Performance Measurement in Nephrology Practice

Background

In order to understand the use of performance measures and other quality benchmarks in nephrology, it is essential to identify and assess the external environmental forces and other factors that influenced how these concepts have evolved. Accordingly, this document discusses the history of performance improvement efforts in the United States (U.S.), the key organizational players in this arena and their roles, and how the changing health care landscape may impact performance measures related to nephrology care. To provide a greater understanding of the status of performance measurement activities in kidney care, RPA maintains an online resource (www.renalmd.org/page/physiciandevelopment) that encapsulates all of the national programs that have a role in nephrology performance measurement. This document informs the nephrology practitioner about these issues amidst the evolving linkage between reimbursement for health care services to information reporting and performance in both the public and private sectors.

History of Performance Improvement

Performance improvement in health care has evolved in recent decades. Methods for providing quality assurance (QA) in health care were used for decades, mainly in hospitals, to detect deficiencies in care delivery and to compel providers of services to make improvements. QA can be broadly defined as intervening on a case-by-case basis in outlier patients, as opposed to quality improvement (QI) which entails intervening in a system of care involving a population of patients. Unfortunately, application of QA principles did little to reduce variation in processes of care or to systematically improve outcomes. Subsequently, two developments in this area served to advance the process. First, in what would become a dominant paradigm in describing quality in health care organizations, Donabedian published work in the early 1960s that differentiated structural, process and outcomes measurements. Secondly, in the 1970s the term “health services research” came into the public domain based on work that showed the tremendous variation in practice patterns and outcomes in U.S. health care. As a result, payers, patients and other groups began to raise questions concerning quality and safety in health care, issuing demands for data collection and reporting to demonstrate competency by providers and health care organizations.

Accrediting organizations, including the National Committee for Quality Assurance (NCQA), and The Joint Commission (JC), both adapted to this demand for increased accountability. In 1979 JC created its Quality Assurance Standard, leading to more data collection and analysis by hospitals. Building on the work of Shewhart (who emphasized reduction in
variation in processes and a focus on customer needs), the work of Deming and others helped the manufacturing industry apply measurement in ways that improved quality in production. In 1993 Berwick founded the Institute for Healthcare Improvement (IHI) in an effort to translate these concepts and techniques from manufacturing into medical care. Subsequently, Betaldin and Nelson developed methods for health care providers to organize data and report this information in ‘dashboards’ for comparative purposes that could lead to ongoing improvements.

In 1999 the National Quality Forum (NQF) was founded with the mission of leading national collaboration to improve health and healthcare quality through measurement. NQF is a nonprofit, nonpartisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement. It convenes multiple interdisciplinary stakeholder working groups to review and endorse quality performance measures, set key priorities and related measures for improving the nation’s health, serve as a major driving force for and facilitator of continuous quality improvement (CQI) in American healthcare quality, and ensure that consistent, high-quality performance information is publicly available. These working groups leverage NQF’s rigorous process of measure review and endorsement with formal criteria for measure importance, scientific acceptability, usability, and feasibility. Beginning in 2007, NQF’s renal interdisciplinary stakeholder steering committee has met periodically to review and endorse performance measures for kidney disease. Importantly, the majority of CMS measures go through the NQF endorsement process.

The Institute of Medicine (IOM) published *To Err is Human: Building a Safer Health System* in 1999 and in 2001 *Crossing the Quality Chasm: A New Health System for the 21st Century*. This report put forth six aims to focus on in improving health care, stating that healthcare should be safe, effective, patient-centered, timely, efficient, and equitable. The report called attention to the frequency of medical errors and suggested changes needed to reduce errors. It also detailed the state of quality in the U.S. health care system and offered suggestions for improvement, including specification of targets, adherence to evidence based medicine, use of clinical performance measures (CPMs), and the continuous monitoring of CPMs to sustain improvement. It also suggested changing reimbursement methods from the existing system based on volume-of-service to a system based on value-of-service.

