eCQM Title	Kidney Health Evaluation		2.0.000
Tool)	951	eCQM Version Number	3.0.000
CBE Number Measurement Period	Not Applicable January 1, 20XX through December 31, 20XX	GUID	53ae1027-d9cc-4152-8454-874ab1b95324
Measure Steward	National Kidney Foundation		
Measure Developer Measure Developer	National Kidney Foundation		
Endorsed By Description Convright	None Percentage of patients aged 18-85 years with a diagnosis of dia Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinin Convright 2024 National Kidney Foundation, All Rights Reserve	betes who received a kidney health evaluati le Ratio (uACR) within the measurement per d	on defined by an Estimated iod
	Physician Performance Measures (Measures) and related data intended to facilitate quality improvement activities by health car These Measures are intended to assist health care professional	specifications developed by the National Kid re professionals. s in enhancing quality of care. These Measu	ney Foundation (NKF) are res are not clinical
	guidelines and do not establish a standard of medical care and testing and evaluation of its Measures. Measures are subject to review and may be revised or rescinde written approval from NKF. The measures, while copyrighted, ca	have not been tested for all potential applica d at any time by NKF. The measures may no an be reproduced and distributed, without mo	tions. NKF encourages of be altered without prior odification, for
Disclaimer	incorporation of the measures into a product or service that is so measures require a license agreement between the user and NI measures. THESE MEASURES AND SPECIFICATIONS ARE PROVIDED	"AS IS" WITHOUT WARRANTY OF ANY KI	vD.
	Limited proprietary coding is contained in the Measure specifica all necessary licenses from the owners of these code sets. CPT(R) contained in the Measure specifications is copyright 200	tions for convenience. Users of the proprieta	VC(R) is copyright 2004-
	Health Terminology Standards Development Organisation. ICD- The PCPI's and American Medical Association (AMA)'s signification measure are acknowledged. Due to technical limitations, registered trademarks are indicated	10 is copyright 2023 World Health Organizat nt past efforts and contributions to the devel	opment and updating of the
Measure Scoring Measure Type	Proportion Process		
Stratification Risk Adjustment	None		
Rate Aggregation	None Chronic Kidney Disease (CKD) is a major driver of morbidity, more million American adults have CKD and millions of others are at i estimated population prevalence growing to nearly 17% among 2019; Hoerger et al., 2015). Total Medicare spending in 2016 or billion, comprising 23% of total Medicare fee-for-service spendir (Saran et al., 2019; Nichols et al., 2020). In the US from 2002-20 disability, disability-adjusted life years, and deaths, outpaced ch Patients with CKD are readmitted to the hospital more frequently	ortality and high healthcare costs in the Unite ncreased risk (National Kidney Foundation [Americans aged 30 years and older by the y h both CKD and End-Stage Renal Disease (E ng overall with costs increasing exponentially 016, the burden of CKD, defined as years of anges in the burden of disease for other con y than those without diagnosed CKD (Saran	ed States. Currently, 37 NKF], 2022), with an ear 2030 (Saran et al., ESRD) was over \$114 with advancing CKD life lost, years living with ditions (Bowe et al., 2018). et al., 2019), CKD is the
Rationale	9th leading cause of death in the US and is the fastest growing a (Hoerger et al., 2015; Bowe et al., 2018). This public health issu comorbid risk factor for CKD (Saran et al., 2019; Bowe et al., 20 The intent of this process measure is to improve rates of guideli	non-communicable disease in terms of in bu le is driven largely by the impact of diabetes- 18). ne-concordant kidney health evaluation in pa	rden largely due to death
	more consistently identify and potentially treat or delay progress in patients with diabetes to determine risk of CKD using eGFR a Diabetes Association, 2022; de Boer, 2022; NKF, 2007; NKF, 20 quality improvement initiatives, including Healthy People 2030 (patients with diabetes remains low, with rates that vary across M	and of CKD in this high-risk population. Annu and uACR is recommended by clinical practic (12) and has been a focus of various local ar Healthy People 2030, 2023). However, perfo Medicare (41.8%) and private insurers (49.0%)	al kidney health evaluation ce guidelines (American nd national health care rmance of these tests in 6) (Saran et al., 2019;
	Alfego et al., 2021; Stempneiwicz et al., 2021). Low rates of detu demonstrated to be associated with low patient awareness of th individuals with CKD are unaware of their condition due to unde Disease Control and Prevention, 2023). Currently, an individual' for someone currently aged 30-49 years (Hoerger et al., 2015). provide an opportunity to improve identification and potential rec	ection of CKD in a population of patients with eir own kidney health status (Szczech et al., r-recognition and under-diagnosis (Saran, et s lifetime probability of developing CKD is re Regular kidney health evaluations, utilizing b versal of worseping kidney function, particular	a diabetes have been 2014). Indeed, 90% of al., 2019; Centers for latively high, reaching 54% both eGFR and uACR, r/v in high risk populations
	The following evidence statements are quoted verbatim from the At least annually, urinary albumin (e.g., spot urinary albumin-to-	e referenced clinical guidelines and other so creatinine ratio) and estimated glomerular fill	urces, where applicable:
Clinical Recommendation Statement	Assessed in people with type 1 diabetes with duration of 25 year (American Diabetes Association Professional Practice Committee Patients with diabetes should be screened annually for Diabetic - 5 years after the diagnosis of type 1 diabetes; (A) or - From diagnosis of type 2 diabetes. (B)	Kidney Disease (DKD). Initial screening sho	uld commence:
	Screening should include: - Measurements of urinary albumin-creatinine ratio (ACR) in a - Measurement of serum creatinine and estimation of GFR. (B) (NKF, 2007; NKF, 2012)	spot urine sample; (B)	
Improvement Notation	Higher score indicates better quality Reference Type: CITATION		
Reference	Reference Text: 'Alfego, D., Ennis, J., Gillespie, B., Lewis, M.J., disease testing among at-risk adults in the U.S. remains low: Re 44(9), 2025-2032. https://doi.org/10.2337/dc21-0723'	Montgomery, E., Ferrè, S., Letovsky, S. (eal-world evidence from a National Laborator	2021). Chronic kidney y database. Diabetes Care,
Reference	Reference Type: CITATION Reference Text: 'American Diabetes Association Professional Profesional Professional	ractice Committee. (2023). Chronic kidney di 0.2337/dc23-S011'	sease and risk
Reference	Reference Type: CITATION Reference Text: 'Bowe, B., Xie, Y., Li, T., Mokdad, A. H., Xian, H kidney disease from 2002 to 2016. JAMA Network Open, 1(7).'	., Yan, Y., Al-Aly, Z. (2018). Changes in the	US burden of chronic
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. C https://www.cdc.gov/kidneydisease/publications-resources/ckd-r	hronic Kidney Disease in the United States. national-facts.html'	(2023). Retrieved from:
Reference	Reference Type: CITATION Reference Text: 'de Boer, I.H., Khunti, K., Sadusky, T., Tuttle, K. chronic kidney disease: a consensus report by the American Dia Outcomes (KDIGO). Kidney International, 102(5):974-989. doi: 1	R., Neumiller, J.J., Rhee, Bakris, G. (2022). abetes Association (ADA) and Kidney Diseas 10.1016/j.kint.2022.08.012'	Diabetes management in se: Improving Global
Reference	Reference Type: CITATION Reference Text: 'Healthy People 2030. Retrieved from: https://he kidney-disease'	ealth.gov/healthypeople/objectives-and-data	/browse-objectives/chronic-
Reference	Reference Type: CHAHON Reference Text: 'Hoerger, T. J., Simpson, S. A., Yarnoff, B. O., P future burden of CKD in the United States: A simulation model fo 403-411. doi:10.1053/j.ajkd.2014.09.023'	Pavkov, M. E., Burrows, N. R., Saydah, S. H., or the CDC CKD Initiative. American Journal	Zhuo, X. (2015). The of Kidney Diseases, 65(3),
Reference	Reference Text: 'National Kidney Foundation. (2007). KDOQI Cl diabetes and chronic kidney disease. Retrieved from: https://ww	inical practice guidelines and clinical practic w.kidney.org/sites/default/files/docs/diabetes	e recommendations for s_ajkd_febsuppl_07.pdf
Reference	Reference Text: 'National Kidney Foundation. (2012). KDOQI Cl from: http://www.kidney.org/sites/default/files/docs/diabetes-ckd- Reference Type: CITATION	inical practice guideline for diabetes and CK -update-2012.pdf	D: 2012 Update. Retrieved
Reference	Reference Text: 'National Kidney Foundation. (2022). About chro https://www.kidney.org/atoz/content/about-chronic-kidney-diseas Reference Type: CITATION	onic kidney disease. Retrieved from: se'	
Reference	Reference Text: 'Nichols, G.A., Ustyugova, A., Déruaz-Luyet, A. type of expenditure across eGFR stages among patients with ar the American Society of Nephrology, 31(7), 1594-1601. DOI: https://doi.org/10.1681/asn.2019121308'	, O'Keeffe-Rosetti, M., & Brodovicz, K.G. (20 nd without diabetes, cardiovascular disease,	20). Health care costs by and heart failure. Journal of
Reference	Reference Text: 'Saran R. B., Abbott K. C., Agodoa, L.Y.C., Brag system 2018 annual data report: Epidemiology of kidney diseas DOI: https://doi.org/10.1053/j.ajkd.2019.01.001'	gg-Gresham, J., Balkrishnan, R., Shahinian, e in the United States. American Journal of H	V. (2019). US renal data Kidney Diseases, 73(3).
Reference	Reference Type: CHAHON Reference Text: 'Stempneiwicz, N., Vassalotti, J.A., Cuddeback, Chronic kidney disease testing among primary care patients with Care, 44(9), 2000-2009. https://doi.org/10.2337/dc20-2715'	J.K., Ciemins, E., Storfer-Isser, A., Sang, Y. h type 2 diabetes across 24 U.S. health care	, Coresh, J. (2021). organizations. Diabetes
Reference	Reference Type: CITATION Reference Text: 'Szczech, L. A., Stewart, R. C., Su, H., Deloske care detection of chronic kidney disease in adults with type-2 dia type 2 diabetes and chronic kidney disease). PLoS ONE, 9(11). DOI: https://doi.org/10.1371/journal.pone.0110535'	y, R. J., Astor, B. C., Fox, C. H., Vassalor abetes: The ADD-CKD study (Awareness, de	ti, J. A. (2014). Primary etection and drug therapy in
Reference	Reference Type: CITATION Reference Text: "Centers for Disease Control and Prevention. C https://www.cdc.gov/kidneydisease/publications-resources/ckd-r	Chronic Kidney Disease in the United States. national-facts.html'	(2023). Retrieved from:
Definition	None This measure assesses performance of a comprehensive kidne discourage the use of regular laboratory testing for CKD in patie years of age).	y evaluation in adults aged 18-85. This measents outside of the age range (patients under	sure does not preclude or 18 years and those over 85
Guidance	This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to information on the QDM.	o the eCQI resource center (https://ecqi.heal	thit.gov/qdm) for more
Transmission Format	TBD All patients aged 18-85 years with a diagnosis of diabetes at the	e start of the measurement period with a visit	during the measurement
Denominator Exclusions	period Equals Initial Population Patients with a diagnosis of ESRD active during the measureme	ent period; Patients with a diagnosis of CKD	Stage 5 active during the
Numerator	measurement period; Patients who have an order for or are rece Patients who received a kidney health evaluation defined by an	eiving hospice or palliative care eGFR AND uACR within the measurement p	period
Numerator Exclusions	Not Applicable		
Supplemental Data Elements	For every patient evaluated by this measure also identify payer,	race, ethnicity and sex	

