



Measure Information

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

Brief Measure Information

NQF #: 1668

Corresponding Measures:

De.2. Measure Title: Adult Kidney Disease: Laboratory Testing (Lipid Profile)

Co.1.1. Measure Steward: Renal Physicians Association

De.3. Brief Description of Measure: Percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) who had a fasting lipid profile performed at least once within a 12-month period

1b.1. Developer Rationale: This measure is aimed at increasing the number of patients with CKD who have a lipid profile performed. The principal reason to evaluate dyslipidemias in patients with CKD is to detect abnormalities that may be treated to reduce the incidence of atherosclerotic CVD (ACVD). A number of observational studies have reported that various dyslipidemias are associated with decreased kidney function in the general population and in patients with CKD. Many factors influence the prevalence of dyslipidemias in CKD. Changes in proteinuria, GFR, and treatment of CKD may alter lipoprotein levels. Therefore, it is prudent to evaluate dyslipidemias more often than is recommended in the general population.

There are 2 major overlapping categories of CVD: (1) disorders of cardiovascular perfusion, which include atherosclerotic CVD (ACVD); and (2) disorders of cardiac function, such as heart failure and left ventricular hypertrophy. Some risk factors are unique to each category of CVD, and some risk factors are shared by both categories of CVD. The National Kidney Foundation (NKF) Task Force on CVD concluded that the incidence of ACVD is higher in patients with CKD compared to the general population. The Task Force concluded that patients with CKD should be considered to be in the highest risk category, ie, a CHD risk equivalent, for risk factor management. This measure hopes to help reduce the incidence of ACVD in the CKD population by encouraging regular evaluation of dyslipidemias.

Reference: National Kidney Foundation. KDOQI Clinical Practice Guidelines for Managing Dyslipidemias in Chronic Kidney Disease. Am J Kidney Dis 41(4):S1-S91, 2003 (suppl 3).

S.4. Numerator Statement: Patients who had a fasting lipid profile performed at least once within a 12-month period

S.7. Denominator Statement: All patients aged 18 years and older with a diagnosis of CKD (stage 3, 4 or 5, not receiving RRT)

S.10. Denominator Exclusions: Documentation of patient reason(s) for not performing a fasting lipid profile (eg, patient declined, other patient reasons)

De.1. Measure Type: Process

S.23. Data Source: Claims, Electronic Health Data, Electronic Health Records, Other, Registry Data

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Apr 02, 2012 **Most Recent Endorsement Date:** Apr 02, 2012

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 has a companion (paired) measure that is designated for Quality Improvement only. That measure title is: Laboratory Testing (Calcium, Phosphorus, and Intact Parathyroid Hormone (iPTH)).

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

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

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
[1668_Evidence_MSF5.0_Data-635278463364750327.doc](#)

1b. Performance Gap

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

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

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

This measure is aimed at increasing the number of patients with CKD who have a lipid profile performed. The principal reason to evaluate dyslipidemias in patients with CKD is to detect abnormalities that may be treated to reduce the incidence of atherosclerotic CVD (ACVD). A number of observational studies have reported that various dyslipidemias are associated with decreased kidney function in the general population and in patients with CKD. Many factors influence the prevalence of dyslipidemias in CKD. Changes in proteinuria, GFR, and treatment of CKD may alter lipoprotein levels. Therefore, it is prudent to evaluate dyslipidemias more often than is recommended in the general population.

There are 2 major overlapping categories of CVD: (1) disorders of cardiovascular perfusion, which include atherosclerotic CVD (ACVD); and (2) disorders of cardiac function, such as heart failure and left ventricular hypertrophy. Some risk factors are unique to each category of CVD, and some risk factors are shared by both categories of CVD. The National Kidney Foundation (NKF) Task Force on CVD concluded that the incidence of ACVD is higher in patients with CKD compared to the general population. The Task Force concluded that patients with CKD should be considered to be in the highest risk category, ie, a CHD risk equivalent, for risk factor management. This measure hopes to help reduce the incidence of ACVD in the CKD population by encouraging regular evaluation of dyslipidemias.

Reference: National Kidney Foundation. KDOQI Clinical Practice Guidelines for Managing Dyslipidemias in Chronic Kidney Disease. Am J Kidney Dis 41(4):S1-S91, 2003 (suppl 3).

