KIDNEY CARE QUALITY ALLIANCE

KCQA-Phase 2 Webinar/Conference Call #2

June 30, 2014
5-6 pm Eastern Time

DRAFT AGENDA

5:00 pm Roll call, Welcome and Opening Remarks, Review of Agenda
Ed Jones, MD – KCQA Co-Chair
Allen Nissenson, MD – KCQA Co-Chair

5:05 pm Review of Modified Delphi Round Results and Today's Discussion

- What specific support or concerns do KCQA members wish to convey to fellow members about the overall list?
- The candidate measure development area *Fluid Management* has clear separation and consensus as the #1 ranked area. What support or opposition do you wish to convey to fellow members about this measure development area?
- Given the outcome presented in Table 1, the Steering Committee proposes that Round 3 of KCQA's modified Delphi not be a ranking survey. Rather, KCQA members would be asked: *Can you support "Fluid Management" as the consensus KCQA measure development area for 2014?* Do KCQA members object to this approach?

5:55 pm Next Steps and Public Comment

6:00 pm Adjourn

*We recommend you access this link a few minutes prior to the call; depending on your system, some set-up and installation may be required. If you are unable to participate in the webinar component, you may still participate via conference call; the slides will be posted following the call.

KCQA-2 MODIFIED DELPHI PACKAGE: ALL-KCQA DISCUSSION

KCQA has undergone two cycles of its modified Delphi process to prioritize measure development areas, both via surveymonkey input from Lead Representatives. **The next step is an All-KCQA discussion in which all representatives from KCQA members may participate.** This package provides the results of Round 2 as the foundational background for that discussion.[1] Specifically provided in this package are:

- An overview of how the results were calculated for Round 2;
- Table 1, a summary table presenting the total weighted scores for the candidate measure development areas in rank order;
- Table 2, the weighted average scores by criteria, along with the submitted comments, for each candidate area; and
- Approach for All-KCQA discussion.

Calculation of Results

Twenty-three (23) KCQA members submitted responses, one member abstained, and 11 members did not participate. The response options were assigned point values as in Round 1: Very High (10 points), Neutral (6 points), Low (4 points). The average response was calculated for each criterion for each candidate measure development area, and then the previously indicated weights were applied. In Round 2, the five original criteria were retained and an additional global question was added: *This (sub)domain should be a [Very High, Neutral, Low] priority for KCQA-2 measure development.*[2]

The final total weighted score represents the sum of the weighted values for all five criteria and the global question, multiplied by 10 so as to normalize to a 100 point scale. (KCQA operates on a one vote per organization basis, so each of the 23 survey respondents' input are weighted equally in the total.)

Results

Table 1 summarizes the candidate measurement development areas, in rank order of their normalized total scores. Table 2 presents the weighted average scores by criteria for the specific candidate area and also presents the comments submitted by KCQA Lead Representatives though surveymonkey for that area. Comments were not edited except to correct obvious spelling and/or typographical errors.

Lastly, Attachment A presents histograms for each candidate measure development area. Please note that these represent the **unweighted**, raw numbers for responses to each of the 14 candidate measure development areas in Round 2.

[1] Previously, we provided all KCQA members with the results of Round 1, wherein 29 members participated, 1 member abstained, and 5 members did not participate. As a point of reference that material is provided (tables only) as Attachment B.

[2] Clinical Impact=25%, External Impact=2.5%, Collaboration/Engagement=2.5%, Feasibility=10%, Usability/Actionability=10%, Global question re: priority for KCQA measure development=50%.

Table 1: Candidate Measure Development Area Total Weighted Scores, Round 2

RANK	MEASUREMENT AREA	TOTAL WEIGHTED SCORE
1	Fluid Management (Disease Management)	87.35
2	Rehospitalization (Care Coordination)	81.24
3	Vascular Access (Disease Management)	80.83
4	Nutrition (Disease Management)	78.67
5	Healthcare-Associated Infections (Safety)	78.63
6	Transplantation Referral and Access (Quality of Life)	77.67
7	Care Transitions (Care Coordination)	77.57
8	Frequency and Duration of Dialysis (Patient Engagement and Education)	76.98
9	Medication Management (Care Coordination)	76.80
10	Modality Options Selection (Patient Engagement and Education)	75.46
11	Renal Replacement Modality Selection (Disease Management)	72.72
12	Immunization (Disease Management)	72.41
13	Dialysis Patient Education (Patient Engagement and Education)	70.24
14	Stage 4 Pre-Dialysis Education (Patient Engagement and Education)	69.00

The Steering Committee emphasized that an area that did not appear in Round 2 is not unimportant. Rather, the Round 2 candidate areas represented KCQA members' collective input for 2014 measure development priorities, given the resources are for development of 1-2 related measures in one area.

Table 2: Weighted Average Scores of Candidate Measure Areas and Submitted Comments

MEASUREMENT AREA	CLINICAL IMPACT	EXTERNAL IMPACT	COLLABORATION / ENGAGEMENT	FEASIBILITY	USABILITY / ACTIONABILITY	THIS (SUB)DOMAIN SHOULD BE A _____ PRIORITY FOR KCQA-2 MEASURE DEVELOPMENT
Max Weighted Values	2.5	0.25	0.25	1	1	5
Fluid Management	2.348	0.209	0.204	0.748	0.836	4.391
• This is the most important measure to develop in that targets in this area could save patient lives. Lots of issues with data: What to measure, how to avoid unintended consequences. A worthy goal for KCQA! • This is one area that the industry has not historically addressed in great detail and it impacts the patient and many outcomes in so many ways, it would be beneficial to patients to have quality measures related to fluid management. • This is a critical subdomain and an area in which a measure could actually change practice patterns and improve care. It is actionable by dialysis facilities and important for patient outcomes. Outcomes are also highly dependent upon patient compliance. In developing a measure, it will be important to address missed treatments and variability of patient compliance, as well as gaining consensus around achieving estimated dry weight. • No agreement on how it is to be measured. • This is a critical subdomain and an area in which a measure could actually change practice patterns and improve care. There needs to be an appreciation that patient compliance also plays a huge role in achieving outcomes for a fluid management CPM. In addition, there is no gold standard for determining achievement of estimated dry weight. Therefore, while the potential to impact outcomes is high, there is also a large potential for variability even with implementing the exact same programs. Depending on the measure, it could be actionable by dialysis facilities and important for patient outcomes. However, we need to recognize that patient compliance will play a role in the variability observed. • Critical subdomain with important clinical impact as well as impact on other key domains. Actionable. The challenge will be the "what and how" to measure. In my opinion, its importance is worthy of the effort. • Important, but not sure the metrics are well defined enough to make this higher priority • Priority to improve outcome - no metric exists - provider responsible for fluid management with the nephrologist and patient. • Different rates of fluid removal acceptable in Pediatrics. • The problem here is how to reliably measure and report.						
Rehospitalization	2.457	0.228	0.230	0.730	0.783	3.696

