

KIDNEY CARE QUALITY ALLIANCE

HOME DIALYSIS WORKGROUP MEETING 1 SUMMARY JULY 1, 2021

Attendees: Vanessa Evans; Emiliya Kechker; Rajnish Mehrotra MD, MS; Donna Painter MS, RN, CNN; Rebecca Schmidt DO, FACP, FASN; Avram Traum MD; Kathy Lester JD, MPH; Lisa McGonigal MD, MPH

Not Present: Bryan Fore; Eric Weinhandl PhD

BACKGROUND AND CHARGE

After roll call and introductions, Dr. McGonigal reviewed the meeting agenda and provided an overview of the 2021-2022 KCQA Project, including the Workgroup's scope and charge.

Project Overview

Dr. McGonigal summarized that in 2005, Kidney Care Partners (KCP) launched the Kidney Care Quality Alliance (KCQA) as a quasi-independent measure development entity with the express purpose of developing dialysis facility-level performance metrics for National Quality Forum (NQF) endorsement to address absent or faulty measures deployed in CMS's ESRD Quality Incentive Program (QIP), Five-Star Program, and now also the ESRD Treatment Choices (ETC) Model. She informed the Workgroup that KCQA launched a new project cycle in May 2021 to develop metrics in five clinical priority areas consistently identified by KCP members as being particularly problematic in these federal programs: home dialysis, transplant, anemia, bone mineral metabolism, and bloodstream infection. Consistent with KCQA's Guiding Principles, the measures must be community-supported, empirically sound, actionable, patient-centric, appropriately address social risk and health inequities, and meet the needs of patients, providers, other members of the kidney care community, and federal policymakers.

Home Dialysis Project Scope

In accordance with KCQA's mission to meet the needs of our stakeholders, Dr. McGonigal indicated that home dialysis measure development will focus specifically on utilization. She reminded the Workgroup that the July 2019 Executive Order on Advancing American Kidney Health envisions much higher utilization of home dialysis than is current practice in the United States. Additionally, the recently finalized ETC payment model includes as a core measure the utilization of home dialysis among Medicare patients with ESRD. Finally, CMS, in conjunction with the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC), has also recently convened a Technical Expert Panel (TEP) to develop a home dialysis utilization measure and will likely submit the metric to NQF for endorsement consideration within the next year. These events confirm this topic is an immediate priority for policymakers and CMS, and will soon be brought to NQF's floor for debate. KCQA's goal is to be at NQF's table alongside CMS during the deliberative processes to ensure the community's voice is heard.

Workgroup Charge

Dr. McGonigal indicated that over the next 4-6 weeks the Home Dialysis Workgroup will first identify 1-3 home dialysis utilization measure concepts for Steering Committee approval, and from there will develop measure specifications (numerator, denominator, exclusions) and make recommendations on risk adjustment and/or stratification approaches (if deemed necessary). Of these, the KCQA body will select 1 (or 2 related) measure(s) for empiric testing for the purpose of submitting to NQF for endorsement consideration.

Workplan and Timeline

Dr. McGonigal next reviewed the detailed Home Dialysis Workplan and Timeline, noting that it is essential for the Workgroup to proceed expeditiously for KCQA to meet anticipated deadlines; the

fully specified measures must be available no later than mid-August. She reviewed the overall, high-level workflow, as follows:

