



Measure Information

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

Brief Measure Information

NQF #: 0323

Corresponding Measures:

De.2. Measure Title: Adult Kidney Disease: Hemodialysis Adequacy: Solute

Co.1.1. Measure Steward: Renal Physicians Association

De.3. Brief Description of Measure: Percentage of calendar months within a 12-month period during which patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis three times a week for ≥ 90 days have a $\text{spKt/V} \geq 1.2$

1b.1. Developer Rationale: Adequate dialysis dose ($\text{Kt/V} > \text{or} = 1.2$), is strongly associated with better outcomes, including decreased mortality, fewer hospitalizations, decreased length of hospitalizations, and decreased hospital costs.(1,2)

1. Plantinga LC, Fink NE, Jaar BG, et al. Attainment of clinical performance targets and improvement in clinical outcomes and resource use in hemodialysis care: a prospective cohort study. BMC Health Serv Res. 2007 Jan 9;7:5.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1783649/pdf/1472-6963-7-5.pdf>. Accessed April 27, 2011.

2. Sehgal AR, Dor A, Tsai AC: Morbidity and cost implications of inadequate hemodialysis. Am J Kidney Dis 37:1223-1231, 2001

S.4. Numerator Statement: Calendar months during which patients have a $\text{spKt/V} \geq 1.2$

S.6. Denominator Statement: All calendar months during which patients aged 18 years and older with a diagnosis of ESRD are receiving hemodialysis three times a week for ≥ 90 days

S.8. Denominator Exclusions: There are no denominator exceptions.

De.1. Measure Type: Outcome

S.17. Data Source: Claims, Electronic Health Records, Other, Registry Data

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Nov 15, 2007 **Most Recent Endorsement Date:** Oct 02, 2015

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

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

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? This measure is not a composite or paired measure.

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

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

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

[MeasSubm_Evidence_0323-_update.docx](#)

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

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1b. Performance Gap

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

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

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

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Adequate dialysis dose ($Kt/V > \text{or} = 1.2$), is strongly associated with better outcomes, including decreased mortality, fewer hospitalizations, decreased length of hospitalizations, and decreased hospital costs.(1,2)

1. Plantinga LC, Fink NE, Jaar BG, et al. Attainment of clinical performance targets and improvement in clinical outcomes and resource use in hemodialysis care: a prospective cohort study. BMC Health Serv Res. 2007 Jan 9;7:5.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1783649/pdf/1472-6963-7-5.pdf>. Accessed April 27, 2011.

2. Sehgal AR, Dor A, Tsai AC: Morbidity and cost implications of inadequate hemodialysis. Am J Kidney Dis 37:1223-1231, 2001

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Data show that the quality of some aspects of dialysis care has remained high. The percentage of patients receiving adequate hemodialysis with a mean delivered $spKt/V = 1.2$ increased from 85% in 1998 to 94% in 2008. In 2007, 95% of female patients and 89% of male patients received adequate hemodialysis.(1)

This measure was used in the CMS Physician Quality Reporting Initiative (PQRI), in the 2008 claims option and the Registry option starting in 2009. The measure is in use in the CMS Physician Quality Reporting System for 2015.(2)

There is a gap in care as shown by this 2008 data; 41.36 % of patients reported on did not receive the optimal care.

10th percentile: 7.80%

25th percentile: 29.77 %

50th percentile: 60.00 %

75th percentile: 79.29 %

90th percentile: 91.30%

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

1. 2008 Annual Report, End Stage Renal Disease Clinical Performance Measures Project. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of Clinical Standards & Quality, Baltimore, Maryland, December 2008.

2. Confidential CMS PQRI 2008 Performance Information by Measure (PQRI Measure #81). Jan-Sept TAP file.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

1. Racial differences in the quality of dialysis care have been observed. In 1994, data from the core indicator project conducted by the Center of Medical and Medicaid Services (CMS) showed that 60% of African Americans on dialysis received an “inadequate” dose of dialysis (as defined by process, not outcome measures). Although evidence suggests that this percentage has decreased over time, in 1997 African Americans still had a 20% chance of receiving inadequate dialysis.