MEASUREMENT AREA	CLINICAL IMPACT	EXTERNAL IMPACT	COLLABORATION / ENGAGEMENT	FEASIBILITY	USABILITY / ACTIONABILITY	THIS (SUB)DOMAIN SHOULD BE A ____ PRIORITY FOR KCQA-2 MEASURE DEVELOPMENT
Max Weighted Values	2.5	0.25	0.25	1	1	5
• Again a very important measure and one we do have data for; recognizing the problems with small sample sizes, ranked this lower for measure development • This is an important subdomain, but currently there is no agreement on how to design this type of a measure. NQF has also indicated that such a measure needs to be adjusted based upon patient socio-economic status, which is not possible at this time. • Current measures exist so no need to reinvent the wheel. • This is an important subdomain, but currently there is no agreement on how to design this type of a measure. There is a competing measure, the SRR or standardized readmission ratio that CMS has already piloted for 2012. However, it has not been validated particularly in terms of actionability. Furthermore, NQF has also indicated that such a measure needs to be adjusted based upon patient socio-economic status, which is not possible at this time. • Not provider specific. • CMS has already developed a measure in this domain that is undergoing NQF review; it is unclear that it is worthwhile for KCQA to expend resources to develop a competing measure. That said, the CMS measure has serious flaws, such as inclusion of patients who are readmitted before they even have their first outpatient dialysis treatment in the measure, that a new measure might be able to overcome. • Getting engagement from other stakeholders will remain the most difficult part of this domain.						
Vascular Access	2.457	0.217	0.209	0.913	0.896	3.391
• CMS will continue to drive this measure; if they don't choose to adopt a graft measure, they likely would not adopt one KCQA develops. • The fact that there are already measures in this area argues against using the limited resources of the KCQA to develop yet another measure. • No new measures are really needed in this area. This could be easily addressed by leaving only a catheter measure in the QIP and removing the fistula measure • While this measure scores high, the fact that there are already measures in this area argues against using the limited resources of the KCQA to develop yet another measure in this area. Moreover, there is also with contribution of other providers as well as patient factors making additional CPMs more problematic in terms of feasibility and actionability. • There are vascular access measures already, but the existing measures could be better focused. • Nobody questions the critical importance of access for outcome. As there are metrics, the refinement/ modification of the metric is questionable to improve outcomes. • Providers are already addressing this issue through Fistula First, plus the measure is currently in the QIP. • This is a domain that already has sufficient measures - both for increased fistula use and to decrease catheter use • I think the greater than 90-day catheter data could be a workable quality target and gets away from Fistula First and inherent problems with this measure. • There are several QAPI measures on this already.						
Nutrition	4.655	0.459	0.448	1.366	1.503	
• Good data not collected. • This is an area in which a measure could change practice patterns and improve care. It is actionable by dialysis facilities and important for patient outcomes. Current evidence, however, can only support a process measure. • This is an area in which a measure could change practice patterns and improve care. It is actionable by dialysis facilities and important for patient outcomes. Current evidence, however, can only support a process measure. Furthermore, there is a patient compliance factor that needs to be addressed. • Important, but improvement is hampered by reimbursement limitations and socioeconomic issues beyond a facility's control. • Too many factors contribute to these parameters; not clear what intervention is or its effect. • Priority to improve outcomes in ESRD patients! Should be a focus for us all. • Methods to accomplish the desired outcomes remain disappointingly ineffective.						
HAIs (Safety)	2.370	0.215	0.209	0.765	0.826	3.478
• While this is rated very high in all parameters, NHSN is being developed to address this issue, therefore ranked it neutral for KCQA. • These subdomains are important, but the Centers for Disease Control and Prevention are already moving initiatives in these domains. Expending resources in this area would be duplicative. Many of the current HAI targets by the Centers for Disease Control and Prevention are not directly related to dialysis care. • Already a measure here not sure there is a need for more. • Many domains of HAI's targeted by CDC/DHHS are not directly related to dialysis facility care. Some subdomains are important (e.g. bloodstream infections - and there is already an existing measure), but the Centers for Disease Control and Prevention are already moving initiatives in these domains. Expending resources in this area would be duplicative. However, antibiotic stewardship could be a direction we could pursue. • Measures already exist, but, in my opinion, not necessarily the most important or most focused for our patient population. • Already in place with NHSN • If this is all healthcare infections, the actionability by the dialysis provider is low. If it is dialysis related, it is already being accomplished through CDC. • HAI are very important, however there are a number of well developed existing measures in this domain (e.g. NHSN); it does not seem that this is a domain where KCQA should be expending resources. • This reporting measure already exists and I'm not sure another measure is needed.						
Transplantation Referral/Access	2.217	0.220	0.217	0.757	0.704	3.652

MEASUREMENT AREA	CLINICAL IMPACT	EXTERNAL IMPACT	COLLABORATION / ENGAGEMENT	FEASIBILITY	USABILITY / ACTIONABILITY	THIS (SUB)DOMAIN SHOULD BE A ____ PRIORITY FOR KCQA-2 MEASURE DEVELOPMENT
Max Weighted Values	2.5	0.25	0.25	1	1	5
• There is data collected on transplant waitlist rate; using this as a measure might improve the rate. Don't see this one as a high priority for KCQA • While quality of life is an important aspect of care, the subdomain focuses on an area that is not actionable by dialysis facilities; physicians control the referral of patients. There are many other drivers that impact outcomes in this area. Additionally, facilities are required to provide modality education, which includes information about transplant, under the Conditions for Coverage. Most importantly, transplant referral is not the primary problem – it is a lack of organs and life-long funding for immunosuppressive drugs. • It is not referrals that become the primary problem - it is addressing the limited supply of organs and the absence of life-long funding for immunosuppressive drugs that can improve patient outcomes. While quality of life is an important aspect of care, the subdomain focuses on an area that is not actionable by dialysis facilities. There are many other drivers that impact outcomes which is not under the facility's sphere of influence such as availability and accessibility of transplant centers in a local area, different criteria for accepting patients as eligible for transplant, and the length of the local kidney transplant patient waiting list. • Very important subdomain, but availability of organs is the major versus referral. • Needs to be appropriate referral, not referral for sake of referral; many not appropriate for transplant • This is a very important domain for measure development in children. • While transplant referral is very important, currently referral is not the major barrier to transplantation; organ availability is the major rate-limiting barrier to transplant. • Limitation on organ and donor availability and aging dialysis population make this measure difficult to achieve improving outcomes. • Several recent publications that highlight the low rates of transplant referral and transplantation rates in the USA, particularly in rural facilities.						
Care Transitions	2/370	0.241	0.241	0.583	0.670	3.652
• This is a critical area for improvement; having a good measure in this area could improve the care delivered • This is an important subdomain and there is sufficient literature to support developing a measure in this area. However, a facility-only outcomes measure is not feasible, because accomplishing the benchmark would depend upon other providers to make the measure actionable for dialysis facilities. • Currently no set of standard tools and its difficult for facilities to force hospitals to provide the information, but legislation could change this • This is an important subdomain and there is sufficient literature to support developing a measure in this area. However, a facility-only outcomes measure is not feasible under the current payment system, because accomplishing the benchmark would depend upon other providers who are not incentivized to cooperate to make the measure actionable for dialysis facilities. • Excellent area to improve clinical care, but clearly not provider specific outcome measure. Preferred in an ESCO type model, but not the current delivery setting. • Continues to have considerable support from our patient reps. • This measure would be limited by engagement from the multiple stakeholders who would be responsible for this measure.						
Frequency and Duration	2.304	0.189	0.178	0.765	0.739	3.522
• Don't see this as a measure—too controlled by reimbursement • Having a fluid management measure would be more valuable than an education measure. There is a clinical trial underway. Early results raise questions about the impact on vascular access. The study should be completed before a measure is developed in this area. • Best area to measure for fluid management. • A clinical trial is ongoing to test the impact of hemodialysis treatment time. While FHN showed improved composite endpoint for SDHD but there were questions regarding the potential adverse impact on vascular access. There should be individualized dialysis prescriptions and a CPM may not be ready for primetime as we learn more. • More and longer dialysis is the ideal, but not sure it should be a measure. • Likely to undo "chronic underdialysis" - possibly the route cause of many issues! • Pediatric patients are often dialyzed more frequently. • Level of evidence supporting benefit associated with increased frequency and/or duration of treatment is limited. Unclear if the purpose of this would be to improve patient adherence to current prescription or to encourage longer/more frequent treatments. • Current data reporting methods will not permit this measure to be reported. Not sure how to get around this. • The emphasis should be on Duration, with all patients starting at least four hours. Frequency is very difficult to change from current 3x a week.						
Medication Management	2.261	0.196	0.198	0.670	0.704	3.652
• Current measures are insufficient; a good measure could drive care improvements, but this is not as critical as the two areas ranked Very High for measure development. • This is an important subdomain, but a facility-only measure is not appropriate. There are also concerns about this subdomain because it would be highly dependent upon patient compliance. If selected, a process measure would be more appropriate because of variable patient compliance. • This is an important subdomain, but a facility-only measure is not appropriate because of changes effected by other providers. There are also concerns about this subdomain because it would be highly dependent upon patient compliance. Therefore, if this topic were to be selected for CPM development, it will need to be a process measure that can be implemented by the facility, not an outcome measure. • No doubt a huge area for improvement, but requiring stakeholders to participate who are outside of the provider's control - nephrologists often reject responsibility for drugs other than the ones prescribed by the nephrologist. Hard to see this as a provider specific outcome measure.						