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

Testing to identify the usual complications of progressive kidney disease is lacking, with low rates of calcium/phosphorus, parathyroid hormone, lipid, and glycemic testing.(1) Among CKD patients with recognized cardiovascular disease, 61 percent use a lipid lowering agent.(1) In a study, as part of the Healthy People 2010 Initiative administered by The Centers for Disease Control and Prevention, using data of a random sample of 5% Medicare patients, focusing on preventative care of CKD patients, lipid screenings were performed for only 65% of CKD patients. Lipid monitoring was also associated with a 20% decrease in harmful events.(2)

In a database analysis to assess practice patterns and conformance to clinical practice guidelines among nephrologists and non-nephrologists who care for patients with advanced CKD, data shows that management of advanced CKD is suboptimal for all patients but is particularly poor for patients who are treated solely by non-nephrologists.(3) Out of 1933 patients total, only 52.3% of patients were regularly monitored for dyslipidemias; out of 1131 patients treated by nephrologists and 802 patients treated by non-nephrologists, only 60.9% and 40.1% (respectively) were regularly monitored for dyslipidemias.(3)

This measure was used in the CMS Physician Quality Reporting Initiative, in the claims option (2008, 2009, 2010) as well as the Registry and Measure Group options (2009, 2010) and it will be used in the CMS Physician Quality Reporting System for 2011. This measure was also included in the Final Rule for Stage 1 of Meaningful Use.

There is a gap in care as shown by this 2008 data; 56.7% of patients reported on did not receive the optimal care.(4)

10th percentile: 5.7%

25th percentile: 18.5%

50th percentile: 46.7%

75th percentile: 66.7%

90th percentile: 90.0%

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) U S Renal Data System, USRDS 2010 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2010.

(2) Snyder JJ, Collins AJ. Association of Preventive Health Care with Atherosclerotic Heart Disease and Mortality in CKD. J Am Soc Nephrol. 2009 July; 20(7): 1614–1622.

(3) Patwardhan MB, Samsa GP, Matchar DB, Haley WE. Advanced Chronic Kidney Disease Practice Patterns among Nephrologists and Non-Nephrologists: A Database Analysis. Clin J Am Soc Nephrol 2: 277–283, 2007.

(4) Confidential CMS PQRI 2008 Performance Information by Measure. 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 endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

In a case presentation of health and health care disparities, Neil R. Powe from Johns Hopkins University School of Medicine describes an African American man who had not had the opportunity for early intervention to delay progression of chronic kidney disease or to prepare for eventual renal replacement therapy.(1) Powe explains that lack of health insurance coupled with the silent nature of hypertension and chronic renal insufficiency are major culprits in the late presentation to medical care for individuals with known risk factors for chronic renal disease.(1) There is little opportunity to attend early to comorbid conditions occurring before end-stage renal disease (ESRD), including coronary artery disease, hypertension, anemia, and hyperlipidemia.(1) Decisions about the choice of renal replacement therapy sometimes must be made in an accelerated fashion. This haste raises concerns about whether the health care providers, the patient, and the family have adequately considered the different treatment options. The case presented also illustrates the special plight of African American patients, whose risk factors make them more likely to develop progressive renal insufficiency and who are less likely to receive peritoneal dialysis or undergo renal transplantation.(1)

To demonstrate disparities in regular monitoring for dyslipidemias (which is part of attending early to comorbid conditions occurring before end-stage renal

disease (ESRD)), one should look at differences in CKD progression to ESRD. African-Americans have the highest reported prevalence and incidence of treated ESRD.(2) Overall, African-Americans are four times more likely to progress to ESRD compared to whites (988 vs. 254 patients per million) and at a higher-than-average risk for developing ESRD in the Southeastern US.(2) Diabetes is the leading cause of ESRD in all racial and ethnic groups, but occurs at a much higher rate among African-Americans, Hispanics and Native Americans (422,382.9, and 307.2 vs. 115 per million, respectively) compared to whites. In addition, African-Americans have the highest rate of hypertension-related ESRD, which far exceeds other racial and ethnic groups. As a result, hypertension remains a close second to Diabetes Mellitus as the leading cause of ESRD in the African-American community.(2)

Hispanic-Americans have a diabetes rate more than twice that of whites, and are twice as likely to progress to ESRD than whites. Furthermore, the higher prevalence of diabetes among Hispanic individuals is only partially explained

by the increased rate of ESRD progression.(2) Registry level data from the USRDS show that US Asians have a 34% higher age and gender adjusted risk of ESRD compared to US whites and have a 12-fold increase in the prevalence of ESRD since 1980.(2)

A prospective study of 300,645 white and 20,222 black men screened for enrollment in the Multiple Risk Factor Intervention Trial showed over 16 years of follow-up that for each of several levels of systolic blood pressure, African American men were more likely to develop ESRD than were white men.(3, in 1) An age-adjusted 3.2-fold greater relative risk of developing ESRD for African

Americans versus whites was reduced to 1.9-fold after adjustment for differences between African Americans and whites in blood pressure, income, and risk factors such as cholesterol, cigarette smoking, diabetes, and history of myocardial infarction.(1)