2. The proportion of all patients with an adequate hemodialysis dose increased 2-fold from 43% in 1993 to 86% in 2000. In 1993, 46% of white patients and 36% of black patients received an adequate dose. Corresponding figures for 2000 were 87% and 84%, respectively. Thus, the gap between white and black patients decreased from 10% to 3%. In 1993, 54% of female patients and 31% of male patients received an adequate hemodialysis dose. Corresponding figures for 2000 were 91% and 82%, respectively. Thus, the gap between female and male patients decreased from 23% to 9%. In addition, the magnitude of gaps between whites and blacks and between women and men varied by region. Eleven regions had race gaps of 4% or less. However, no region had similarly small sex gaps.

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

1. Powe NR. To have and have not: Health and health care disparities in chronic kidney disease. Johns Hopkins University School of Medicine, Baltimore, Maryland, USA, Kidney International, Vol. 64 (2003), pp. 763–772

2. Sehgal AR. Impact of Quality Improvement Efforts on Race and Sex Disparities in Hemodialysis. JAMA, February 26, 2003-Vol 289, No. 8.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

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

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

Renal, Renal : End Stage Renal Disease (ESRD)

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

Safety, Safety : Complications

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

Elderly

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

<http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>

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

This is not an eMeasure Attachment:

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

Attachment Attachment: [AMA-PCPI_AKID-10_HDAdequacy_11.8.2011-635289365199063523.pdf](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

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

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

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

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

Calendar months during which patients have a $\text{spKt/V} \geq 1.2$

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

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

Note: Urea kinetic modeling (UKM) or the second generation Daugirdas formula (simplified multivariable equation) are the most appropriate ways to calculate spKt/V , and the two accepted methods for calculating spKt/V per the KDOQI guidelines. For more information on these methods, please refer to National Kidney Foundation's KDOQI Clinical Practice Guidelines and Clinical Practice Recommendations for 2006 Updates: Hemodialysis Adequacy, Peritoneal Dialysis Adequacy and Vascular Access. Am J Kidney Dis 48:S1-S322, 2006 (suppl 1).

For Administrative/Claims, report the quality data code designated for this numerator: G8713 - spKt/V greater than or equal to 1.2 (single-pool clearance of urea [Kt] / volume [V])

During the NQF Maintenance Process, an EHR specification was provided for this performance measure, see attachment in field S.2b. Data Dictionary Code Table.

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

All calendar months during which patients aged 18 years and older with a diagnosis of ESRD are receiving hemodialysis three times a week for ≥ 90 days

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

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

During the NQF Maintenance Process, an EHR specification was provided for this performance measure, see attachment in field S.2b. Data Dictionary Code Table.

For Administrative/Claims:

Patients aged ≥ 18 years old

AND

Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.6

Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.6

AND

Encounter for Dialysis and Dialysis Catheter Care (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V56.0, V56.1, V56.32

Encounter for Dialysis and Dialysis Catheter Care (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z49.01, Z49.31, Z49.32

AND

Hemodialysis treatment performed exactly three times per week for ≥ 90 days: G8714

AND

Patient encounter during the reporting period (CPT): 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

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

There are no denominator exceptions.

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

N/A

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

We encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and primary language.

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

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

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

Better quality = Higher score

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

Calculation algorithm is included in S.2b. Data Dictionary Code Table

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

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

This measure does not require sampling or a survey.

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

Specify calculation of response rates to be reported with performance measure results.

N/A

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

If other, please describe in S.18.

Claims, Electronic Health Records, Other, Registry Data

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

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

N/A

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

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

Clinician : Group/Practice, Clinician : Individual

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

Home Care, Other, Outpatient Services, Post-Acute Care

If other: Domiciliary, Rest Home, or Custodial Care Services

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

2. Validity – See attached Measure Testing Submission Form

[MeasTesting_0323-update.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

If other:

3b. Electronic Sources

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

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

ALL data elements are in defined fields in electronic health records (EHRs)

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

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

Attachment:

3c. Data Collection Strategy

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

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

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

This measure was found through testing to be both feasible and reliable. Data collection was performed in a reasonable timeframe. There is no fee for use of the measure.