1. **Meeting 1: Identify Candidate Concepts.** The Workgroup's first meeting will focus on the identification of 1-3 home dialysis utilization measure concepts for the Steering Committee's consideration. To facilitate this process, Dr. McGonigal indicated that staff conducted an Environmental Scan of public sources, grey and international literature, and KCQA's dialysis organization members to identify existing measures. Staff also crafted a measure "prototype" to be used as a starting point for the group's deliberations.
2. **Meeting 2: Define Measure Specifications.** For the second meeting (date July 16), Dr. McGonigal noted the Workgroup will identify a preliminary numerator, denominator, and exclusions for the approved concept(s) for Steering Committee consideration.
3. **Meeting 3: Assess Need for Risk Adjustment/Stratification.** For each Steering Committee-approved preliminary measure, the Workgroup will in its third meeting (TBD) finalize the measure specifications and consider and make recommendations on the need for risk adjustment and/or stratification to appropriately address clinical and social risk variables. Dr. McGonigal informed the Workgroup that it is not expected to be involved in the *development* of a risk model, but will rather generate recommendations on a measure's perceived *need* for adjustment and/or stratification, as well as potential variables for consideration. She noted that NQF's recently released [recommendations](#) on risk modeling for social and functional-related risk will be used for guidance in this regard. Upon completion, the Workgroup's risk adjustment/stratification recommendations will be advanced to the Steering Committee for review and approval and, subsequently, to KCQA's Methodologist to inform his work.
4. **Meetings 4 and 5: Finalize the Measure(s).** To complete its charge, the Workgroup will in its fourth (TBD) and fifth (if needed) meeting(s) make any final revisions to the measure specifications and risk adjustment/stratification recommendations. The resulting completed measures will then be reviewed by the Steering Committee and full KCQA for approval to advance to the measure testing phase of the project, which will take place in the fall.

At this point (mid-August), Dr. McGonigal indicated that the KCQA Home Dialysis Workgroup will adjourn, but may be asked to weigh in on any issues that arise during measure testing this fall. Like Steering Committee and KCQA members, the Workgroup may also be asked to review the NQF submission materials (anticipated date December 2021); however, by virtue of its involvement in identifying importance, reviewing evidence, and assisting with testing design, the Workgroup will in fact have reviewed much of the information piecemeal prior to this stage.

NQF ENDORSEMENT CRITERIA

Next, Dr. McGonigal reminded the Workgroup that the KCQA initiative was launched with the express purpose of identifying facility-level measures for NQF endorsement. As such, she noted that it is critically important that the Workgroup keep the five NQF criteria in mind as it considers candidate concepts and then measure specifications:

1. **Importance to Measure and Report (Evidence).** The extent to which:
 - a. the measure focus is evidence-based;
 - b. the measure focus is important to making significant gains in healthcare quality; and
 - c. there is variation in or overall less-than-optimal performance.
2. **Scientific Acceptability of Measure Properties.** The extent to which the measure would produce consistent (reliable) and credible (valid) results related to quality of care.
3. **Feasibility.** The 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.

4. **Use and Usability.** The extent to which potential audiences (e.g., patients, providers, purchasers, policymakers) could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.
5. **Comparison to Related or Competing Measures.** If a measure meets the above criteria and there are endorsed or new related and/or competing measures, the measures are compared to address harmonization and/or selection of the best measures.

Dr. McGonigal indicated that each NQF criterion has several sub-criteria, as summarized in detail on NQF's [website](#), but noted that Workgroup members are not expected to be experts in the NQF evaluation criteria and sub-criteria. However, KCQA staff are likely to refer to them during the Workgroup's deliberations and query Members as to relevancy of x, y, or z to meeting the criteria. She also reminded the Workgroup that its efforts during the first meeting focusing on measure concepts will necessarily address NQF Criterion 1 (Importance/ Evidence) and, to a lesser degree, Criterion 3 (Feasibility). Other criteria will be teed-up by staff, as pertinent, throughout the remaining meetings.