Key legislative activities mirrored these societal and health care changes. In 1982 the Tax Equity and Fiscal Responsibility Act (TEFRA) was passed by Congress, allowing the government to place cost-per-case limitations on Medicare services, which in turn led to the Diagnosis Related Group (DRG) system and a great expansion of data collection activities. In the mid-1980s state data systems evolved, and two states even began collecting physician specific outcomes data. In 1989 the Omnibus Reconciliation Act resulted in the creation of the then-Agency for Health Care Policy and Research—AHCPR—now the Agency for Health Care Research and Quality (AHRQ) to address concerns about the variability and effectiveness of health care practices and services. AHRQ subsequently formulated principles for developing clinical practice guidelines (CPGs) and clinical performance measures (CPMs). Other major legislative initiatives that advanced performance measurement efforts include:
• The National Technology Transfer and Advancement Act (NTTAA) of 1996, which established the National Voluntary Consensus Standards process under which individual measures in health care become endorsed for public use.

• The Balanced Budget Act of 1997, which required CMS to develop and implement a method to measure and report the quality of renal dialysis services under the Medicare program. This led to the ESRD CPM Project.

• The Medicare Modernization Act of 2003, which directed the IOM to examine specific aspects of the quality improvement infrastructure, leading to its publication of the Pathways to Quality Health Care series. The first of those three reports focused on performance measurement.

• The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which linked achievement of CPM benchmarks to reimbursement for the first time.

• The Health Information Technology for Economic and Clinical Health Act (HITECH Act), enacted under Title XIII of the American Recovery and Reinvestment Act of 2009, included the provisions for Meaningful Use.

• The Patient Protection and Affordable Care Act of 2010 (PPACA, more commonly known as the ACA, or Obamacare), which extended or adjusted the linkage of payment to “never events” occurring in hospitals, set a modifier under the physician fee schedule for payment for “quality of care furnished” and incented the physician quality reporting system (PQRS). The law also specified quality measure development prioritization, funding, subcontracting, and mandated transparency. PPACA also created the Center for Medicare and Medicaid Innovation (CMMI) within CMS to explore systems of healthcare delivery and new methods of treating disease and reimbursement for healthcare while incenting improved quality and lower costs.

• The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which combined the three Medicare physician incentive programs in existence in 2015 (Meaningful Use of electronic health records, PQRS, and the Value-Based Modifier) into a single program known as the Medicare Incentive Payment System (MIPS) and also allocated $75 million for quality measure development in Medicare.

In the field of kidney disease, the most fundamental legislation was the 1972 HR-1 Act, which entitled Medicare beneficiaries to coverage for End-Stage Renal Disease (ESRD). It remains the only disease-specific entitlement program in Medicare. Since 1972, regulations promulgated under the then-Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services (CMS)) have led to significant requirements for data reporting concerning ESRD patients. The ESRD Network System was created to carry out quality data collection, collate and analyze that data, and report it to CMS. Subsequently, CMS delegated to State Survey Agencies the responsibility for monitoring and enforcing standards of care and structure within dialysis facilities. The ESRD Core Indicators Project was the first effort at collection of quality data on a national level, stratified by Network area. One of the unique aspects of nephrology’s involvement in the issues of quality improvement relates to the prescient nature of the specialties’ activities in this area over the past two decades. Nephrology’s commitment to quality measurement and quality improvement has foreshadowed not only those efforts on the part of other disciplines within organized medicine but has also guided CMS toward the development of appropriate quality measures and information systems necessary to support quality improvement. Included among the other significant milestones are:
• 1999: That project is merged with the Core Indicators Project as the ESRD CPM Project.
• 2001: CMS launches the Dialysis Facility Compare website, on which specific CPMs are regularly reported publicly, intended to inform consumers about their choices of dialysis providers.
• 2003: CMS rolls out the In-Center Hemodialysis Patient Survey (also known as the Consumer Assessment of Healthcare Providers and Systems—CAHPS survey) to pursue mandated, consumer-driven data collection activity on ESRD care.
• 2003: The Fistula First Breakthrough Initiative is launched to increase the appropriate use of AV fistulas in hemodialysis access.
• 2008: CMS issues its revised Conditions for Coverage (CfC) for ESRD facilities that, among other proposals, mandates a focus on quality management at the dialysis facility level and requires the Medical Director of each facility to organize and lead Quality Assessment and Performance Improvement (QAPI) efforts. The CfC also holds the Medical Director accountable for the quality and safety of every aspect of care in the facility.
• 2008: The Consolidated Renal Operations in a Web-based Network (CROWNWEB) becomes available for use by dialysis facilities. Section 494.1840 of the CfC required the electronic, real-time, submission of patient-specific, administrative and clinical data by facilities directly to CMS. The patient-specific data includes information on quality outcome measures which allows CMS to monitor the quality of care delivered in dialysis facilities.
• 2012: The ESRD Quality Incentive Program (QIP) establishes clinical and reporting performance measures that will be incentivized through payment withholds or reductions. This is the first disease-specific linkage of quality and payment outside of a hospital setting. CMS made public facility-specific scores on the Dialysis Facility Compare (DFC) website, and beginning in 2014, applied the payment reductions. Performance measures are updated annually through rule making.
• 2014: CMS introduces its Five-Star Ratings Program for Dialysis Facilities, under the umbrella of Dialysis Facility Compare, which seeks to implement an easily understood, consumer–friendly system to facilitate patient choice of dialysis facility.
• 2015: CMS launches a new accountable care organization (ACO) model called the Comprehensive ESRD Care (CEC) Model. Dialysis facilities, nephrologists, and other providers joined together to form ESRD Seamless Care Organizations (ESCOs) that are responsible for the cost and quality of care for aligned beneficiaries. CMS partners with health care providers in a first of its kind shared risk payment model to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. For the 2016 performance year, 13 ESCOs participated in the CEC Model. For the 2017 performance year, 24 ESCOs joined the model, for a total of 37 participating ESCOs.
While each of these initiatives has increased the focus on performance measurement, progress is often tempered by the ebb and flow of such programs, as well as the complexities of achieving changes in the face of structural, institutional, and individual resistance.