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Max Weighted Values	2.5	0.25	0.25	1	1	5
• Can use electronic data. • In discussing this measure with others who have been participating in Medical Home demonstration projects, this was the number one cost saver for their project but required a dedicated staff person to accomplish. Hence, cost will be an issue here.						
Modality Options Selection	2.174	0.198	0.200	0.809	0.774	3.391
• Feel that this is actually quite difficult to measure—especially whether or not the patient is given an actual choice; too much risk here of this being an "hollow" measure—one where you check "yes" whether choice was actually provided or not. • Modality selection is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. • Extremely important to patients to have choices. It improves patients experience with care. Clinical outcomes for transplant are far superior to dialysis so its important the facility have a role in increasing transplantation • Modality selection is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. • Already existing. • Process measure. • How to measure and report this is the question. • Not clear the difference between Modality selection and modality options.						
Modality Selection	2.022	0.198	0.191	0.704	0.722	3.435
• Feel that this is actually quite difficult to measure—especially whether or not the patient is given an actual choice; too much risk here of this being an "hollow" measure—one where you check "yes" whether choice was actually provided or not. • Modality selection is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. It should also be individualized and not prescribed as a one-size fits all. • Extremely important to patients to have choices. It improves patients experience with care. Clinical outcomes for transplant are far superior to dialysis so its important the facility have a role in increasing transplantation • Modality selection is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. There are already incentives built-in to the PPS that promotes home therapies. Furthermore, modality selection should be individualized because not one size fits all. • Process outcome. Already existing per CfC. • This is required by Conditions of Coverage but I suspect not consistently achieved. How to reliably measure this is the problem.						
Immunization	2.130	0.176	0.170	0.809	0.826	3.130
• Don't think this is the focus we should take---think the immunization rates will be improved without KCQA help. • There are already measures in this area, which argues against using the limited resources of the KCQA to develop yet another measure. • Current pneumococcal measure needs to be revised or redeveloped. • While this measure scores high, the fact that there are already measures in this area argues against using the limited resources of the KCQA to develop yet another measure in this area. • Important, but already well covered. • Already existing in DFR? • While immunization measures are highly valuable, there are multiple existing measures in this domain that there seems to be little value in devoting resources to new measure development. • With increasing utilization of primary care physicians and medical homes, I wonder how well the dialysis unit can accomplish this. • My evaluation applies to pneumonia vaccine, which is not the focus of most dialysis facilities.						
Dialysis Patient Education	2.217	0.187	0.185	0.730	0.748	2.957
• Don't see this as a measure to be developed—too easy to be a meaningless checkmark. • This area is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. • This area is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources of KCQA are focused. • Important, but likely not the best use of KCQA resources. • Process measure. • I am not sure how to reliably report this.						
CKD Stage 4 Pre-Dialysis Education	2.174	0.196	0.209	0.635	0.687	3.000
• Don't see this as a measure to be developed—too easy to be a meaningless checkmark.						

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Max Weighted Values	2.5	0.25	0.25	1	1	5

- While critically important, CKD education is not something dialysis facilities are reimbursed for providing under Medicare. In addition, facilities typically do not see patients until the onset of ESRD. Thus, they should not be held accountable for providing such services and any measure in this area would not be actionable.
- There is little contact between dialysis facilities and CKD Stage 4 patients making a CPM on this aspect of care that requires patient compliance outside the influence/domain of the facility. Furthermore, while critically important, CKD education is not something dialysis facilities are reimbursed for providing under Medicare. Thus, they should not be held accountable for providing such services and any measure in this area would not be actionable. Current education programs open to and available at no cost to attendees still fail to attract the majority of pre-dialysis CKD patients.
- Important, but likely not the best use of limited KCQA resources.
- Process measure.
- While pre-dialysis education is important, what happens before a patient reaches ESRD status is generally outside of the sphere of influence of the dialysis facility.
- I believe this would require changes in the current CKD and ESRD education laws.

Approach for All-KCQA Discussion

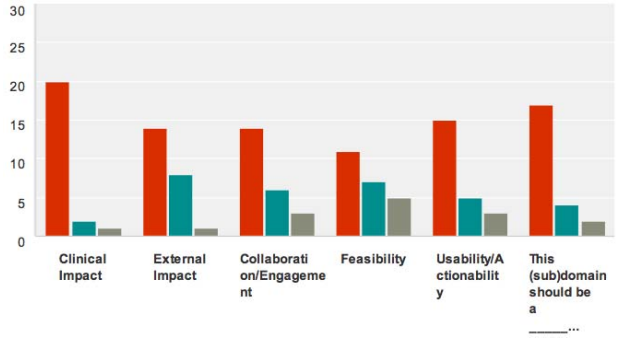
As noted in the previous All-KCQA webinar/conference call and the background materials, a hallmark of the Delphi/modified Delphi process is that participants' input is kept anonymous—even after results are finalized—so as to prevent the authority or personality of some participants from dominating others in the process, minimize the "bandwagon effect", allow free expression of opinions, encourage open critique, and facilitate admission of errors when revising earlier judgments. Balanced against this, however, the Steering Committee felt it important to provide an opportunity for all representatives from KCQA members to participate and for open (and therefore non-anonymous) dialogue to occur prior to finalizing KCQA's priority measure development area for 2014. Accordingly, the KCQA process incorporates an All-KCQA discussion following the two initial surveymonkey rounds.

For the All-KCQA discussion, we strongly encourage you to review the comments submitted by KCQA members through Table 2. On the webinar/call we will provide a *brief* recap of the results to date and then ask KCQA members to discuss the following questions related to Round 3, which will be used to approve/disapprove (not rank) a final list.

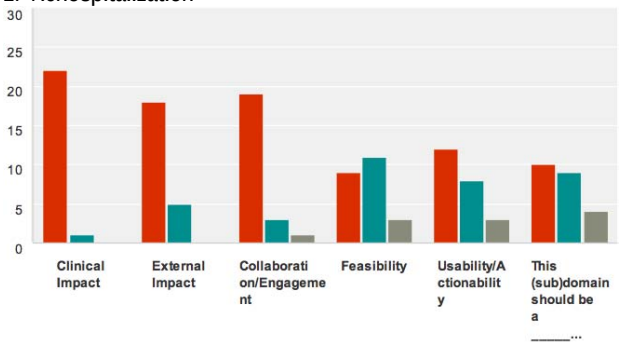
1. What specific support or concerns do KCQA members wish to convey to fellow members about the overall list?
2. The candidate measure development area *Fluid Management* has clear separation and consensus as the #1 ranked area. What support or opposition do you wish to convey to fellow members about this measure development area?
3. Given the outcome presented in Table 1, the Steering Committee proposes that Round 3 of KCQA's modified Delphi not be a ranking survey. Rather, KCQA members would be asked: *Do you support "Fluid Management" as KCQA's measure development area for 2014?* Do KCQA members object to this approach?

The following histograms represent the **unadjusted**, raw numbers for responses to each of the 14 (sub)domains in Round 2 of KCQA's modified Delphi to prioritize measure development areas. The total number of respondents for each candidate measure development area was 23 KCQA members, with 1 abstention and 11 not voting. The graphs have been placed in order as they were ranked in the Table 1 Summary, not their order on the survey. The response color scheme is:

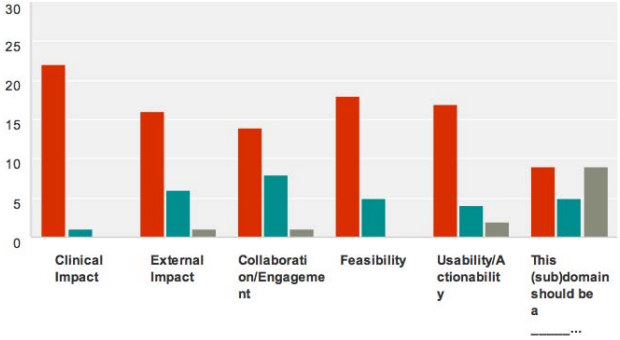
1. Fluid Management



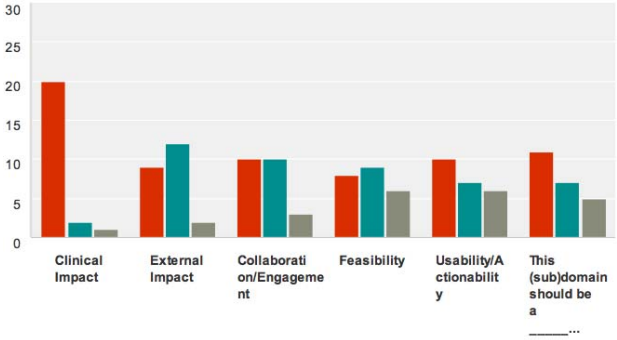
2. Rehospitalization



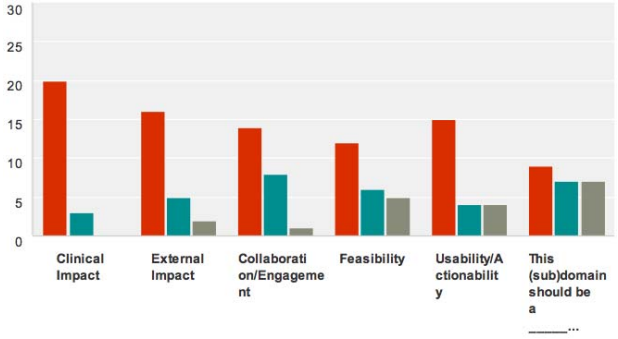
3. Vascular Access



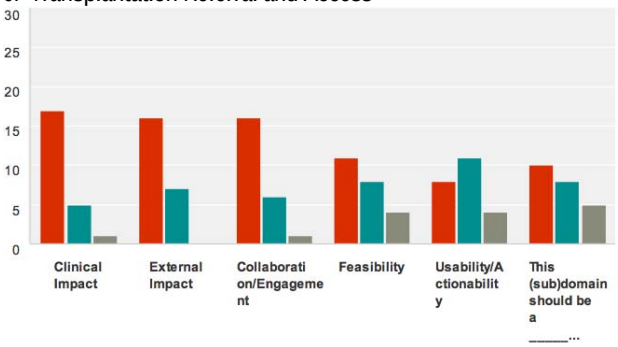
4. Nutrition



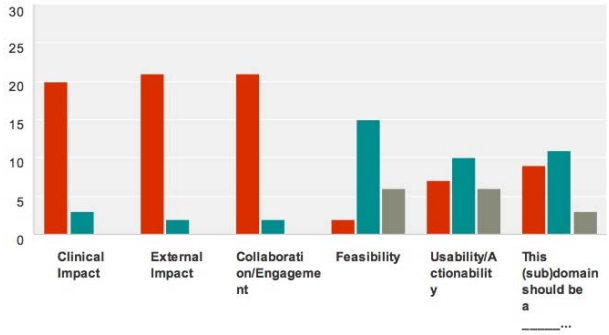
5. Healthcare-Associated Infections



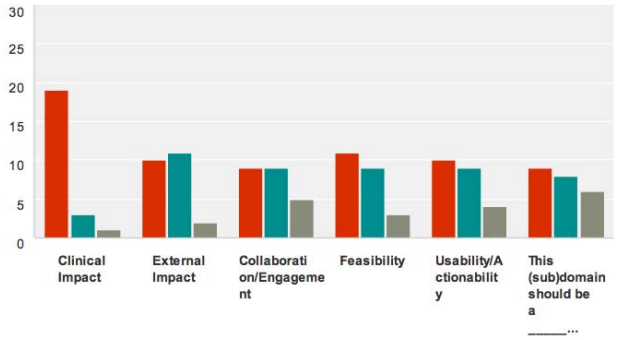
6. Transplantation Referral and Access



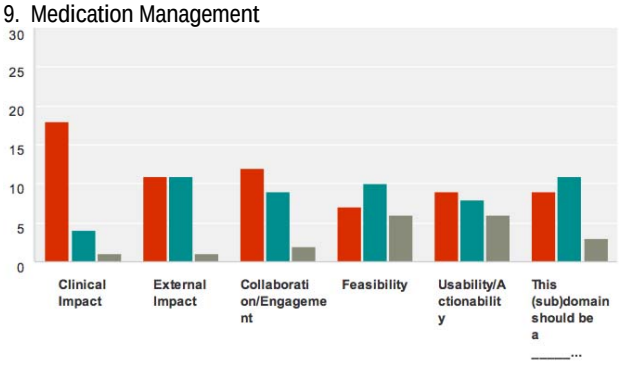
7. Care Transitions



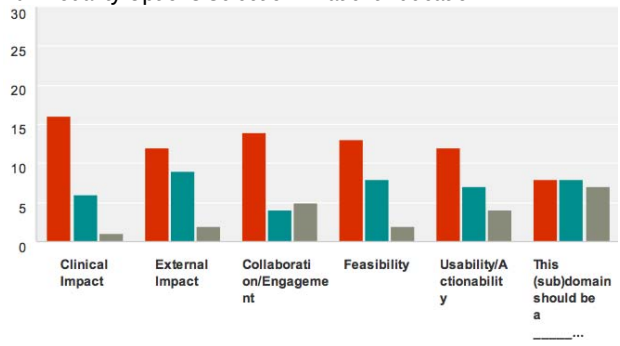
8. Frequency and Duration of Dialysis



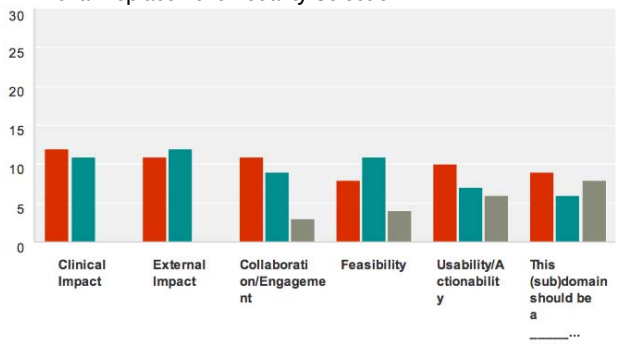
9. Medication Management



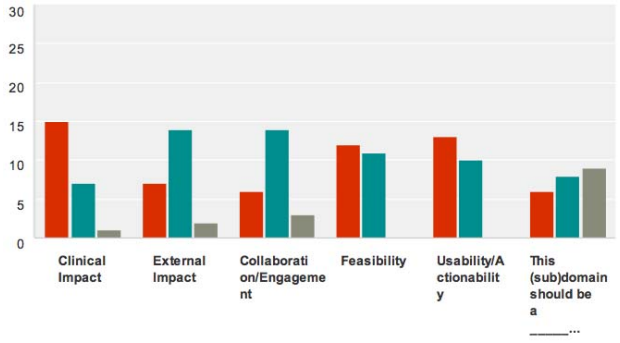
10. Modality Options Selection—Patient Education



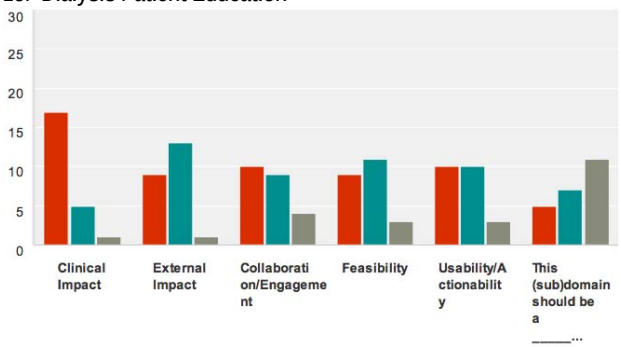
11. Renal Replacement Modality Selection



12. Immunization



13. Dialysis Patient Education



14. CKD Stage 4 Pre-dialysis Education

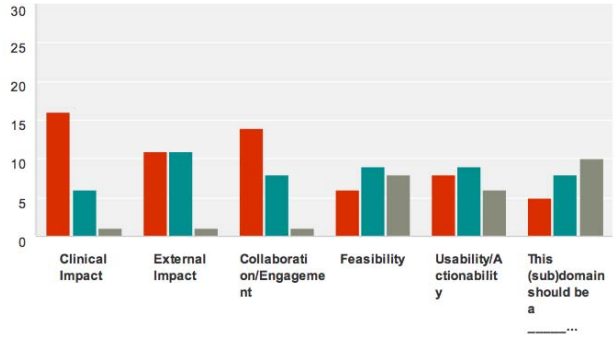


Table 1: Candidate Measure Development Area Total Weighted Scores, Round 1

RANK	MEASUREMENT AREA	TOTAL WEIGHTED SCORE
1	Vascular Access (Disease Management)	89.21
2	Fluid Management (Disease Management)	84.90
3	Immunization (Disease Management)	84.59
4	Rehospitalization (Care Coordination)	84.31
5	Healthcare-Associated Infections (Safety)	82.72
6	Frequency and Duration of Dialysis (Patient Engagement and Education)	80.66
7	Transplantation Referral and Access (Quality of Life)	80.49
8	Medication Management (Care Coordination)	80.10
9	Dialysis Patient Education (Patient Engagement and Education)	78.38
10	Modality Options Selection (Patient Engagement and Education)	78.28
11	Nutrition (Disease Management)	78.03
12	Renal Replacement Modality Selection (Disease Management)	77.14
13	CKD Stage 4 Pre-Dialysis Education (Patient Engagement and Education)	76.97
14	Care Transitions (Care Coordination)	76.38
15	Patient Satisfaction and Patient Experience with Care	74.83
16	Nutrition (Patient Engagement and Education)	74.48
17	Palliative and End-of-Life Care	73.79
18	Integrated Care (Care Coordination)	73.45
19	Adherence to Dialysis Rx, Medications, Diet, etc. (Pt Engage/Education)	73.38
20	Adverse Events (Safety)	72.69
21	Anemia (Disease Management)	70.45
22	Depression (Quality of Life)	68.55
23	Comorbidities Management (Disease Management)	68.45
24	Functional Status (Quality of Life)	68.38
25	Bone Mineral Metabolism (Disease Management)	66.03
26	Adequacy (Disease Management)	65.66
27	Health Information Exchange/Data Coordination (Infrastructure)	65.14
28	Rehabilitation and Employment (Quality of Life)	63.28
29	Care Models (infrastructure)	61.55
30	Workforce (Infrastructure)	60.17
31	Telehealth/Medicine (Infrastructure)	54.62

