



Measure Information

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

Brief Measure Information

NQF #: 1421

Corresponding Measures:

De.2. Measure Title: Method of Adequacy Measurement for Pediatric Hemodialysis Patients

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services

De.3. Brief Description of Measure: Percentage of pediatric (less than 18 years old) in-center hemodialysis patients (irrespective of frequency of dialysis) for whom delivered HD dose was measured by spKt/V as calculated using UKM or Daugirdas II during the reporting period.

1b.1. Developer Rationale: The dose of dialysis is used to estimate the ability of hemodialysis to clear the blood of accumulated toxins. In the pediatric population, smaller scale observational studies support the association between delivered hemodialysis dose and patient outcomes including the potential for improved growth with intensive hemodialysis regimens.

S.4. Numerator Statement: Number of patients in the denominator for whom delivered HD dose for a single dialysis session was calculated using UKM or Daugirdas II during the reporting period and for whom the frequency of HD per week is specified.

S.7. Denominator Statement: Number of pediatric (less than 18 years old) in-center hemodialysis patients (irrespective of frequency of dialysis) in the sample for analysis.

S.10. Denominator Exclusions: Patients on home hemodialysis.

De.1. Measure Type: Process

S.23. Data Source: Other

S.26. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Aug 16, 2011 **Most Recent Endorsement Date:** Aug 16, 2011

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

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

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Pediatric HD Adequacy - Frequency of Hemodialysis Adequacy Measurement

Pediatric HD Adequacy - Minimum Target spKt/V

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

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

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

1421_Evidence_MSFS.0_Data.doc

1b. Performance Gap

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

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

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

The dose of dialysis is used to estimate the ability of hemodialysis to clear the blood of accumulated toxins. In the pediatric population, smaller scale observational studies support the association between delivered hemodialysis dose and patient outcomes including the potential for improved growth with intensive hemodialysis regimens.

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

The 2008 ESRD CPM project showed that among the random sample of 8,730 adults receiving hemodialysis, only 76% of patients had their delivered spKt/V calculated using either UKM or the Daugirdas II formula. Although this study is in the adult population, it is possible that similar findings may be observed in the pediatric ESRD population.

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

The 2008 ESRD CPM project can be found using the link below:
www.cms.hhs.gov/CPMProject.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

In the North American Pediatric Renal Transplant Cooperative Study (NAPRTCS), monthly hemodialysis adequacy data were analyzed from 138 children from 32 centers. Multivariate modeling indicated that after adjusting for body surface area and lack of any Kt/V center measures, the mean Kt/V dose was significantly higher among females compared to males ($\beta=0.13$, $p<0.05$) and among Nonblack patients compared to Black patients ($\beta=0.22$, $p<0.001$).

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

Leonard MB, et al. Racial and center differences in hemodialysis adequacy in children treated at pediatric centers: a North American Pediatric Renal Transplant Cooperative Study (NAPRTCS) report. J Am Soc Nephrol. 2004 Nov;15(11):2923-32

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

The measure addresses:

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

1c.1. Demonstrated high priority aspect of healthcare

Frequently performed procedure, Severity of illness

1c.2. If Other:

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

The incidence and prevalence rates of pediatric ESRD continue to increase with 7209 pediatric patients with ESRD in 2007 [1]. Although the majority of these patients are managed with kidney transplantation, approximately 2000 pediatric patients receive maintenance dialysis. Data also reveal that the five-year survival among pediatric patients receiving maintenance dialysis has not improved [1], demonstrating the need to improve the quality of dialysis care in this fragile patient group, particularly since no dialysis quality measures have been in place for the pediatric ESRD population. Finally, improving patient outcomes in pediatric

patients is a priority particularly since the cost of care for a pediatric ESRD patient is markedly higher than for an adult patient [2].

The dose of dialysis is used to estimate the ability of hemodialysis to clear the blood of accumulated toxins. In the adult population, outcome studies have shown an association between dose of hemodialysis in terms of small solute removal and clinical outcomes [3,4]. No equivalent large scale clinical trials have been conducted in the pediatric hemodialysis population but smaller scale observational studies support the association between delivered hemodialysis dose and patient outcomes [5] including the potential for improved growth with intensive hemodialysis regimens [6,7].