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Population Criteria

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Supplemental Data Elements **Risk Adjustment Variables**

Population Criteria

▲ Initial Population

AgeInYearsAt(date from start of "Measurement Period") in Interval[18, 85] and "Has Active Diabetes at the start of the Measurement Period" and "Has Outpatient Visit During Measurement Period"

Denominator Exclusions

exists "Has CKD Stage 5 or ESRD Diagnosis Overlaps Measurement Period" or Hospice."Has Hospice Services" or PalliativeCare."Has Palliative Care in the Measurement Period"

▲ Numerator

"Has Kidney Panel Performed During Measurement Period"

Numerator Exclusions

None

Denominator Exceptions

None

⊿ Stratification

None

Definitions

⊿ Denominator

)

)

)

"Initial Population"

Denominator Exclusions

exists "Has CKD Stage 5 or ESRD Diagnosis Overlaps Measurement Period" or Hospice."Has Hospice Services or PalliativeCare."Has Palliative Care in the Measurement Period"

▲ Has Active Diabetes at the start of the Measurement Period

exists (["Diagnosis": "Diabetes"] Diabetes where Diabetes.prevalencePeriod overlaps before "Measurement Period"

▲ Has CKD Stage 5 or ESRD Diagnosis Overlaps Measurement Period

(["Diagnosis": "Chronic Kidney Disease, Stage 5"] union ["Diagnosis": "End Stage Renal Disease"]) CKDOrESRD where CKDOrESRD.prevalencePeriod overlaps day of "Measurement Period"