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

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
Professional Certification or Recognition Program	Public Reporting PQRS participation reported on Physician Compare http://www.medicare.gov/physiciancompare/staticpages/data/aboutthedata.html

	<p>Payment Program PQRS http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html</p> <p>Quality Improvement (Internal to the specific organization) RPA Kidney Quality Improvement Registry https://www.medconcert.com/content/medconcert/rpaqir/</p>
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4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

The Centers for Medicare & Medicaid Services (CMS) implemented the Physician Quality Reporting System (PQRS) (formerly, Physician Quality Reporting Initiative or PQRI), authorized under Section 101(b) of division B of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109423; 120 Stat. 2975), in 2007. PQRS is a national CMS reporting program that uses a combination of incentive payments and negative payment adjustments to promote reporting of quality information by eligible professionals (EPs). A total of \$167,815,193 in Physician Quality Reporting System incentive payments were paid by CMS for the 2012 program year (most recent data available), which reflects successful participation of 29,254 practices that included 367,228 eligible professionals.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

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

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4a2.2.2. Summarize the feedback obtained from those being measured.

4a2.2.3. Summarize the feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Improvement

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

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

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

4b2. Unintended Consequences

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

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

[We are not aware of any unintended consequences related to this measurement.](#)

4b2.2. Please explain any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

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

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

[0249 : Delivered Dose of Hemodialysis Above Minimum](#)

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

[Yes](#)

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

interpretability and data collection burden.

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

Our measure is specified at the clinician level, but measure results can be aggregated at a higher level of measurement.

We have developed and will maintain specifications for multiple data sources, including Electronic Health Records (EHRs) and Claims-Based Reporting. Our specifications for EHRs are developed in accordance with the terminology standards (eg, SNOMED, RxNorm, LOINC) named in the Meaningful Use Program (CMS EHR Incentive Program).

Appendix

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

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Renal Physicians Association

Co.2 Point of Contact: Dale, Singer, dsinger@renalmd.org, 301-468-3515-

Co.3 Measure Developer if different from Measure Steward: Renal Physicians Association

Co.4 Point of Contact: Amy, Beckrich, abeckrich@renalmd.org, 301-468-3515-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

Louis H. Diamond, MBChB, FCP (SA), FACP, FHIMSS (Work Group Co-Chair) (Nephrology, Methodology) President, Quality Healthcare Consultants, Rockville, MD

Barbara Fivush, MD (Work Group Co-Chair) (Nephrology - Pediatrics) Professor of Pediatrics, Division Chief of Pediatric Nephrology, Johns Hopkins University, Baltimore, MD

Paul M. Palevsky, MD, FACP, FCCD, FASN (Work Group Co-Chair) (Nephrology - Adult) Professor of Medicine, University of Pittsburgh School of Medicine, Chief, Renal Section, VA Pittsburgh Healthcare System, Pittsburgh, PA

Eileen D. Brewer, MD (Nephrology - Pediatrics) Professor and Head, Pediatric Renal Section, Baylor College of Medicine Chief, Renal Service, Texas Children's Hospital, Houston, TX

John W. Foreman, MD (Nephrology - Pediatrics) Department of Pediatrics, Professor of Pediatrics, Duke University, Durham, NC

Richard S. Goldman, MD (Nephrology - Adult, Methodology) Nephrology and Internal Medicine, Albuquerque, NM

Stuart L. Goldstein, MD (Nephrology - Pediatrics) Director, Center for Acute Care Nephrology, Cincinnati Children's Hospital Medical Center; Medical Director, Pheresis Service, Professor of Pediatrics, University of Cincinnati College of Medicine, Cincinnati, OH

John Hartman, MD (Nephrology - Adult) CEO, Visonex, LLC, Treasurer, Wisconsin Medical Society, Green Bay, WI

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PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 06, 2011

Ad.4 What is your frequency for review/update of this measure? Every 3 years or as new evidence becomes available that materially affects the measures.

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

Ad.6 Copyright statement: Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA) convened Physician Consortium for Performance Improvement® (PCPI™).

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: The following updates were made on 11/09/11:

Specifications:

2a1.1 Numerator note was added regarding calculation methods

2a1.2 Time window was updated

2a1.6 Time window was updated

Importance:

1b.4 New disparities data added

1b.5 Citation for new disparities data added