Various methods for estimating urea clearance (Kt/V) were considered. Firstly, the second generation natural logarithmic (Daugirdas II formula) has been shown to approximate Kt/V obtained from formal urea kinetic modeling [8-10]. In addition, data from a single-center pediatric study showed that calculation of $spKt/V$ using urea kinetic modeling (UKM) or Daugirdas II was reliable [11]. The use of an equilibrated two-compartment model eKt/V was also evaluated. Although eKt/V has some advantage over $spKt/V$ in that it takes into account urea rebound, data suggest a low rate of $spKt/V$ and eKt/V discordance (defined as $spKt/V > 0.2$ higher than eKt/V) [12]. The use of standardized Kt/V was considered but not accepted due to potential difficulty in interpreting this metric as it is currently not widely used in patients receiving less than five times weekly hemodialysis. Surface area normalized Kt/V [13] was also considered but not included in the measure because this has not been studied in the pediatric population, and the implications of its use including the need for more frequent and intensified dialysis may not be feasible. Finally, the use of $spKt/V$ as calculated using formal urea kinetic modeling or the Daugirdas II formula is consistent with clinical practice guidelines in the pediatric population, as well as with the clinical performance measures in the adult population.

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

1. U.S. Renal Data System, USRDS 2009 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2009.
2. Michael Leavitt, Secretary of Health and Human Services. A Design for a Bundled End-stage Renal Disease Prospective Payment System, Report to Congress, 2008.
3. Lowrie EG, et al. Effect of the hemodialysis prescription of patient morbidity: report from the National Cooperative Dialysis Study. *N Engl J Med* 305:1176–1181, 1981.
4. Owen WF Jr, et al. The urea reduction ratio and serum albumin concentration as predictors of mortality in patients undergoing hemodialysis. *N Engl J Med* 329:1001–1006, 1993.
5. Gorman G, et al. Clinical outcomes and dialysis adequacy in adolescent hemodialysis patients. *Am Journal Kidney Dis*; 47: 285-93, 2006.
6. Fischbach M, et al. Intensified and daily hemodialysis in children might improve statural growth. *Pediatr Nephrol* 21:1746–1752, 2006.
7. Tom A, et al. Growth during maintenance hemodialysis: impact of enhanced nutrition and clearance. *J Pediatr. Apr*;134(4):464-71, 1999.
8. Daugirdas JT, Greene T, Depner TA, Gotch FA, Star RA: Relationship between apparent (single-pool) and true (double-pool) urea distribution volume. *Kidney Int* 56:1928-1933, 1999.
9. Depner TA: Multi-compartment model, in *Prescribing Hemodialysis: A Guide to Urea Modeling*. Boston, MA, Kluwer, pp 91-126, 1999.
10. Daugirdas JT: Second generation logarithmic estimates of single-pool variable volume Kt/V : An analysis of error. *J Am Soc Nephrol* 4:1205-1213, 1993.
11. Goldstein SL, Brewer ED. Logarithmic extrapolation of a 15-minute postdialysis BUN to predict equilibrated BUN and calculate double-pool Kt/V in the pediatric hemodialysis population. *Am J Kidney Dis: the official journal of the National Kidney foundation* (2000) 36:98-104.
12. Goldstein SL, Brem A, Warady BA, et al. Comparison of single-pool and equilibrated Kt/V values for pediatric hemodialysis prescription management: analysis from the Centers for Medicare & Medicaid Services Clinical Performance Measures Project. *Pediatric nephrology* (Berlin, Germany) 21:1161-6, 2006.
13. John T. Daugirdas, Melisha G. Hanna, et al. Dose of dialysis based on body surface area is markedly less in younger children than in older adolescents. *American Society of Nephrology*, (2010 in press).

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

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

Renal : End Stage Renal Disease (ESRD)

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

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

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

Attachment:

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

URL Attachment:

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

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

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

Number of patients in the denominator for whom delivered HD dose for a single dialysis session was calculated using UKM or Daugirdas II during the reporting period and for whom the frequency of HD per week is specified.

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

The entire calendar month.

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

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

The numerator will be determined by counting the patients in the denominator for whom Kt/V “Hemodialysis Method” is ‘Daugirdas II’ OR ‘UKM’.

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

Number of pediatric (less than 18 years old) in-center hemodialysis patients (irrespective of frequency of dialysis) in the sample for analysis.

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

Children

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

The patient's age will be determined by subtracting the patient's date of birth from the first day of the reporting month. In-center hemodialysis patients are defined as follows: "Admit Date" to the specified facility is prior or equal to the first day of the study period, AND the patient has not been discharged ("Discharge Date" is null or blank), OR "Discharge Date" from the facility is greater than or equal to the last day of the study period AND "Treatment Dialysis Broad Start Date" is prior or equal to the first day of the study period, AND "Dialysis Broad Type of Treatment" = 'HD', AND "Primary Dialysis Setting" = 'Dialysis Facility/Center' on the last day of the study period, AND "Date Regular Chronic Dialysis Began" is prior to the first day of the study period. The denominator will include all patients <18 years old who are determined to be in-center hemodialysis patients.