ENVIRONMENTAL SCAN

Dr. McGonigal next reviewed the Environment Scan, indicating that it is intended to serve two purposes: To inform the Workgroup on what home dialysis utilization measures and measure concepts already exist and are in use, and to spark Workgroup members' creativity for their brainstorming session. She noted that the document sets forth the 40 unique¹ home dialysis utilization measures/measure concepts identified through a review of public sources, grey and international literature, and a survey of KCQA member dialysis organizations for applicable measures being used internally for quality improvement. Dr. McGonigal indicated that as anticipated, many identified metrics are similar, with the majority being variations on one of three overarching themes:

1. Simple rate measures, such as *Overall Home Dialysis Rate, Incident [or Prevalent] Home Dialysis Rate; Overall Peritoneal Dialysis Rate, etc.*
2. Modality "switch" measures with a specified timeframe—for instance, *Percent of In-Center Patients Who Transitioned to Home Dialysis within X Days/Weeks/Months of Dialysis Initiation.* (Notably, CMS/UM-KECC is proposing use of modality switch rate as a proxy for effective patient education within the facility.)
3. Retention/attrition measures; e.g., *Home Dialysis Exits at X Months, Home Dialysis Attrition Due to Technique Failure.*

Despite the commonalities, however, Dr. McGonigal indicated that there are nuanced but substantive variations in the measure details that the Workgroup may find useful to facilitate brainstorming.

HOME DIALYSIS UTILIZATION MEASURE PROTOTYPE

Dr. McGonigal next reviewed the prototype measure drafted by staff for the Workgroup's consideration and to be used as a starting point for the Workgroup's deliberations. She informed the Workgroup that the prototype was not intended to be prescriptive or to push the Workgroup towards a particular measure or measure type, but rather to stimulate discussion, kick off the consensus process, and to allow the group to visualize what a "finished" measure in this area might look like.

IDENTIFICATION OF TOP 1-3 MEASURE CONCEPTS

The Workgroup spent the majority of the first meeting brainstorming to identify its top 1-3 home dialysis utilization measure concepts for advancement to the Steering Committee for consideration. The Environmental Scan, Measure Prototype, NQF's Importance/ Evidence Criterion, and Workgroup

¹ Redundant metrics were eliminated; e.g., if a KCP organization is using a USRDS metric to track internal quality, we did not list the measure twice.

members' own insights and expertise informed this discussion. Three candidate measure concepts were identified by the Workgroup, summarized in the following section.

DISCUSSION

The three measure concepts identified by the Workgroup are described below, along with a brief summary of the discussion and decisions for each.

Concept 1: Rate + retention measure addressing all (incident + prevalent) home dialysis patients.

- *Discussion Points:*
 - Workgroup members agreed that retention/attrition should be captured as a component of the KCQA measure(s) to dissuade prescription of home dialysis to patients who may not be good candidates for the modality. The Workgroup recognizes that any amount of time on home dialysis is important and meaningful to patients, but agreed that defining some retention period is vital to appropriately balance any perverse pressure providers may feel as a result of the measure(s) to prescribe the modality when they might otherwise not do so.
 - Workgroup members were not in agreement, however, what the appropriate "retention" timeframe should be. Staff proposed 6 months in the prototype measure, but some Workgroup members expressed concern that too long a retention period would discourage home dialysis attempts in all but the most ideal patients. Some tentatively suggested 3 months as a reasonable period in a measure addressing both incident and prevalent patients. Dr. McGonigal noted that there is no existing evidence to support this—or any—decision on an "appropriate" retention timeframe; this is an instance in which "expert opinion" will ultimately serve as the basis of the recommendation.
 - There was consensus among the Workgroup that requiring consecutive months on home dialysis will discourage attempts to meet the retention criterion cumulatively through sporadic, repeated starts in potentially inappropriate candidates.
 - Some Workgroup members voiced belief that the greatest potential for dramatic improvements in this aspect of care lies with the incident population, and that including prevalent patients will dilute the impact of the measure. Others argued there is considerable room for improvement with the prevalent population, as well; as the underlying intent of the measure is to increase utilization of home dialysis, the exclusion of prevalent patients is necessarily contradictory that goal. Ultimately, the Workgroup tentatively came to consensus that both patient groups should be addressed in any home dialysis utilization measure (or measure set) put forth by KCQA.
 - Although definitions vary, in its preliminary discussions the Workgroup tentatively defined "incident" patients as those in their first year of dialysis. This is consistent with both CMS's proposed definition in its forthcoming home dialysis measure and (largely) USRDS methodologies.
 - All members agreed both peritoneal and home hemodialysis should be addressed in the KCQA home dialysis measure(s).