**Measure Development and Endorsement**

Development of performance measures for quality of care is an ongoing process. Measures are developed in a formal manner by groups such as CMS, AHRQ, RPA, the National Committee for Quality Assurance (NCQA), Kidney Care Partners (KCP), and others. RPA has played a lead role in the development of nephrology-specific, physician-level measures.

It is important to distinguish between clinical performance measures and clinical practice guidelines. Clinical practice guidelines are defined as recommendations for care based on expert opinion and available evidence, whose purpose is to summarize complex literature, whose focus is a comprehensive coverage of diverse aspects of care for a condition, and whose specificity is general and allows physicians to tailor recommendations to individual patient circumstances. In contrast, clinical performance measures are defined as tools to assess compliance within certain standards of clinical care whose purpose is to measure, report, and benchmark quality of care among providers. Here the focus is on essential recommendations of the highest quality of evidence with a commitment toward improved performance for the population measured.

Measures are typically categorized as structural, process, outcome or patient experience measures which are described in more detail below:

- **Structural Measures** relate to the characteristics of a health care organization or clinician related to the capacity to provide high quality health care, such as design, policies and procedures, environment, equipment, and education, certification, and experience of providers.

- **Process Measures** relate to the way actions were undertaken by a provider of health care to a patient in order to gain an intended outcome. Process measures can be informally defined as measuring what providers of health care do to patients.

- **Intermediate Outcome** measures are outcomes that while not of direct importance are closely linked to ultimate health outcomes. These measures are often milestones on the pathway to an outcome.

- **“Tightly Linked”** measures can be defined as achievement of an intermediate outcome or an appropriate response by the provider to an abnormal value.

- **Outcome Measures** are patient-centered and aimed at capturing a major change in health care status of a patient as a result of the application of a health care process
or processes. Outcomes measures can be informally defined as measuring what happens to patients.

- Patient Experience Measures relate to reports concerning observations of and participation in health care by the patient. These include measures of satisfaction with care and measures of experiences of care. Patient experience measures are essential to quality improvement efforts as they provide the patient’s perspective in relation to areas of health care quality.

Measure development is a lengthy process that usually entails field testing prior to inclusion into CMS programs. Measures usually go through the NQF endorsement process where they are evaluated by an interdisciplinary stakeholder committee according to strict criteria as defined under the National Voluntary Consensus Standards process prior to implementation by CMS for public reporting or pay for performance programs. Alternatively, under legislative authority, the NQF-convened Measure Applications Partnership (MAP) may directly endorse measures in addition to its role in advising the federal government and private sector payers on the optimal measures for use in specific payment and accountability programs.

However, CMS retains the discretion to use non NQF-endorsed measures to fill gaps in care and does so through the Merit-based Incentive Payment System (MIPS). Additionally, custom measures submitted for inclusion in CMS-approved qualified clinical data registries (QCDRs) go through a separate CMS review and approval process. Furthermore, the Secretary of Health and Human Services has the ultimate authority to veto any measure at his/her discretion. Finally, measures must be maintained, reviewed, and periodically updated. These measures may or may not be incorporated into alternate payment models (which in Medicare were also created by MACRA and are parallel to the MIPS program) but are separate and distinct entities and whose use of quality measures will be defined by the contractual arrangements within the Medicare contract.

Contributing to these complexities is the everchanging landscape of organizations participating in these efforts. Numerous groups contribute evidence, opinions, and data regarding process and performance measures that may overlap or conflict with other measure sets. For this reason, it is imperative that the provider appreciate the clinical targets, and for which program those measures apply. Not only do they have different approaches, but the organizations responsible for measure development themselves have evolved rapidly over this timeframe.

**The Role of Registries**

Registries are observational databases focused on a clinical condition, procedure, therapy, or population. Data are collected systematically for specified scientific, clinical, or policy purposes. Registries exist in numerous forms with varying intents and data sources.

The major public source of data comes from Medicare claims and data collection forms under CMS. The United States Renal Data System (USRDS), funded by the National Institute of Diabetes and Digestive and Kidney Diseases, uses CMS claims data to maintain
a national data registry of the ESRD population. The USRDS conducts analytics on disease trends, treatments, and outcomes, reporting them in an annual data report. Because of the nature of claims data, there is generally a 2-year lag in reporting results. CMS contracts with other entities to report data about facilities. The University of Michigan Kidney Epidemiology and Cost Center is one of these entities, and it produces Dialysis Facility Reports that describe summary process and outcome data at the dialysis facility level. Proprietary databases also exist, such as the databases assembled by Arbor Research Collaborative for Health to inform analyses for the Dialysis Outcomes and Practice Patterns Study. The goals of care in the current era have shifted towards patient-centered care. These registries with complete clinical, humanistic, and economic information are essential to help monitor and improve patient outcomes.

The creation of QCDRs changed the process for measure development and endorsement. In 2014 CMS announced the QCDR as a new reporting mechanism for PQRS (now MIPS) and other quality reporting programs. The QCDR is a CMS-approved entity that collects medical and/or clinical data for patient and disease tracking to foster improvement in the quality of care provided to patients. Data typically comes directly from electronic health records (EHRs) rather than claims. It also allows medical specialty societies to select and develop their own custom performance measures, rather than limiting them to those included in MIPS. Custom measures included in a QCDR are evaluated during the annual QCDR self-nomination process rather than through NQF endorsement or the MAP process. RPA launched its QCDR, the Kidney Quality Improvement Registry, in 2015.

The National Quality Registry Network (NQRN) is a voluntary network of organizations operating registries and others interested in increasing the usefulness of clinical registries to measure and improve patient health outcomes. NQRN was created in 2011 by the AMA Physicians Consortium for Performance Improvement (PCPI). RPA, along with other organizations with registries, national and state health care provider organizations, health plans and employers, and federal government representatives, participates in NQRN. This Network establishes and disseminates leading practices for registries, supports a learning platform to accelerate registry development, growth and use, and develops resources for the clinical registry community.

**Uses of Performance Measurement in Health Care**

With the ultimate goal of achieving the Triple Aim of improving the health of populations, enhancing the experience of care for individuals, and reducing the per capita cost of health care the incentive to link reimbursement to quality has intensified substantially. In March 2015, the U.S. Department of Health and Human Services (HHS) set ambitious goals of tying traditional fee-for-service Medicare payments to quality through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements. HHS also set goals of tying all traditional Medicare payments to quality or value through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs. Intended as first steps toward the goal of complete value-based purchasing of American health care, these programs have been met with mixed levels of success in reducing health care costs and improving quality performance for patients. Going forward, it is anticipated more programs will migrate from one-sided risk programs where only the payer bears the financial risk for the outcomes of the program.
toward two-sided risk models where both parties bear the financial risk for the outcome of the population attributed to that particular organization in which all models will have performance measures determining the degree of success.

**Quality Assessment and Performance Improvement (QAPI)**

QAPI emanates from CMS’ April 2008 publication of its final rule implementing revised Conditions for Coverage (CfC) for ESRD facilities as a requirement for participation in the Medicare program. The CfC state, “The dialysis facility must develop, implement, maintain and evaluate an effective, data driven, quality assessment and performance improvement program led by the facility medical director with participation by the professional members of the interdisciplinary team (IDT).” In essence QAPI is ongoing monitoring and management of quality, safety and other indicators of performance. [See RPA Position Paper on Dialysis Facility Medical Director Responsibilities under Revised CMS Conditions for ESRD Facilities and Keeping Kidney Patients Safe (https://www.renalmd.org/mpage/KKPS_home) for additional information on meeting QAPI requirements.]