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

Patients on home hemodialysis.

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

See denominator exclusions.

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

No stratification is required for this measure.

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

No risk adjustment or risk stratification

If other:

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

N/A

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

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

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

S.16. Type of score:

Rate/proportion

If other:

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

Better quality = Higher score

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

adjustment; etc.)

The patient's age will be determined by subtracting the patient's date of birth from the first day of the reporting month. In-center hemodialysis patients are defined as follows: "Admit Date" to the specified facility is prior or equal to the first day of the study period, AND the patient has not been discharged ("Discharge Date" is null or blank), OR "Discharge Date" from the facility is greater than or equal to the last day of the study period AND "Treatment Dialysis Broad Start Date" is prior or equal to the first day of the study period, AND "Dialysis Broad Type of Treatment" = 'HD', AND "Primary Dialysis Setting" = 'Dialysis Facility/Center' on the last day of the study period, AND "Date Regular Chronic Dialysis Began" is prior to the first day of the study period. The denominator will include all patients <18 years old who are determined to be in-center hemodialysis patients.

The numerator will be determined by counting the patients in the denominator for whom Kt/V "Hemodialysis Method" is 'Daugirdas II' OR 'UKM'.

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

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

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

N/A

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

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

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

Required for Composites and PRO-PMs.

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

If other, please describe in S.24.

Other

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

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

CROWNWeb

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

URL

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

Facility

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Post-Acute Care

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

1421_MeasureTesting_MSF5.0_Data.doc

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

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

3b. Electronic Sources

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

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

Yes

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

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

Attachment:

3c. Data Collection Strategy

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

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

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

Because data elements required for this measure are already being collected as part of the ESRD CPM, facilities are familiar with data required for this measure. This reduces the likelihood of errors in the data collection process.

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

4. Usability and Use

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

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are

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

4.1. Current and Planned Use

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

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement (Internal to the specific organization)	

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

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

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

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

4b. Improvement

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

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

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

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

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

4c. Unintended Consequences

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

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

Data elements for this measure are already being collected and are unlikely to be susceptible to inaccuracies, errors or unintended consequences.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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

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

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications completely harmonized?

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

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

This measure is for pediatric (<18 years) patients only. The NQF endorsed measure is for patients ≥18 years old.

Related Measures: NQF # 0248ESRD- HD Adequacy CPM II: Method of measurement of delivered hemodialysis dose.

Appendix

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

Attachment:

Contact Information
<p>Co.1 Measure Steward (Intellectual Property Owner): Centers for Medicare & Medicaid Services</p> <p>Co.2 Point of Contact: Corette, Byrd, MMSSupport@Battelle.org, 202-786-1158-</p> <p>Co.3 Measure Developer if different from Measure Steward: Centers for Medicare & Medicaid Services</p> <p>Co.4 Point of Contact: Thomas, Dudley, Thomas.Dudley@cms.hhs.gov, 410-768-6738-</p>
Additional Information
<p>Ad.1 Workgroup/Expert Panel involved in measure development Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. Dr. Bradley Warady, panel chair (University of Missouri, Kansas City School of Medicine, Kansas City, MO) Dr. Carolyn Abitbol (University of Miami, Holtz Children's Hospital, Miami, FL) Dr. Eileen Brewer (Baylor College of Medicine/Texas Children's Hospital, Houston, TX) Dr. Stuart Goldstein (Baylor College of Medicine/Texas Children's Hospital, Houston, TX) Dr. Alicia Neu (Johns Hopkins Medical Institution, Baltimore, MD) Dr. Irene Restaino (Children's Hospital of The King Daughters, Norfolk, VA) Dr. Douglas Silverstein (Children's National Medical Center, Washington, D.C.) Dr. Sylvia Ramirez, Moderator (Arbor Research Collaborative for Health) Alissa Kapke, Analyst, (Arbor Research Collaborative for Health) Jeffrey Pearson, Analytical Manager, (Arbor Research Collaborative for Health)</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: Ad.3 Month and Year of most recent revision: Ad.4 What is your frequency for review/update of this measure? Three years Ad.5 When is the next scheduled review/update for this measure? 2013</p>
<p>Ad.6 Copyright statement: Ad.7 Disclaimers:</p>
Ad.8 Additional Information/Comments: