# IT-1.17: Hemodialysis Adequacy for Pediatric Hemodialysis Patients

| **Measure Title** | **Minimum spKt/V for Pediatric Hemodialysis Patients** |
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| **Description** | Percentage of all pediatric (<18 years old) in-center hemodialysis patients who have been on hemodialysis for 90 days or more and dialyzing 3 or 4 times weekly whose delivered dose of hemodialysis (calculated from the last measurements of the month using the UKM or Daugirdas II formula) was a spKt/V greater than or equal to 1.2.  |
| **NQF Number** | 1423 |
| **Measure Steward** | Centers for Medicare and Medicaid Services |
| **Link to measure citation** | <https://www.qualityforum.org/QPS/1423>  |
| **Measure type** | Stand-alone (SA) |
| **Measure status** | P4P  |
| **DSRIP-specific modifications to Measure Steward’s specification** | None |
| **Denominator Description**  | Number of pediatric (<18 years old) in-center HD patients who have been on hemodialysis for 90 days or more and dialyzing 3 or 4 times weekly. |
| **Denominator Inclusions** | The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description. |
| **Denominator Exclusions** | Patients on home hemodialysis, patients on hemodialysis less than 90 days, patients receiving dialysis less than 3x/week or greater than 4x/week. |
| **Denominator Size** | Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)* For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
* For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
* For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
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| **Numerator Description**  | Number of patients in the denominator whose delivered dose of hemodialysis (calculated from the last measurements of the month using the UKM or Daugirdas II formula) was a spKt/V>=1.2. The numerator will be determined by counting the patients in the denominator for whom “Kt/V Hemodialysis Method” is ´Daugirdas II´ OR ´UKM´ AND “Kt/V” is greater than or equal to 1.2. |
| **Numerator Inclusions** | The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description. |
| **Numerator Exclusions** | The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. |
| **Setting** | Multiple |
| **Data Source** | Clinical data |
| **Denominator Sub-set Definition (Optional)**  | Providers have the option to further narrow the denominator population for this measure across one or more of the following domains. If providers wish to use this option, they must indicate their preference to HHSC through the measure selection process. **Payer:** Providers may define the denominator population such that it is limited to one of the following options: 1. Medicaid
2. Uninsured/Indigent
3. Both: Medicaid and Uninsured/Indigent

**Gender:** Providers may define the denominator population such that it is limited to one of the following options:1. Male
2. Female

**Ethnicity:** Providers may define the denominator population such that it is limited to one of the following options:1. White/Caucasian
2. Black/African American
3. Latino/Hispanic
4. Asian
5. American Indian/Alaskan Native
6. Native Hawaiian/Other Pacific Islander

**Age:** Providers may define the denominator population such that it is limited to an age range:Lower Bound: \_\_\_\_ (Provider defined)Upper Bound: \_\_\_\_ (Provider defined)**Comorbid Condition:** Providers may define the denominator population such that it is limited to individuals with one or more comorbid conditions:Comorbid condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider defined)**Setting/Location:** Providers may define the denominator population such that it is limited to individuals receiving services in a specific setting or service delivery location(s).Service Setting/Delivery Location(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider defined)   |
| **Demonstration Years** | **DY3****10/01/13 – 09/30/14** | **DY4****10/01/14 – 09/30/15** | **DY5****10/01/15 – 09/30/16** |
| **Measurement Periods***(Note: For P4P measures, DY3 Measurement Period is equivalent to the Baseline Period for purposes of measuring improvement.)* | **Providers must report data for one of the following DY, SFY, or CY time periods:**12 Month Period: 1. 10/01/13 – 09/30/14, or
2. 09/01/13 – 08/31/14, or
3. 01/01/13 – 12/31/13, or
4. 10/01/12 – 09/30/13, or
5. 09/01/12 – 08/31/13

6 Month Period: 1. 04/01/14 – 09/30/14, or
2. 03/01/13 – 08/31/14, or
3. 01/01/13 – 06/30/13, or
4. 07/01/13 – 12/31/13

Other: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC. | **Providers must report data across a 12-month time period that meets the following parameters:**1. Start date: The start date for the reporting period must occur after the provider’s DY3 Measurement Period.2. End date: The end date for the reporting period must occur on or before 09/30/15. | **Providers must report data across a 12-month time period that meets the following parameters:**1. Start date: The start date for the reporting period must occur after the provider’s DY4 Measurement Period.2. End date: The end date for the reporting period must occur on or before 09/30/16. |
| **Reporting Opportunities to HHSC** | 10/31/2014 | 4/30/201510/31/2015 | 4/30/201610/31/2016 |
| **Pay for Performance Target Methodology***(Note: See DSRIP Category 3 Companion Document for detailed P4P target methodology descriptions pertaining to (1) QISMC methodology, and (2) Improvement Over Self methodology.)* | Not Applicable | QISMC | QISMC |
| **Pay for Performance QISMC Benchmark Definition**  | Not Applicable | National; CMS Program | National; CMS Program |
| **Pay for Performance QISMC Benchmark Source** | Not Applicable | CMS - ESRD Program | CMS - ESRD Program |
| **Pay for Performance QISMC High Performance Level Definition** | Not Applicable | 90th percentile | 90th percentile |
| **Pay for Performance QISMC High Performance Level Value** | Not Applicable | 97% | 97% |
| **Pay for Performance QISMC Minimum Performance Level Definition** | Not Applicable | 15th percentile | 15th percentile |
| **Pay for Performance QISMC Minimum Performance Level Value** | Not Applicable | 83% | 83% |