**Accountability**

External reporting requirements are familiar to the nephrology community and have been a part of provider activity since the inception of the ESRD program. Much of the data reporting by dialysis providers has been directed through the Networks then, after collation and analysis, on to CMS. The implementation of CROWNWEB has for the first time required direct reporting by dialysis facilities to CMS. Outlined below are two primary ways in which performance measures are used: pay for performance and public reporting.

- Pay-for-performance has been implemented by CMS to improve quality of care and patient safety.
  - The ESRD Quality Incentive Program (QIP), as noted by CMS, is “the first of its kind in Medicare, [and] changes the way CMS pays for the treatment of ESRD patients by linking a portion of payment directly to facilities' performance on quality care measures.” CMS withholds 2 percent of total Medicare payment owed a dialysis facility from the measurement year and returns all or a percentage of the 2 percent withheld depending on a formula utilizing a “performance score” derived from a mathematical “weighting” of pre-selected performance standards, or measures. In addition, “CMS publicly reports facility ESRD QIP scores; these scores are available online on Dialysis Facility Compare.” [Also], each facility is required to display a Performance Score Certificate that lists its Total Performance Score, as well as its performance on each of the quality measures identified for that year.” At the time this paper was written, the methodology for calculating the payment withhold can be found at the following website - www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html.
  - MIPS is part of the Quality Payment Program (QPP), which emanated from the MACRA legislation. MIPS was designed to tie payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of health care information, and reduce the cost of care.
Performance is measured through the data clinicians report in four areas - Quality, Improvement Activities, Promoting Interoperability (formerly Advancing Care Information), and Cost. MIPS consolidated previous programs, including: Medicare Electronic Health Records (EHR) Incentive Program for Eligible Clinicians, PQRS, and the Value-Based Payment Modifier (VBM). Eligible providers may earn a positive, negative or neutral payment adjustment.

- Alternative Payment Models (APMs) are also part of the QPP. APMs can apply to a specific clinical condition, a care episode, or a population. In the Advanced APM track of the QPP, eligible providers may earn a 5 percent incentive for achieving threshold levels of payments or patients through Advanced APMs. For providers who achieve these thresholds, they are excluded from the MIPS reporting requirements and payment adjustment. Providers may also be in a “MIPS APM” which is not excluded from MIPS, but providers may be scored using the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM. For example, the APM scoring standard eliminates the need for MIPS clinicians to duplicate submission of Quality and Improvement Activity performance category data and allows them to focus instead on the goals of the APM.

- Maintenance of Certification (MOC) is required by the medical and surgical specialty and sub-specialty accrediting bodies such as the American Board of Internal Medicine (ABIM). Following initial certification, physicians must participate in ongoing continuous medical education in order to maintain Board certification. The activities may include practice assessment which includes areas of quality and patient safety from within one’s practice, ABIM certified CME activities and recurrent 2 year knowledge check-ins or 10 year comprehensive certifying examinations. Board certification is often required for advanced privileges at many hospitals and by payer groups. It is also required to retain privileges as a medical director in a dialysis facility. Internists and subspecialists certified in or after 1990 must renew certification to maintain their status as board certified within the ABIM.

- Public accountability (also called “public reporting”) is an increasing aspect of performance transparency on the part of dialysis providers. The goals of public reporting are two-fold: encourage consumers to make informed choices and incentivize physicians or facilities to maximize performance. Dialysis Facility Compare lists a continually increasing number of ESRD Quality Improvement Program (QIP) measures and the Physician Compare website includes whether providers take part in CMS quality improvement programs such as MIPS.