Concept 2: Separate rate and retention measures, each addressing all (incident + prevalent) patients.

- *Discussion Points:*
 - Some Workgroup members suggested Concept 1 would better be split into two distinct but complementary metrics—a home dialysis rate measure balanced with a separate retention measure—to simplify data collection and measure implementation. Concept 2 is thus, in effect, Concept 1 divided into distinct rate and retention metrics.

- The measure set would again address all patients (incident and prevalent), both peritoneal and home hemodialysis, and would employ a “consecutive months” construct. The appropriate retention was again not explicitly yet defined by the Workgroup, with options of 3 and 6 months being suggested for consideration.

Concept 3: Separate rate + retention measures, by dialysis duration.

- *Discussion Points:*
 - Some Workgroup members suggested addressing incident and prevalent patients separately might be a better approach, the underlying rationale being that the two populations are intrinsically different and having a distinct measure for each would allow for a more nuanced assessment of—and more precise and effective interventions in response to—performance.
 - Again, it was noted that the greatest potential for dramatic improvements in home dialysis utilization is with the incident population. A measure specifically targeting this population would allow the community to “push the needle” to achieve greater gains in utilization at dialysis outset. However, as there is also considerable room for improvement with the prevalent population, a separate measure addressing this population would incentivize gains in this patient group, as well.
 - Here, because the two populations would be handled separately, the Workgroup believed there is also room for a more nuanced consideration of the retention timeframes. As such, the group agreed that the incident population measure would benefit from a briefer retention requirement to avoid the unintentional creation of additional barriers to a trial of home dialysis in new patients; a definitive retention timeframe was not identified, but 2-3 months was tentatively suggested. Conversely, the Workgroup believes a longer retention timeframe would be appropriate for the prevalent population, to help minimize pressure providers may feel to push long-standing in-center patients towards a modality they may not want or may not be compatible with their current psychosocial circumstances. However, the Workgroup indicated it would like to have additional discussion around this point in future meetings.

Other Discussion Points

The Workgroup also noted the following in its deliberations:

- The greatest opportunity for improving home dialysis utilization is during the pre-dialysis phase of care. Early patient education is critical to improving home dialysis uptake, and “upstream” efforts will necessarily have the most substantial impact on this aspect of care.
- Not all patients are appropriate candidates for home dialysis; any measure generated through these efforts must consider what home dialysis rates truly should be and should strive to define what “success” looks like for the measure. These considerations could be addressed through the identification and recommendation of benchmarks, for instance.
- It must be acknowledged that a patient’s decision for home dialysis is complex and requires consideration of clinical, socioeconomic, and psychosocial factors. Even under “ideal” circumstances, and despite the fact that 70-80% of patients have no medical or social contraindications, many patients will “fail” a trial of home dialysis. A measure in this area must not be so punitive as to prohibit providers from encouraging their patients to consider this life-changing and underutilized modality. The goal should be to encourage maximum offering of home dialysis. (Staff noted that “failure” could be addressed through defining benchmarks for the measure(s) and will be explored in subsequent meetings.)
- Any measure in this area must appropriately and effectively account for both “home dialysis only” facilities/groups and organizations that do not currently offer home dialysis.

- Nursing home dialysis must also be appropriately handled by the measure(s). This has generally been identified as an exclusion in ongoing work in this area, but the Workgroup is not certain it need be handled this way. The measure should strive to incentivize dialysis facilities to assist nursing homes in this regard.
- The Workgroup acknowledged that the pediatric population is quite distinct in terms of home dialysis. Currently, one-third of pediatric patients receive care in “adult” units. One-half of all pediatric ESRD patients are already on home dialysis, with most starting treatment on peritoneal dialysis. Wait-time for transplant is also significantly shorter than in the adult population.

PUBLIC COMMENT

There were no public comments.

NEXT STEPS

Dr. McGonigal concluded the meeting by reviewing next steps:

- The Steering Committee will meet on July 7 to review and approve the selected candidate measure concepts.
- Staff will complete its assessment of existing EQRS data elements and will draft measure specifications and measure calculation algorithm(s) for all Steering Committee-approved concepts to inform the Workgroup’s feasibility discussion during its next meeting.
- The Home Dialysis Workgroup will reconvene July 16 to identify measure specifications for the approved concept(s).

KIDNEY CARE QUALITY ALLIANCE

HOME DIALYSIS WORKGROUP MEETING 2 SUMMARY JULY 16, 2021

Attendees: Bryan Fore; Emiliya Kechker; Rajnish Mehrotra MD, MS; Donna Painter MS, RN, CNN; Rebecca Schmidt DO, FACP, FASN; Eric Weinhandl PhD; Kathy Lester JD, MPH; Lisa McGonigal MD, MPH

Not Present: Vanessa Evans; Avram Traum MD

MEETING SUMMARY

After welcoming remarks and roll call, Dr. McGonigal reviewed the meeting agenda. The Workgroup then reviewed staff's summary of its Meeting 1 discussion/decisions and Steering Committee input on its three recommended Home Dialysis Measure Concepts. The Workgroup also considered three draft candidate measures developed by staff through a synthesis of the Workgroup's and Steering Committee's prior decisions:

- **Measure 1:** Single rate + retention measure addressing all (incident and prevalent) patients.
- **Measure 2v1:** Separate rate and retention measures, each addressing all (incident + prevalent) patients.
- **Measure 2v2:** Separate rate and attrition measures, each addressing all (incident + prevalent) patients.

The group's discussion and decisions are summarized below.

Meeting 2 Decisions Summary:

- The KCQA home dialysis measure(s) will address both incident and prevalent patients.
- The measure(s) will include pediatric patients.
- The level of analysis will be aggregated by parent dialysis organization within an HRR.
- The measure(s) will use a patient-months construction.
- The Workgroup agreed to continue development of Measure 1 and Measure 2v1.

General Discussion Points:

- The Workgroup cautioned against use of the word "retention." Retention is a concept applicable to the incident population; "utilization" is a more appropriate concept when considering prevalent patients.
- The Workgroup debated eliminating the counterbalancing retention component altogether, with several indicating that "over-prescription" of home dialysis is not a significant issue at this time. Conversely, others felt that there is now a sufficiently intense focus on achieving monthly home dialysis goals that some minimum "guardrail" should be included to prevent indiscriminate prescriptions. It was also noted that patient retention reflects the ability of the facility to properly prepare and train patients, and some again advocated for a three-month requirement. Ultimately, the Workgroup tentatively agreed to a one-month retention period¹² for Measure 1, but cautioned that the more "guardrails" we construct in a measure, the less successful we will be at maximizing home dialysis utilization. The Workgroup again stressed that the goal should be to encourage maximum offering of home dialysis and that the

¹ While the Steering Committee cautioned against defining a retention period of two months or less because home hemodialysis training may take up to two months to complete, the Workgroup disagreed, noting that the vast majority of home patients are on peritoneal dialysis, which has a typical training period of only two weeks.

² CMS also defined "retention" as 30 days in its home dialysis switch measure currently in development.

measure(s) must not set so high a bar as to prohibit providers from encouraging patients to consider home modalities. Likewise, the measure should not create a scenario wherein, once started, providers feel pressured to keep patients on home dialysis to meet the time criterion after it is discovered the modality is not appropriate or is no longer desired by the patient. It was again acknowledged that many patients will “fail” a home dialysis trial. As a potential alternative to the retention component, the Workgroup will consider how to identify patients who are not well-suited for home modalities when it discusses exclusions on its next call.