A recent nationally representative, prospective study of 9082 adult men and women, ages 30 to 74, enrolled in the Second National Health and Nutrition Examination Survey II examined the cumulative incidence of chronic kidney disease by linking data from baseline interviews, physical examinations, and laboratory tests performed at baseline from 1976 to 1980 with the Medicare ESRD registry and the National Death Index.(4, in 1) This study examined whether socioeconomic status, lifestyle, or clinical factors would explain the excess incidence of chronic kidney disease among African Americans. Eleven percent of the excess risk was accounted for by socioeconomic status, 24% by lifestyle factors, and 32% of by clinical factors such as control of blood pressure. All three factors combined accounted for more than 40% of the excess risk.(1)

A similar study of diabetic renal disease in 1434 diabetic adults in four United States communities examined factors that might explain why African Americans compared to whites have an age- and gender-adjusted three-and-one-half-fold higher risk of early renal function decline during 3 years of follow-up (defined as an increase in serum creatinine of 0.4 mg/dL).(5, in 1) The relative odds of early renal function decline decreased by 15% when health behaviors were taken into account, by 45% when physiologic factors were taken into account, by 52% when socioeconomic status was taken into account, and by 83% when all three factors were combined.(1) These studies suggest that genetic factors are not the predominant reason for the greater burden of renal disease among minorities, at least among African Americans, and provide attractive targets for interventions.(1)

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

(1) Powe, Neil R. 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) Alves TP, Lewis, J. Racial differences in chronic kidney disease (CKD) and end-stage renal disease (ESRD) in the United States: a social and economic dilemma. Clinical Nephrology.2010;74(1):S72-S77.

(3) Klag MJ, Whelton PK, Randall BL, et al: End-stage renal disease in African-American and white men. 16-year MRFIT findings. JAMA 277:1293–1298, 1997.

(4) Tarver-Carr ME, Powe NR, Eberhardt MS, et al: Excess risk of chronic kidney disease among African-American versus white subjects in the United States: A population-based study of potential explanatory factors. J Am Soc Nephrol 13:2363–2370, 2002.

(5) Krop JS, Coresh J, Chambless LE, et al: A community-based study of explanatory factors for the excess risk for early renal function decline in blacks vs whites with diabetes: The Atherosclerosis Risk in Communities Study. Arch Intern Med 159:1777–1783, 1999.

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

The measure addresses:

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

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, A leading cause of morbidity/mortality, Frequently performed procedure, High resource use, Patient/societal consequences of poor quality, Severity of illness

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

Chronic kidney disease (CKD), affects approximately 13.1% of United States adults and leads to end-stage renal disease (ESRD),

cardiovascular disease (CVD), and premature death.(1)

CKD affects up to 5% of the population and 25% of those aged 70 years or older. An additional 6% of the population has signs of kidney damage, which may progress to ESRD.(2)

CKD is now recognized as a major public health concern. It is estimated that approximately 26.3 million adults in the U.S. have nondialysis dependent kidney disease and over 470,000 have ESRD, collectively representing over 13% of the US population. In the next 20 years, the burden of CKD is expected to increase, with over 2 million individuals projected to be receiving renal replacement therapy (dialysis or kidney transplant) by 2030.(3)

CKD is a world-wide public health problem, with increasing incidence and prevalence, high cost, and poor outcomes. The major outcomes of CKD are loss of kidney function and development of cardiovascular disease (CVD). Increasing evidence indicates that the adverse outcomes of CKD can often be prevented or delayed through early detection and treatment. (4)

Currently, patients with CKD are five to 10 times more likely to die than to reach ESRD.(5)

Costs for CKD patients are now 23 percent of Medicare expenditures in the fee-for-service sector; when added to costs for ESRD patients, it appears that 31 percent of all Medicare expenditures are incurred by patients with a diagnosis of kidney disease.(6)

In 1993, costs for Medicare patients with CKD accounted for 3.8 percent of overall Medicare expenditures. By 2008, this had grown to 14.2 percent, in part reflecting growth in the number of recognized CKD patients.(6)

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

1. Snyder JJ, Collins AJ. Association of Preventive Health Care with Atherosclerotic Heart Disease and Mortality in CKD. J Am Soc Nephrol. 2009 July; 20(7): 1614–1622.

2. Alves TP, Lewis, J. Racial differences in chronic kidney disease (CKD) and end-stage renal disease (ESRD) in the United States: a social and economic dilemma. Clinical Nephrology.2010;74(1):S72-S77.

3. Choi AI, Rodriguez RA, Bacchetti P, Bertenthal D, et al. White/Black Racial Differences in Risk of End-Stage Renal Disease and Death. Am J Med. 2009 July;122(7):672-678.