▲ Has Kidney Panel Performed During Measurement Period

exists (["Laboratory Test, Performed": "Estimated Glomerular Filtration Rate"] eGFRTest where Global."NormalizeInterval" (eGFRTest.relevantDatetime, eGFRTest.relevantPeriod) during day of "Measurement Period" and eGFRTest.result is not null

and exists (["Laboratory Test, Performed": "Urine Albumin Creatinine Ratio"] uACRTest

where Global."NormalizeInterval" (uACRTest.relevantDatetime, uACRTest.relevantPeriod) during day of "Measurement Period" and uACRTest.result is not null

Has Outpatient Visit During Measurement Period

- exists ((["Encounter, Performed": "Annual Wellness Visit"]
- union ["Encounter, Performed": "Home Healthcare Services"] union ["Encounter, Performed": "Office Visit"]
- union ["Encounter, Performed": "Outpatient Consultation"] union ["Encounter, Performed": "Preventive Care Services Established Office Visit, 18 and Up"] union ["Encounter, Performed": "Preventive Care Services Initial Office Visit, 18 and Up"] union ["Encounter, Performed": "Telephone Visits"]) ValidEncounter union ["Encounter, Performed": "Telephone Visits"]) ValidEncounter

- where ValidEncounter.relevantPeriod during "Measurement Period"

▲ Hospice.Has Hospice Services

exists (["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter where (InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)" or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"

-)
- and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"

) or exists (["Encounter, Performed": "Hospice Encounter"] HospiceEncounter

where HospiceEncounter.relevantPeriod overlaps day of "Measurement Period"

or exists (["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment where HospiceAssessment.result ~ "Yes (qualifier value)" and Global."NormalizeInterval" (HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod) overlaps day of "Measurement Period"

or exists (["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder where HospiceOrder.authorDatetime during day of "Measurement Period"

or exists (["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed where Global."NormalizeInterval" (HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod) overlaps day of "Measurement Period"

or exists (["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis where HospiceCareDiagnosis.prevalencePeriod overlaps day of "Measurement Period")

▲ Initial Population

AgeInYearsAt(date from start of "Measurement Period") in Interval[18, 85] and "Has Active Diabetes at the start of the Measurement Period" and "Has Outpatient Visit During Measurement Period"

Numerator

)

"Has Kidney Panel Performed During Measurement Period"

PalliativeCare.Has Palliative Care in the Measurement Period

exists (["Assessment, Performed": "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)"] PalliativeAssessment where Global."NormalizeInterval" (PalliativeAssessment.relevantDatetime, PalliativeAssessment.relevantPeriod) overlaps day of "Measurement Period"

or exists (["Diagnosis": "Palliative Care Diagnosis"] PalliativeDiagnosis

where PalliativeDiagnosis.prevalencePeriod overlaps day of "Measurement Period"

or exists (["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter where PalliativeEncounter.relevantPeriod overlaps day of "Measurement Period"

or exists (["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention

where Global."NormalizeInterval" (PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod) overlaps day of "Measurement Period")

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Functions

▲ Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

- if pointInTime is not null then Interval[pointInTime, pointInTime]
- else if period is not null then period else null as Interval<DateTime>

Terminology

- Code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")

 code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")

 code "Functional Assessment of Chronic Illness Therapy Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")

 code "Yes (qualifier value)" ("SNOMEDCT Code (45755-6)")

 code "Yes (qualifier value)" ("SNOMEDCT Code (45755-6)")

 code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")

 valueset "Chronic Kidney Disease, Stage 5" (2.16.840.1.113883.3526.3.1200)

 valueset "Chronic Kidney Disease, Stage 5" (2.16.840.1.113883.3526.3.1002)

 valueset "Encounter Inpatient" (2.16.840.1.113883.3.526.3.353)

 valueset "End Gomerular Filtration Rate" (2.16.840.1.113883.3.6929.3.1000)

 valueset "Hongice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)

 valueset "Hospice Diagnosis" (2.16.840.1.113883.3.464.1003.101.12.1016)

 valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.464.1003.101.12.1016)

 valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.464.1003.101.12.1016)

 valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.464.1003.101.12.1008)

 valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1008)

 valueset "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.101.12.1008)

 valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1008)

 valueset "Palliative

Data Criteria (QDM Data Elements)

"Assessment, Performed: Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire

- (FACIT-Pal) (LOINC Code 71007-9)"

- "Assessment, Performed: Functional Assessment of Chronic Illness Therapy Palliative Care Questionnaire (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Palliative Care Participation (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy Palliative Care Question (FACIT-Pal)" using "Functional Palliative Care Palliative Care Question (FACIT-Pal)" using "Functional Palliative Care Question (FACIT-Pal)" using "Functional Palliative Care Pallia

Supplemental Data Elements

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

None

Risk Adjustment Variables

None