- The Workgroup also noted that because of coding idiosyncrasies, differentiating the training period from the “official” home start date with any accuracy would only be possible in Medicare FFS patients; the group will turn its attention to a decision on which payer populations should be included in the measure and the implications of that decision in a later meeting.
- The Workgroup agreed with the Steering Committee that because many facilities do not currently offer home dialysis (and some offer only home dialysis), the appropriate level of analysis for the measure(s) is not the individual facility, but rather an aggregate of performance scores across providers. Specifically, the group considered aggregating scores across localities (agnostic of parent company) and across parent organizations within an HRR or HSA. The group agreed that aggregating by parent company within a defined HRR, similar to the mechanism used in the ETC Model, is the most feasible and would allow for a more seamless uptake of the measure(s) if endorsed and adopted by the federal programs. It was noted that some units within a given HRR are independent; it was agreed that examining the ETC Model’s approach to this issue would be examined prior to the next call for further discussion on how best to handle such facilities. It was also noted that some HRRs are situated within a home dialysis “desert,” which will necessarily adversely impact facilities’ performance; the group agreed to consider weighting as a potential means of addressing this issue on a later call.
- The Workgroup agreed with the Steering Committee that a patient-months construction will be used to account for patients’ variable time contributions to the denominator and numerator.
- The Workgroup noted that as a home dialysis rate of 100% is not achievable for the vast majority of providers, performance improvement must be a consideration for the measure(s); the group will turn its attention to defining achievement and improvement benchmarks and recommended scoring schema in a later meeting.
- The Workgroup agreed with the Steering Committee that home dialysis “interruptions” must be appropriately defined and accounted for. The Workgroup will consider on its next call if there is an effective manner in which this issue can be appropriately captured through exclusions.
- The measure(s) will address both incident and prevalent patients.
- The measure(s) will include pediatric patients, noting this is a relatively small population that will not likely impact scores appreciably. Inclusion will reinforce the already substantial use of home modalities in pediatric patients; exclusion would disadvantage facilities with larger pediatric populations.
- The Workgroup noted again that nursing home dialysis must be appropriately handled. This has generally been identified as an exclusion in other work in this area, but Workgroup wishes to consider all options in this regard during its next discussion.
- The Workgroup agreed to continue development of Measure 1 and Measure 2v1, and abandoned Measure 2v2:
 - Measure 1 is the single rate + retention measure addressing all (incident and prevalent) patients. The Workgroup agreed the metric is simple, straight-forward, and if developed properly, can provide a balanced measure that will appropriately

incentivize HD uptake. The Workgroup tentatively agreed to a one-month retention timeframe (see above), but will revisit on Wednesday.

- Measure 2v1 is the measure set consisting of a separate rate and retention measure, each addressing all (incident + prevalent) patients. The Workgroup agreed the two measures used together would prove more informative and actionable than HD-1 as they would allow for separate analyses of performance as well as for targeted interventions for both uptake and retention. Here the Workgroup tentatively agreed that a longer timeframe (e.g., three months) might be appropriate for the retention measure because the rate measure (Measure A) would independently serve to drive increased utilization. (Note to Workgroup: Will revisit this issue on Wednesday for additional clarification around this point.)
- Measure 2v2 was abandoned due to its complexity. (E.g., the group was uncertain if a single month off home dialysis should be sufficient to trigger a "failure," how attrition could be differentiated from HD "interruptions," and if there should be a requisite minimum time on home dialysis for inclusion in the denominator.

PUBLIC COMMENT

There were no public comments.

NEXT STEPS

Dr. McGonigal concluded the meeting by reviewing next steps:

- The Home Dialysis Workgroup will reconvene July 21 (12-2 pm ET) to identify exclusions and finalize measure specifications for the approved concept(s).