Considerations for Performance Measure Development and Use

Clinical performance measures are objective measures of health care quality, indicators of gaps in care, identify high and low performing facilities and providers, motivate and target improvements in quality of care, and monitor progress toward quality care goals. However, performance measures and their use also suffer from limitations, noted below.
• The strength of evidence underpinning certain performance measures is lacking.
• For many disease states, performance measures do not exist to cover all aspects of clinical disease management.
• Unintended consequences can result in use of performance measurement. In some cases, a measure can be improperly applied to a population in whom the measure was never vetted and negative health consequences may result. It is important to recognize that there may be legitimate exceptions to adhering to a measure. More broadly, as attention focuses on those aspects of disease management that are being measured, other important aspects of disease management that are not measured suffer from a lack of proper attention (i.e., tunnel vision). Additionally, health care providers must avoid concentrating only on measures upon which their performance is being evaluated and missing other opportunities for proper patient care.
• Gaming of the system or adverse selection may occur where service providers may employ ‘cherry picking’ or ‘lemon dropping’ to inflate their performance.
• It is possible that some measures have been inappropriately developed (e.g., not based on robust evidence), or improperly endorsed (e.g., not endorsed by accepted procedures). It is now accepted that most measures should not be used alone but rather be included in a set of measures (e.g., nephrology measure set). Measures need to be developed with methods that are evidence-based and scientifically rigorous, and then tested for reliability and validity in the appropriate population prior to endorsement. Any conflicts of interest by those participating in the development process must be disclosed for reviewers during the endorsement process.
• Measures can lose relevance or effectiveness over time. Therefore, measures, once endorsed and implemented, must be monitored and updated over time or even discarded if proven to be faulty or ineffective, or if they have “topped out” and no longer have significant room for improvement. It is essential that measures remain patient-centered, namely that when adhered to will improve health of patients.
• Performance measures often focus on an isolated episode of care. Chronic disease management is a longitudinal process; therefore, trends over time in performance measures are key.
• As noted in recent dialysis facility star ratings, some aspects of health outcomes are beyond the control of providers. Hence, performance measures characterizing such outcomes must be interpreted and used by governmental, non-governmental agencies, and consumers in a proper manner.
• Finally, performance measures may impose variable burdens of reporting on health care providers and systems.

Related to the above concerns, RPA believes that there are several critically important underlying considerations that public and private performance measurement programs must address in developing a system that links reimbursement and performance. First, it is essential to patients and providers of service that the issue of adverse risk selection, or “cherry picking/lemon dropping,” be addressed and prevented to the greatest extent possible. Second, programs should avoid any system that is based on a “one patient, one payment” principle for physician accountability. Third, RPA believes that programs must be harmonized to avoid placing an excessive burden on providers. Current measurement systems use similar measures yet have different reporting structures and timelines.
RPA urges the streamlining of the programs to allow providers to focus on the key objective of providing high quality patient care. Finally, RPA believes that special consideration must be given to the unique characteristics of the pediatric dialysis population. Children are not “little adults” and consequently, the development, evidence basis and pilot testing of guideline statements and performance measures for children must reflect the unique characteristics of their conditions and care and must be considered separately from those applied to adults.

Summary

RPA supports the use of performance measurement in nephrology practice. The wide degree of variability in practice patterns and patient outcomes that existed prior to the movement toward development of performance measures is well documented. There is a public demand for accountability as well as for continuous quality improvement that is enhanced with the use of evidence-based medicine. Similarly, the use of performance measures for public reporting and internal quality improvement are appropriate across the spectrum of nephrology practice including, but not limited to, management of CKD and transplantation. Carefully constructed clinical practice guidelines and performance measures have the potential to both provide this accountability and improve patient outcomes. The RPA’s Kidney Quality Improvement Registry will further the standards for quality nephrology care in the U.S. by empowering the specialty to develop and test measures for the discipline.

Recommendations

1. Clinical performance measures must be rigorously developed in a transparent manner.

2. Development of clinical performance measures must utilize a collaborative process that solicits and incorporates the input of diverse stakeholders and allied organizations.

3. Performance measurement programs must be harmonized to avoid placing an excessive burden or redundancy on providers. RPA urges the streamlining of the programs to allow providers to focus on the key objective of providing high quality patient care.

4. Systems that link reimbursement and performance must be true to the principles of performance measurement and specifically, prevent adverse risk selection, avoid the principle of one patient/one payment, and maintain a commitment to quality improvement.

5. The development, evidence basis and pilot testing of performance measures for children must be considered separately from those applied to adults.

6. RPA strongly encourages CMS to support specialty societies in their development of appropriate combinations of process and outcome measures.
References and Resources


National Quality Forum: http://www.qualityforum.org/

National Quality Registry Network (NQRN): https://www.thepcpi.org/page/NQRN


RPA Kidney Quality Improvement Registry: https://www.medconcert.com/content/medconcert/RPAQIR