Green = Candidate measure development areas agreed to by Steering Committee for advancement to Round 2, using healthy majority/75% cut-off. *The Steering Committee emphasizes that an area that does not appear in Round 2 is not unimportant. Rather, the Round 2 candidate areas represent KCQA members' collective input for 2014 measure development priorities, given the resources are for development of 1-2 related measures in one area.*

Table 2: Candidate Measure Development Areas: Weighted Average Scores by Criteria and Submitted Comments, Round 1

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
Vascular Access (DM)	4.690	0.428	0.424	1.752	1.628
• Would aim at catheter reduction, but would need a novel measure that does not overlap with existing measures. • Still difficult to move incident rate of AVF up; don't see much space for a new measure except to add graft measure. • Getting surgical input and engagement here is the greatest frustration. While you can have the best access coordination and management resources available, surgical expertise and available resources is subject to geographic variability. This is especially true in rural areas. These resources are often influenced by patients' ability to travel distances and seek centers of expertise. • Access issues are very different in pediatric than adult patients. Pediatric patients are transplanted more rapidly than adult patients. • While this measure scores high, the fact that there are already measures in this area argues against using the limited resources of the KCQA to develop yet another measure in this area. Moreover, there is also overlap with contribution of other providers as well as patient factors making additional CPMs more problematic in terms of feasibility and actionability. • No new measures are really needed in this area. This could be easily addressed by leaving only a catheter measure in the QIP and removing the fistula measure. • Clinically important, but already existing. • Measures already exist in this domain. Not a high priority. • This parameter should be evaluated on initial admission, with the actionability directly ascribed to the treating/admitting nephrologist. Once a patient is admitted with a catheter, it increases risk to the patient and makes the referral process to the surgeon much slower. • A measure of catheter last, instead of fistula first. • While this measure scores high, the fact that there are already measures in this area argues against using the limited resources of the KCQA to develop yet another measure in this area.					
Fluid Management (DM)	4.621	0.407	0.414	1.476	1.572
• Very important clinically; need agreement on measure and data for it. • I think this is an area this is not as well addressed in the industry and has the ability to influence a lot of other measures-hospitalizations, rehabilitation, collaboration, mortality, etc. • This is the second most common cause of hospitalization and morbidity in dialysis patients but suffers from the lack of evidence-based guidelines and clinically defined measurements that can be used for assessment. This area needs further clinical research and a consensus among providers as to how to measure and how much resources need to be used in measurement. Requiring Crit-line, echocardiography, bio-impedence, and other assessments of volume can get very pricy very quickly. • Different rates of fluid removal are acceptable in pediatric vs. adult patients • This is a critical subdomain and an area in which a measure could actually change practice patterns and improve care. There needs to be an appreciation that patient compliance also plays a huge role in achieving outcomes for a fluid management CPM. In addition, there is no gold standard for determining achievement of estimated dry weight. Therefore, while the potential to impact outcomes is high, there is also a large potential for variability even with implementing the exact same programs. Depending on the measure, it could be actionable by dialysis facilities and important for patient outcomes. • No agreement on how it is to be measured. • Critical element as quality metric - difficult metric to develop, but should have high priority to advance ESRD care. • Highly dependent on the measure. • A key medical management goal that now can be done objectively, without relying on physician (usually non-existent) intervention. • More recently this has become an area of focus and is important for patient health and well-being. • This is an area that great improvements can be made in quality of care. Allowing nurses enough time to do a thorough assessment is critical. Also, measuring blood volume change during dialysis is critical for optimal patient dry weight assessment. • This is a critical subdomain and an area in which a measure could actually change practice patterns and improve care. It is actionable by dialysis facilities and important for patient outcomes. Outcomes are also highly dependent upon patient compliance. In developing a measure, it will be important to address missed treatments and variability of patient compliance, as well as gaining consensus around achieving estimated dry weight.					
Immunization (DM)	4.310	0.410	0.386	1.697	1.655
• Important topic, but already well covered with existing measures. • Current measures exist. • This would be a very high public health measure and easy to implement but would likely not have great clinical impact. This could be a component of another measure. • Measures in this domain can be easily harmonized between adult and pediatric populations. • While this measure scores high, the fact that there are already measures in this area argues against using the limited resources of the KCQA to develop yet another measure in this area. • Current pneumococcal measure needs to be revised or redeveloped. • Information not readily available to providers - done by PCP, nephrologist in practice, refusal by patients. • In addition to Influenza, it should also include Pneumococcus vaccination, as well as Hep B. • While this measure scores high, the fact that there are already measures in this area argues against using the limited resources of the KCQA to develop yet another measure in this area.					

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
Rehospitalization (CC)	4.655	0.459	0.448	1.366	1.503
• While I consider rehospitalization an important issue, I have major concerns about a measure in this domain with regard to several issues including low sample size for a facility-level measure for small to moderate size facilities minimizing the statistical value of any measure and issues related to case mix and attribution. • Dialysis facilities can influence a portion of this risk but best coordinated with primary care physician, medical home and home health care. We are engaged in dialysis access risk but caring for the myriad of other morbidities that precipitate rehospitalization will require engagement of these other entities which we have little direct influence. • Cause specific rehospitalization I would favor. There has already been a TEP here and we expect to see this measure soon in a proposed rule. • This is an important subdomain, but currently there is no agreement on how to design this type of a measure. There is a competing measure, the SRR or standardized readmission ratio that CMS has already piloted for 2012. However, it has not been validated particularly in terms of actionability. Furthermore, NQF has also indicated that such a measure needs to be adjusted based upon patient socio-economic status, which is not possible at this time. • Current measures exist so no need to reinvent the wheel. • Important and partially dependent on provider - but mainly geared towards hospitalization. Rehospiralization often outside of provider's control. Fluid and access-related hospitalizations more provider metric appropriate than all-cause rehospitalizations. • This really is often beyond the facility's control, and it is not clear that rehospitalization often reflects mismanagement in the hospital or the outpatient setting rather than being a marker for increasing clinical fragility. • This is an important subdomain, but currently there is no agreement on how to design this type of a measure. NQF has also indicated that such a measure needs to be adjusted based upon patient socio-economic status, which is not possible at this time. Patient representatives to the Forum thought this was particularly important to them. • Patient representatives to the Forum thought this was particularly important to them.					
HAIs (Safety)	4.414	0.424	0.400	1.476	1.559
• NHSN offers some data access. • Number one reason patients get admitted in most surveys. Difficult area to address. • This area needs more research. • Many domains of HAI's targeted by CDC/DHHS are not directly related to dialysis facility care. Some subdomains are important (e.g. bloodstream infections - and there is already an existing measure), but the Centers for Disease Control and Prevention are already moving initiatives in these domains. Expending resources in this area would be duplicative. • Already a measure here not sure there is a need for more. • NHSN metric in place. • Already monitored through NHSN. • Get rid of catheters and infection rates will plummet. • Extremely high importance, but issue of existing measures in this domain diminishes rating on clinical impact. • These subdomains are important, but the Centers for Disease Control and Prevention is already moving initiatives in this domain. Expending resources in this area would be duplicative. Many of the current HAI targets by the Centers for Disease Control and Prevention are not directly related to dialysis care.					
Frequency & Duration (Pt Ed)	4.310	0.362	0.345	1.490	1.559
• Intimately related to payment. • I believe current reporting systems cannot handle this information. If this were to be developed, data entry via Crown Web and other data reporting would have to be modified. Outcome measures regarding increased frequency and duration of dialysis are starting to be reported as very positive, but this will require a major change in patient and staffing expectations. Implementation of such a measure may force this, but current data reporting is totally inadequate. • A clinical trial is ongoing to test the impact of hemodialysis treatment time. While FHN showed improved composite endpoint for SDHD but there were questions regarding the potential adverse impact on vascular access. There should be individualized dialysis prescriptions and a CPM may not be ready for primetime as we learn more. • Best area to measure for fluid management. • Patients must be started on at least 4 hours, and then decide if they need a different duration; it is very difficult to increase dialysis time once patients start dialysis. • Likely to have an impact - possibly addressed with enhanced focus on fluid management. • The literature has shown that more dialysis improves outcomes. • Could impact care and outcomes if measure was about missed treatments. • Pediatric patients are often dialyzed more frequently than adult patients. • Having a fluid management measure would be more valuable than an education measure. There is a clinical trial underway. Early results raise questions about the impact on vascular access. The study should be completed before a measure is developed in this area.					
Transplant Referral/Access (QOL)	4.345	0.422	0.414	1.393	1.476
• DFR includes TP waitlist rate. • This measure would likely have the greatest cost effective impact. • It is not referrals that become the primary problem - it is addressing the limited supply of organs and the absence of life-long funding for immunosuppressive drugs that can improve patient outcomes. While quality of life is an important aspect of care, the subdomain focuses on an area that is not actionable by dialysis facilities. There are many other drivers that impact outcomes..					

