will see you all at the next committee cycle. Thank you.

Ms. Farrell: All right, great. Thank you, everyone, enjoy the rest of your day.

(Whereupon, the above-entitled matter went off the record at 3:35 p.m.)