KIDNEY CARE QUALITY ALLIANCE

HOME DIALYSIS WORKGROUP MEETING 3 SUMMARY JULY 21, 2021

Attendees: Vanessa Evans; Bryan Fore; Emiliya Kechker; Rajnish Mehrotra MD, MS; Donna Painter MS, RN, CNN; Rebecca Schmidt DO, FACP, FASN; Eric Weinhandl PhD; Kathy Lester JD, MPH; Lisa McGonigal MD, MPH

Not Present: Avram Traum MD

MEETING SUMMARY

After welcoming remarks and roll call, Dr. McGonigal reviewed the meeting agenda. The Workgroup then reviewed draft specifications for the two home dialysis utilization measures prioritized for further development. The group's discussion and decisions are summarized below.

Prior Decisions:

- The KCQA home dialysis measure(s) will address both incident and prevalent patients.
- The measure(s) will include pediatric patients.
- The level of analysis will be aggregated by parent dialysis organization within an HRR. The approach will be similar to what is used in the ETC Program, in an effort to be compatible with facilities' existing organizational structure.
- The measure(s) will use a patient-months construction.
- The Workgroup agreed to continue development of Measure 1 and Measure 2v1.

Decisions for Today:

- Retention definition.
- Exclusions.
- Identification of patient population (payer).
- Handling of "orphan" facilities.

Meeting Deliverable:

- Full set (numerator, denominator, exclusions) of draft specifications for prioritized measures.

Candidate Measures:

- **Measure 1:** Rate plus retention "guardrail" measure addressing all patients (i.e., incident and prevalent).
- **Measure 2:** Separate rate and three-month retention measures, both addressing all patients.

Discussion Points:

The Workgroup agreed to focus on development of the measure set (Measure 2) to achieve consensus around the core specifications.

- **Home Dialysis Rate Measure:**
 - The Workgroup agreed a patient-months construct will be used to address patients' potentially variable time contributions to the numerator and denominator.
 - The level of analysis will be aggregated by parent dialysis organization within an HRR, similar to the approach used in the ETC Model.
 - The denominator will include incident and prevalent patients, pediatric patients, and peritoneal and home hemodialysis patients. (There is interest in considering separate PD and HHD measures in the future, but the Workgroup agreed the numbers are currently too small to allow for reliable, valid measurement in HHD; the focus of the current metric should be to drive a global increased utilization of home dialysis.)

- The measure will be inclusive of all patients, regardless of payer (i.e., not limited to Medicare patients).
 - Facilities treating <25 patients during the reporting month is a standard KCQA exclusion; the Workgroup agreed it is appropriate for this measure.
 - The Workgroup agreed that most independent “orphan” facilities (i.e., not affiliated with a parent dialysis organization) are hospital based; the Workgroup estimated there are approximately 400 such units. While the group considered that such facilities could be pulled into neighboring aggregate units, it was acknowledged that this would be a “heavy lift” to operationalize. Others noted that the facility-level exclusion for facilities with fewer than 25 patients (see below) would capture most of these units, which are typically quite small. The group ultimately agreed that these facilities should not be pulled into adjacent HRR aggregate units, noting that this is the approach also used in the ETC Program.
 - The Workgroup agreed that “home-only” facilities and organizations would be included the measures, as such an exclusion would be contrary to the goal of increased utilization. .
 - The Workgroup did not believe the proposed exclusion for transplant patients was necessary, given the small number of patients to which this would apply.
 - The Workgroup was somewhat divided on how to handle Nursing Homes and Long-Term Care Facilities (LTCFs). The majority ultimately agreed this should be an exclusion for the rationale that capturing dialysis taking place in these settings is not consistent with the intent of the measure—to shift care from the in-center setting to home. Additionally, as all NH/LTCF patients on dialysis are considered to be on “home” dialysis, the rate measure score would always be 100%. Likewise, the retention criteria would always be met except in instances of treatment cessation or death. However, some believed NHs and LTCFs should be held to the same performance measurement standards as other providers. Some also recognized the intrinsic difficulties associated with NH and LTCF dialysis and believed including this population in the denominator would further incentivize improvements in care. Steering Committee input will be sought.
 - “Transient patients” is a standard KCQA exclusion; the Workgroup agreed the exclusion is appropriate for these measures.
 - The Workgroup considered clinical diagnoses that would be contraindications to *both* home dialysis modalities; blindness and documented dementia were identified as such potential exclusions. It was noted that there are very few “absolute” contraindications to both modalities, e.g., “frailty” and lack of a caregiver are not absolute barriers.
 - The Workgroup also considered non-clinical contraindications, identifying homelessness as an exclusion for a publicly-reported performance measure upon which penalties will be based. (The Workgroup noted that homelessness is not a contraindication to home dialysis per se; rather the concern was about the appropriateness of basing penalties on establishing a successful home program in a population experience such extremen housing instability.)
- **Home Dialysis Retention Measure:**
 - The Workgroup agreed a patient-months construction will be used to address patients’ potentially variable time contributions to the numerator and denominator.
 - The Workgroup struggled with the appropriate “retention” timeframe. Some argued any retention requirement would serve as a barrier to increased home dialysis uptake. Others suggested a timeframe of 6–or even 12–months is necessary to ensure facilities are sufficiently preparing and supporting patients in the transition home. Ultimately, there was consensus that 3 months is a reasonable compromise that will promote