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
• Must discuss with family members about Living related donation. • Very important conceptually in children. • Transplantation is the best event that can happen for our patients. • While quality of life is an important aspect of care, the subdomain focuses on an area that is not actionable by dialysis facilities; physicians control the referral of patients. There are many other drivers that impact outcomes in this area. Additionally, facilities are required to provide modality education, which includes information about transplant, under the Conditions for Coverage. Most importantly, transplant referral is not the primary problem – it is a lack of organs and life-long funding for immunosuppressive drugs.					
Medication Management (CC)	4.483	0.407	0.403	1.255	1.462
• Currently the measure for NQF is just a medication review (a check mark measure) which does not really address patient education on medication regimen. If the measure includes patient education and reconciliation then ANNA would agree it needs to be rated very high, as medication issues can result in rehospitalizations. • This is becoming more available with availability of electronic health records but still only about 50% of providers in our community have electronic records available for medication reconciliation. • Can use electronic data. • Linked to care transitions. • This is an important subdomain, but a facility-only measure is not appropriate because of changes effected by other providers. There are also concerns about this subdomain because it would be highly dependent upon patient compliance. Therefore, if this topic were to be selected for CPM development, it will need to be a process measure that can be implemented by the facility, not an outcome measure. • Facility only metric inappropriate - patient/family important contributor. • Medication management would be much better as medication reconciliation at the facility level. • Medication management is best done by a pharmacist, and several studies have shown a strong impact of such a program on length of stay and frequency of readmissions. • Obtaining information regarding patient adherence to taking meds as prescribed is difficult. A patient may have multiple doctors who don't necessarily communicate with one another. A patient also may be forgetful or not report truthfully about adherence to prescriptions. • What part of medical practice does not include medication management. Take away prescribing medications and what does medical practices look like. • This is an important subdomain, but a facility-only measure is not appropriate. There are also concerns about this subdomain, because it would be highly dependent upon patient compliance. If selected, a process measure would be more appropriate because of variable patient compliance.					
Dialysis Patient Education (Ed)	4.276	0.362	0.359	1.324	1.517
• Too easy to game. • While I think patient education is highly valuable, retention by patients and ongoing efforts to maintain this level of knowledge have been frustrating. Retention and utilization of this patient education remains very low and I have some concerns about whether the overall impact would be that great. • This area is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. • Already measured in Conditions for Coverage. • This could be developed into a process measure. • This area is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused.					
Modality Options Selection (Ed)	4.207	0.376	0.348	1.407	1.490
• Individualizing patient care will lead to optimum outcomes is my strongly held belief, but unfortunately there is little outcome based research to validate. This measure needs research, but I believe has great potential. • Modality selection is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. • Extremely important to patients to have choices. It improves patients experience with care. Clinical outcomes for transplant are far superior to dialysis so its important the facility have a role in increasing transplantation. • Requested in CfC - question how effective. • Already in the Conditions for coverage. • Nephrologist prescribe what they are comfortable with and what treatment options his clinic he is associated with offers. Education is needed to educate new physicians on modality options. Also, more collaboration between the dialysis and transplant community is needed. • This could be developed into a process measure. • Duplicates prior modality selection measure. • Not infrequently patients are encouraged to select a treatment option that benefits the facility financially. • Modality selection is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. • Patient representatives to the Forum thought this was particularly important to them.					
Nutrition (DM)	4.310	0.359	0.376	1.366	1.393
• Feasibility depends on measure, and relaxation of prohibitions on nutritional supplements, and measure would have to be case mix adjusted. • Nutrition has great clinical impact but suffers from resource availability and cost. How dialysis facilities can impact this with limited resources is problematic. Very few outcome-based studies are available and most are observational. I think that education could be important but impact would be relatively low for cost.					

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
• Not clear that can address in setting of inflammation. • Measures in this domain can be easily harmonized between adult and pediatric populations. • This is an area in which a measure could change practice patterns and improve care. • Due to a patient compliance factor, a CPM in this area may very well need to be a process as opposed to an outcome measure. It is actionable by dialysis facilities and important for patient outcomes. • Important topic, but already well covered with existing measures. • Current pneumococcal measures needs to be revised or redeveloped. • Dialysis is a catabolic process, and feeding patients ON DIALYSIS is crucial to replace loss of nutrients in the dialysate. • Nutrition is in Patient Engagement and Education – duplicated. • Information not readily available to providers - done by PCP, nephrologist in practice, refusal by patients. • This is an area in which a measure could change practice patterns and improve care. It is actionable by dialysis facilities and important for patient outcomes. Current evidence, however, can only support a process measure.					
Modality Selection (DM)	4.172	0.379	0.362	1.352	1.448
• Focus on home/self-care modalities. • Internal QI perhaps; too subject to gaming for use as a measure. • I believe this is the most important measure for patient ultimate outcome, as it creates better patient expectations of care and individualizes care. Unfortunately, this has not been well accomplished because of poor resource availability, lack of sufficient payment for efforts, and the problems with defining patient population between Medicare beneficiaries and commercial insurance patients. Commercial insurance pays nothing for this and Medicare will pay in selected areas. This leads to inconsistency in defining eligibility for education benefits. • Critically important in children. • Modality selection is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. Furthermore, modality selection should be individualized because not one size fits all. • Extremely important to patients to have choices. It improves patients experience with care. Clinical outcomes for transplant are far superior to dialysis so its important the facility have a role in increasing transplantation. • Duplicate measure under Patient Engagement and Education. Also part of the conditions for Coverage and monitored through the survey process. • This should be done BEFORE patient is initiated on any specific therapy. • The success of programs like FMC's and DCI's and others before shows that with appropriate education and guidance, the proportion of patients dialyzing at home can be raised significantly. • Modality selection is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused. It should also be individualized and not prescribed as a one-size fits all.					
Stage 4 Pre-Dialysis Education (Ed)	4.310	0.421	0.414	1.186	1.366
• If appropriate payments and re-imbursements for education can be developed, this would be a high impact area. The problem is this is very resource intensive and requires committed staff, time and coordination. We have made serious attempts to implement this and it continues to be frustrated by costs, lack of coordination and difficulty in defining patient populations between Medicare and Commercial insurance patients. There would likely need to be federal legislation developed before such a measure could be successfully adopted. • There is little contact between dialysis facilities and CKD Stage 4 patients making a CPM on this aspect of care that requires patient compliance outside the influence/domain of the facility. Furthermore, while critically important, CKD education is not something dialysis facilities are reimbursed for providing under Medicare. Thus, they should not be held accountable for providing such services and any measure in this area would not be actionable. • May be inadequate due to restricted funding for same. • Often not feasible in the provider setting - dependent on nephrologist. • This could be developed into a process measure. • While critically important, CKD education is not something dialysis facilities are reimbursed for providing under Medicare. In addition, facilities typically do not see patients until the onset of ESRD. Thus, they should not be held accountable for providing such services and any measure in this area would not be actionable.					
Care Transitions (CC)	4.483	0.414	0.424	1.034	1.283
• My biggest problem here is engaging other care providers to cooperate with Care Transitions. Dialysis facilities cannot and do not have any influence over community physicians, hospitals, nursing facilities, or rehabilitation centers in order to facilitate care transitions. While they have similar needs, they have been unwilling to share certain information (such as DNR status) with other facilities. • Will require some cooperation with hospitals, such as the use of a universal transfer form like for NH. • Linked to integrated care. • This is an important subdomain and there is sufficient literature to support developing a measure in this area. However, a facility-only outcomes measure is not feasible under the current payment system, because accomplishing the benchmark would depend upon other providers who are not incentivized to cooperate to make the measure actionable for dialysis facilities. • Currently no set of standard tools and it's difficult for facilities to force hospitals to provide the information. • Highly important measure to improve QOL and patient experience, but dependent on various stakeholders - many of them outside the provider area. Not feasible or appropriate as a metric for providers only. • Getting different health care entities to collaborate on care transitions will meet with strong, but passive resistance by all entities, because it requires					

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
deployment of many staff hours that will not "pay off" directly. • I don't believe there is any consistency in reporting from one area of care to another. • Without Hospitalists buy-in this may prove to be difficult. • This is an important subdomain and there is sufficient literature to support developing a measure in this area. However, a facility-only outcomes measure is not feasible, because accomplishing the benchmark would depend upon other providers to make the measure actionable for dialysis facilities. • Patient representatives to the Forum thought this was particularly important to them.					
Patient Satisfaction and Experience	4.172	0.417	0.383	1.297	1.214
• ICH CAHPS provides a tool for in center HD. • This measure always shows up as having great importance, but I have yet to see any data that striving for patient satisfaction improves outcomes. While I am sure Congress and the public view this as of high importance, I think more important to gauge patient expectations of care and then deal with achieving those expectations. In our own patient satisfaction survey experience, the major concern (for years) has been the temperature of the dialysis unit. We have as yet been unable to impact that for many years. I am not sure how this leads to improved patient outcomes. I do think this is important to measure, but I am not sure how to use this in a quality improvement situation. • There is already a measure in this area. While ICH-CAHPS should be improved, it seems unlikely AHRQ will revise it. Thus, the limited resources should not be spent on pursuing another measure in this area. • IHCHAPS already in place. • A measure to ask the patient after "each treatment" on how they perceived their care needs to be developed. • Already exists. • Different satisfaction surveys presently exists for adult and pediatric populations. • There is already a measure in this area. While CAHPS should be improved, it seems unlikely AHRQ will revise it. Thus, the limited resources should not be spent on pursuing another measure in this area.					
Nutrition (Ed)	4.138	0.338	0.352	1.283	1.338
• Nutrition remains an area where we know there are variables that impact outcomes, but finding interventions that are effective in improving outcomes and cost effective have been a major deficiency. This is not ready for prime time. • Having a nutrition measure would be more valuable than an education measure. • Already measured in the ICHAPS survey as an education measure. • Nutrition is a critical component of a pediatric dialysis visit. • Not clear if related to inflammation if it is actionable. • Having a nutrition measure would be more valuable than an education measure. Nutrition education is already controlled by the Conditions for Coverage. It is the role of the dietitian. If facilities do not meet these requirements, they are sanctioned under those laws.					
Palliative and End-of-Life Care	4.069	0.372	0.386	1.241	1.310
• No current measures; functional status would be a step forward, but measure not currently developed. • I think this area is vastly under utilized but also requires a great deal of time. Devoting resources to this will ultimately save money and increase patient quality of life, but would be very resource intensive for dialysis facilities given current staffing in most facilities. • Palliative and End of Life Care is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. • Therefore, this should not be an area where the limited resources are focused. • Already exists in Conditions for Coverage. • Important but covered by CfC. • This is already controlled by the Conditions for Coverage. If facilities do not meet these requirements, they are sanctioned under those laws. Therefore, this should not be an area where the limited resources are focused.					
Integrated Care (CC)	4.241	0.428	0.414	1.034	1.228
• I think this is a very important concept and likely to be a model that is widely used in the future, the problem I see is that there is little evidence to develop a measure at this point in time. • Defining this for various facilities becomes the problem. Each caregiver sees different needs and wants. Care plans for various facilities best coordinated by medical home and not in a dialysis facility. • Applicable for ESCOs. Given that there has already been a TEP on this, timing may be wrong. • Should be merged with Care Transitions. • Linked with Care Transitions. • Difficult as a facility level measure as many different health care providers would need to be responsive. • Facility only metric not appropriate - physician and outside stakeholder required to participate to be effective. Much needed, but dependent on many stakeholders. • This is an important subdomain, but a facility-only measure is not appropriate under the current reimbursement system. Also, facilities could not act upon the information in a meaningful manner because actions would need to be taken by other health care providers who do not have similarly aligned incentives. • This is an important subdomain, but a facility-only measure is not appropriate. Also, facilities could not act upon the information in a meaningful manner because actions would need to be taken by other health care providers as well. • Patient representatives to the Forum thought this was particularly important to them.					
Adherence (Ed)	4.276	0.355	0.376	1.103	1.228

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
• Should not build an "adherence" measure—no reliable data—very judgmental terminology. • If methods to impact adherence could be developed, this could be a significant area for patients and outcomes, but I have not seen data to suggest that major efforts to increase adherence result in substantial improvement in outcomes. I would have to see this data, because it is not familiar to me. • Adherence is difficult to measure. • Unclear if can address/actionability. • Lack of consistency in patient, staff and facility reporting regarding this area. • Adherence by patients requires that they understand why they need to stay for 4 hours, why they need to take their medications. This should be initiated by the nephrologist and reemphasized by the nursing staff to the patient and their families. • Inappropriate for facility only metric. • While patient adherence is critically important to improving care, a facility-only measure is neither feasible nor actionable because substantial responsibility lies with the patient. • Already exists in Conditions for Coverage and is highly scrutinized during surveys. • While patient adherence is critically important to improving care, a facility-only measure is neither feasible nor actionable because substantial responsibility lies with the patient.					
Adverse Events (Safety)	3.966	0.390	0.390	1.200	1.324
• Difficult to get data; internally collected and protected. • Impacting adverse events remains a stubbornly difficult task in clinical medicine. • Biologic variability, human error, patient non-compliance, and system error are problems that are difficult to impact. I see some ways to improve but patient outcome versus effort will likely be difficult to show. No one wants an adverse event, but impacting them remains a system problem for all health care providers. • These subdomains are important, but the Centers for Disease Control and Prevention are already moving initiatives in these domains. Expending resources in this area would be duplicative. • Infection per NHSN hospitalization, access metric include AEs avoid duplication. • Already monitored through Conditions for Coverage. • Can be collected with electronic patient systems. • These subdomains are important, but the Centers for Disease Control and Prevention is already moving initiatives in this domain. Expending resources in this area would be duplicative.					
Anemia (DM)	3.345	0.348	0.290	1.586	1.476
• Multiple existing measures limit enthusiasm. Might consider transfusion measure, although potential issue of data availability. • Again, well established measure, >12 target reached by majority; could support a below 10 measure if allowed. • Again, this is being actively addressed-if we were to spend time on this measure, it should relate to the lower end hemoglobin outcomes and transfusions. • This engagement in this process measure is already so high as to be meaningless in a quality improvement sense. Efforts to improve this measure will yield very little improvement in outcome for the effort expended. While my staff expends much energy in this area for cost reasons and CMS has major concerns about cost in this area, I see little impact on clinical decision making as a result of anemia management once a basic clinical action plan is in place. • Transfusion data would be required. • Very different outcomes in children. Measures already developed in this area. • Already overpopulated with measures. • Already existing. • Sampling can be inconsistent. For example samples drawn on the first dialysis of the week might be diluted by excessive weight gain while samples drawn on the third dialysis of the week could be concentrated. • Unfortunately, patients and clinicians do not recognize anemia symptoms and consider it acceptable for people to be tired. • There are already measures in this area and very little gap in performance, which argues against using the limited resources of the KCQA to develop yet another measure in this area. • Patient representatives to the Forum thought this was particularly important to them.					
Depression (QOL)	4.000	0.338	0.352	1.034	1.131
• Problem is lack of data. • Depression while very common and causing significant impact on patient quality of life, we have found it difficult to impact on a clinical basis. Dialysis facilities have the expertise to diagnose depression (Social Worker and Depression measurement tools such as the SF-36 & BDI), the treatment and monitoring of therapy has been difficult to implement without engagement of outside help from mental health practitioners, primary care physicians and family. I think this could be implemented, the cost effectiveness of this in a dialysis facility may be difficult to substantiate. • While quality of life is an important aspect of care, the subdomain focuses on an area that has not been proven to be fully actionable by dialysis facilities. In addition, there is no agreement as to what an appropriate screening tool would be. A study is underway to determine the answer to that question; thus, a measure should not be pursued until the study is complete. A PCORI study is also proposed to determine comparative outcomes between behavioral vs. drug therapy for depression in dialysis patients. There is currently no consensus regarding the appropriate treatment strategy and so a CPM is premature in this area. • Detecting depression is very doable and important, but treating depression is beyond the scope of the dialysis facility and out of the facilities control other than for referral to care and following up with the patient. • Clinically important, no data for screening and action available at this moment.					

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
• When patients are depressed they often do not show up for care or take their meds. • Already exists. • Hard to collect this data in pediatrics. • What is the conceptual model for what would be done? • Not clear if actionable. • There are good enough screening tools available. By actively coordinating and promoting detection of and care for depression, facilities can make a major contribution. • While quality of life is an important aspect of care, the subdomain focuses on an area that is not actionable by dialysis facilities. In addition, there is no agreement as to what an appropriate screening tool would be. A PCORI study is underway to determine comparative outcomes between behavioral vs. drug therapy for depression in dialysis patients; thus, a measure should not be pursued until the study is complete.					
Comorbidities Management (DM)	3.897	0.362	0.366	1.034	1.186
• Necessary for case mix adjustment, but don't see as a measure on its own; data exists but not for all comorbids suggested by last proposed rule. • This measure could likely have the most clinical impact of any measure (next to medication reconciliation) but will be the hardest to accomplish because of involvement of multiple stakeholders including patient compliance/noncompliance issues. This would be a very challenging measure for most dialysis facilities and would involve a great deal of effort and expense. • Good for ESCOs. Claims data will be needed. • Trouble capturing all data and residual confounding. • Comorbidity management as a facility-only metric is simply not feasible at this time because it would be highly dependent upon other providers involved in managing the patients' comorbidities. • Good clinical practice, but not a lot of evidence that the dialysis facility alone can do much to improve outcomes. • Clinically extremely critical but beyond dialysis provider's control. Requires nephrologist and specialist team. • Comorbidity management as a facility-only metric is simply not feasible at this time because it would be highly dependent upon other providers involved in managing the patients' comorbidities.					
Functional Status (QOL)	3.897	0.366	0.355	1.062	1.159
• No data; no tool specific for ESRD. • This is an important measurement in the aging population seen in our dialysis facility, I'm not sure how to apply this to the entire population. • While quality of life is an important aspect of care, the subdomain focuses on an area that lacks evidence on whether functional status is actionable by dialysis facilities. There are many other drivers that impact such outcomes. • There is TEP convened unsure of the timeline of the TEP recommendations and if KCQA timing to develop a measure in this area would get consideration. • Clinically important, no data. • Very different outcomes exist for pediatric and adult patients. • Not clear if actionable. • While quality of life is an important aspect of care, the subdomain focuses on an area that is not actionable by dialysis facilities. There are many other drivers that impact outcomes. Additionally, there is not enough evidence to support mechanisms for impacting quality of life.					
Bone Mineral Metabolism (DM)	3.172	0.310	0.279	1.517	1.324
• Community can't agree on a target for PO4 or iPTH. • This one is very important to patient outcomes, would definitely require collaboration, and there isn't any consensus around a good measure in the industry. • There needs to be better research in this area that is outcomes based. So far most of the clinical impact data is about reaching certain targets and "numbers" but as far as patient outcome and impact to patient care, this is a source of patient frustration and patient non-compliance without much ultimate clinical impact, given today's knowledge base. • Very different outcomes in children. Measures already developed in this area. • The evidence base in this area does not provide clear guidance on specific population targets and could lead to better outcomes when individualized. There are already measures in this area and very little gap in performance, which argues against using the limited resources of the KCQA to develop yet another measure in this area. • Already existing - no data to support improvement will lead to improved QOL and patient experience. No data to support alternative interventions than currently in place. • Too many variables to make this a meaningful measure. The only consideration would be if the measure surrounded phosphorus. • This continues to be a controversial area. • There are already measures in this area and very little gap in performance, which argues against using the limited resources of the KCQA to develop yet another measure in this area.					
Adequacy (DM)	3.034	0.328	0.279	1.586	1.338
• Minimal performance gap; existing measures. • Measure established and most providers reach current targets; neutral for additional clinical impact. • Not sure what "adequacy" means- a global concept of ow all medical care is? • This measure is actively being addressed and doesn't appear to be a problem in our industry. I feel it would be a better utilization of committee members' time and for patient benefit, to work on something that will have an impact, that is not already being measured and reported. • Adequacy measurement and attainment has become so high as to be meaningless in a quality improvement sense. The remaining 2 or 3% of patients					

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
who have adequacy below target are there due to choice, non-compliance or are already running more than three times per week and the reporting system cannot accommodate the data for more than three times weekly dialysis treatments. • Very different outcomes in children. Measures are already developed in this area. • A lot on adequacy of urea removal already. Focus should be TIME. • While providing adequate dialysis is a core mission of dialysis providers, there are already measures in this area and very little gap in performance, which argues against using the limited resources of the KCQA to develop yet another measure in this area. • Adequacy as a function of time on dialysis is showing improved clinical results. • Already existing with high % achievement. Further improvement unlikely to have an impact on QOL or patient experience. Likely inappropriate metric for QOL and patient experience. • This measure is already topped out. • Adequacy implies achieving the "minimum"; it should be replaced by "optimization." • There is no consistent method for sampling and there may be enticements for otherwise non-adherent patients on sampling days. • There are already measures in this area and very little gap in performance, which argues against using the limited resources of the KCQA to develop yet another measure in this area.					
HIE/Data Coordination (IS)	3.552	0.355	0.359	1.076	1.172
• Lack of support for HIT negatively impacts potential for use across ESRD. • I remain unconvinced that current technologies which lack interoperability will do much to impact patient care. Unless and until systems start communicating with the community at large (interoperability), I don't see EHR as anything but an expensive endeavor at slowing the care process and alienating patients in the process. While some programs provide better patient access, they still all suffer from lack of interoperability. This problem will likely have to be solved by government in some fashion and then systems will be developed that actually can be used to care of patients with multiple co-morbidities. • This is an important subdomain, but a facility-only measure is not appropriate. Also, facilities could not unilaterally act in a meaningful manner because actions would need to be taken by other health care providers as well. • Feasibility is dependent on the dialysis facilities resources to invest in the infrastructure and exchange of information. There are no meaningful use incentives for dialysis facilities. • Electronic systems don't necessarily talk to one another and staff are less likely to read charts and know the patients well.					
Rehab and Employment (QOL)	3.586	0.376	0.352	0.952	1.062
• Too many variables. • This would be important to the younger patients in our facility, but as the average age of our patients grows every older, not sure how to impact this in the entire patient population. • While quality of life is an important aspect of care, the subdomain focuses on an area that is not actionable by dialysis facilities. There are many other drivers that impact outcomes. • Unlikely to be influenced on provider side. • Not applicable to pediatrics. • Patients become dependent on entitlements. • While quality of life is an important aspect of care, the subdomain focuses on an area that is not actionable by dialysis facilities. There are many other drivers that impact outcomes. Additionally, it is the obligation of the social worker to assist the patient in this area. There is not enough evidence to support mechanisms for impacting quality of life.					
Care Models (IS)	3.448	0.338	0.355	0.979	1.034
• I have not been impressed with any of this data regarding Care Models. I am not very familiar with the area but have not seen much to suggest clinical impact other than theoretical. Needs more outcome data. • Isn't this the same as managing comorbids or integrated care? • This is an important subdomain, however, a facility-only outcomes measure is not feasible under the current reimbursement system, because accomplishing the benchmark would depend upon other providers to make the measure actionable for dialysis facilities. • Likely very critical for patient outcomes, but lack of data and metrics to consider for metric development. • Nice to have but not a measure to use KCQA resources on. • Not sure what that means. • More nurses are being replaced by technicians for direct care so patients are not getting the benefit of total care. Nurses are also leaving dialysis positions because of the burden of responsibility and substandard training and education.					
Workforce (IS)	3.310	0.297	0.300	1.007	1.103
• Data not available for any/all disciplines. • This is becoming more of a problem but I do not see efforts to improve this. I foresee physicians becoming less direct caregivers and more managerial in the context of "team management." Physicians will become educators and directors of the team who actually provide the direct care. This is not the medical care delivery system that I signed up for. Developing these teams will require significant changes in clinical education and will likely be a very slow process. This is not ready for prime time. • There is insufficient consensus and evidence regarding which workforce items lead to improved patient outcomes. Therefore, this is a good area for discussion but not ready for prime time in terms of CPM development. • Too new of an area to evaluate. • CMS regulated training and certification for technicians, but did nothing to assure the same for nurses.					

MEASUREMENT AREA Max Weighted Values	CLINICAL IMPACT 5	EXTERNAL IMPACT 0.5	COLLABORATION /ENGAGEMENT 0.5	FEASIBILITY 2	USABILITY/ ACTIONABILITY 2
• Replacing Nursing care with "technicians" reduces the level of healthcare received by patients. • Not enough data/information how this may work in the provider setting. Premature to develop a metric. • I am again a bit unclear what is meant by "workforce"- does this refer to workforce policies? Hiring practices? I assumed it referred to these kinds of practices. • I often hear that staffing is at the bare minimum from patients, and staff are rushing around. This needs to be addressed through either self-care models, increasing staff ratio or incentives for patients to choose home dialysis.					
Telehealth/Medicine (IS)	3.000	0.293	0.279	0.910	0.979
• Not currently able to use in ESRD. • In my geographic are, this technology is sorely needed but remain largely unsophisticated and poorly implemented. Getting systems to relate to each other (interoperability) remains the Achilles heel of this technology. A great deal of money, effort and time has been expended to expand this availability without much resources available to show for the effort. Reimbursement for providers in this area is also very limited and inconsistent. • This could be an important subdomain, but a facility-only measure is not appropriate under the current reimbursement structure. Also, facilities could not unilaterally act in a meaningful manner because actions would need to be taken by other health care providers as well. • Too new of an area to evaluate. • We aren't there yet. • There is nothing that can replace a face-to-face interaction with patients; it will increase non-compliance by patients because if the physician dies not show up, why should the patient? • Not enough date/information how this may work in the provider setting - premature to develop a metric.					