4. National Kidney Foundation. (2004) K/DOQI clinical practice guidelines on hypertension and antihypertensive agents in chronic kidney disease. Am J Kidney Dis. May;43(5 Suppl 1):S1-S290.

5. Gilbertson DT, Liu J, Xue JL, Louis TA, et al. Projecting the Number of Patients with End-Stage Renal Disease in the United States to the Year 2015. J Am Soc Nephrol 16:3736-3741, 2005.

6. U S Renal Data System, USRDS 2010 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2010.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

Renal, Renal : Chronic Kidney Disease (CKD)

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

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

physicianconsortium.org

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-3_LipidProfile-635289374366519293.pdf](#)

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date 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)

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

[Patients who had a fasting lipid profile performed at least once within a 12-month period](#)

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

[once during the 12 consecutive month measurement period](#)

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

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

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 Claims/Administrative:

Report the following quality data code:

G8725: Fasting lipid profile performed (Triglycerides, LDL-C, HDL-C, and Total Cholesterol)

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

[All patients aged 18 years and older with a diagnosis of CKD \(stage 3, 4 or 5, not receiving RRT\)](#)

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

[Elderly](#)

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

Definition:

RRT (Renal Replacement Therapy)-For the purposes of this measure, RRT includes hemodialysis, peritoneal dialysis, and kidney transplantation

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 Claims/Administrative:

Age >= 18 years old

AND

Diagnosis for stage 3, 4, or 5 CKD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.3, 585.4, 585.5

Diagnosis for stage 3, 4, or 5 CKD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.3, N18.4, N18.5

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Documentation of patient reason(s) for not performing a fasting lipid profile (eg, patient declined, other patient reasons)

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 1668, exceptions may include patient reason(s) for not performing a fasting lipid profile (eg, patient declined, other patient reasons). Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Additional details by data source are as follows:

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

Report the following quality data code:

G8726: Clinician has documented reason for not performing fasting lipid profile (e.g., patient declined, other patient reasons)

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

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

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

No risk adjustment or risk stratification

If other:

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

As a process measure, no risk adjustment is necessary.

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

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

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

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

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

To calculate performance rates:

- 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).
- 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
- 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
- 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for exception when exceptions have been specified [for this measure: patient reason(s) for not performing a fasting lipid profile (eg, patient declined, other patient reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Our measure does not require sampling or a survey.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check *ONLY* the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

[Claims](#), [Electronic Health Data](#), [Electronic Health Records](#), [Other](#), [Registry Data](#)

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

If a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

N/A

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.26. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

[Clinician : Group/Practice](#), [Clinician : Individual](#)

S.27. 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.28. 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.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[1668_MeasureTesting_MSF5.0_Data-635278463364750327.doc](#)

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)

[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.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

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

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

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

The measure was tested looking for laboratory test orders only, not specifically if the test was actually performed. The updated measures include looking to see if the test was performed. We do not believe that this modification changed the data necessary to calculate the measures.

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.

Planned	Current Use (for current use provide URL)
Public Reporting	
Professional Certification or Recognition Program	
Quality Improvement (Internal to the specific organization)	

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

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

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

access to performance results or impede implementation?)

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

4b. Improvement

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

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

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

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

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

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

We are not aware of any unintended consequences related to this measurement.

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.

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

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

5a. Harmonization

The measure specifications are harmonized with related measures;
OR

The differences in specifications are justified

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

Are the measure specifications completely harmonized?

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

In regards to NQF #0626 Chronic Kidney Disease - Lipid Profile Monitoring (also undergoing maintenance), the data source for ActiveHealth measures is what they call "level 2 clinically enriched data" (including data from claims & pharmacy). Our measure is specified for use in administrative claims (using CPT II codes) as well as integration into EHRs. The implementation of measures that are specified using clinically enriched data is significantly limiting in that it would only apply to those groups/settings with access to that type of information (ie, pharmacy data).

NQF staff have noted that the ActiveHealth measures are in use by health plans – a 3 million patient database system. By comparison, our measures are in CMS's PQRS program providing an incentive payment to eligible professionals who satisfactorily report data on quality measures for services furnished to 46 million Medicare beneficiaries.

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

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

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Additional Information

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

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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™).

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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: The next scheduled review/update for this measure will be in 2014.

The following updates were made on 11/08/11:

Specifications

De.2 The measure description was updated and the words "results documented" removed.

2a1.1 The numerator language was updated, as indicated above.

Importance:

1c.4 The directness of evidence to the specified measure was updated as indicated above.

Scientific Acceptability:

2b1.1 The consistency of the evidence with the measure specifications was updated, as indicated above.