appropriate investment in patient support and preparation without appreciably blunting home dialysis prescription.

- The Workgroup agreed that time from the prior year will contribute to the month count to ensure all patients meeting the numerator criteria are captured.
- The Workgroup agreed with the Steering Committee that home dialysis interruptions (e.g., due to hospitalization, respite) should be differentiated from true “exits” due to treatment failure. It was noted that an “interruption” is typically ≤ 30 days and that most patients will be readmitted to the in-center facility on day 31. However, due to the time constraints, the Workgroup did not define how this data element would be captured in the measure; this will be revisited on the next call.
- The Workgroup agreed the level of analysis will be aggregated by parent dialysis organization within an HRR, similar to the approach used in the ETC Model.
- The Workgroup agreed the measure will be inclusive of all patients (i.e., not limited to Medicare patients).
- The Workgroup agreed the denominator will include incident and prevalent patients, pediatric patients, and peritoneal and home hemodialysis patients.
- There is Workgroup interest in considering separate PD and HHD retention measures in the future, given the fundamental differences between the two modalities. But the Workgroup noted that HHD numbers are currently too small to allow for reliable, valid measurement and that in the interim, 3 months is a reasonable retention period that will serve as an appropriate counterbalance to the rate measure for both modalities.
- No patient-level exclusions were specified, as only those already on home dialysis are captured in the denominator (i.e., exclusions for home dialysis need not be captured).

PUBLIC COMMENT

Ms. Nieltje Gedney from Home Dialyzers United addressed the Workgroup, emphasizing the importance of assessing home dialysis retention to offer insight to dialysis facilities on the effectiveness and success of their efforts to create a sustainable home dialysis program through their approaches to patient education, preparation, and support in the transition home. She noted that Home Dialyzers United typically advocates for a twelve-month assessment to get a full picture of these issues but acknowledged the Workgroup’s concerns about creating barriers to home dialysis with too long a retention component. She indicated she would prefer a six-month definition in the measure but would settle for three should that be where the Workgroup and Steering Committee land.

NEXT STEPS

Dr. McGonigal concluded the meeting by reviewing next steps:

- The Steering Committee will meet on Monday July 26 (2-4 pm ET) to consider the Workgroup’s recommended measure specifications.
- The Home Dialysis Workgroup will reconvene Thursday July 29 (10 am-12 pm ET) to finalize measure specifications and to generate recommendations on risk adjustment and/or stratification variables.