SUMMARY
Kidney Care Quality Alliance Conference Call
January 08, 2016

A conference call of the Kidney Care Quality Alliance (KCQA) was convened on Friday, January 08, 2016. Representatives of the following organizations participated: AbbVie, American Kidney Fund, American Nephrology Nurses' Association, American Society of Nephrology, Amgen, Baxter, DaVita Healthcare Partners Inc., Dialysis Patient Citizens, Dialysis Clinic Inc., Greenfield Health Systems, Kidney Care Council, Kidney Care Partners, National Kidney Foundation, Nephrology Nursing Certification Commission, NxStage Medical, Renal Physicians Association, US Renal Care.

OPENING REMARKS
Following the roll call, Drs. Allen Nissenson and Ed Jones, KCQA Steering Committee Co-Chairs, welcomed and thanked the group for participating in the call and commended the Steering Committee and Workgroup for their work to date.

AGENDA
Dr. Nishimi reminded participants the purpose of today's conference call is for KCQA members to discuss the Steering Committee's concurrence with the Workgroup's recommendation to advance the two medication reconciliation measures to testing—MM-2: *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities* and MM-3: *Medication Reconciliation at Care Transitions for Patients Receiving Care at Dialysis Facilities*. Dr. Nishimi noted that, following the call, a 2-week review period will be provided for KCQA Lead Representatives to ensure support for or raise concerns about the measures within their organizations; this review period will be followed by a vote (via survey monkey) on advancing the measures to the testing phase.

SUMMARY OF PROGRESS
Dr. Nishimi noted since the All-KCQA call on December 16 to review the draft medication management measure specifications, the Feasibility/Testing Workgroup deliberated on the comments it received from Steering Committee and KCQA members and concluded its deliberations. The Workgroup then voted on its preference for which measures to advance to the testing phase, as described in the call materials, and the Steering Committee reviewed the Workgroup's deliberations and has put forth a recommendation for KCQA members' discussion today.

Workgroup Consideration of Comments
Dr. Nishimi noted the Workgroup discussed the following comments received from the Steering Committee and KCQA members:

1. Specification requirements in the context of chemotherapy agents or clinical trials;
2. Check-box nature of the measures;
3. Shortening the 30-day timeframe for "high-risk" patients undergoing a care transition;
4. Use of LPNs for medication documentation; and
5. Utility/efficacy of medication reconciliation without review.

She informed call participants that the Workgroup reached the following conclusions:

1. The Workgroup believed chemotherapeutic agents should be included in the list of medications for each measure and felt the existing language encompassed such a scenario. For patients who may be in clinical trails, the Workgroup agreed the specifications should acknowledge the unknown nature of placebo vs. agent and a footnote was added in this regard.
2. The Workgroup again discussed the feasibility of collecting detailed information vs. a pure check-box. It confirmed the need for an attestation, but also noted the addition of additional auditable fields (e.g., date and eligible professional) at least went beyond the approach of the currently endorsed NQF measures.
3. Workgroup members discussed the 30-day timeframe permitted for documentation/reconciliation/review for home dialysis patients and the recommendation by a KCQA member that this be shortened. They affirmed they felt this timeframe was appropriate for this population.
4. The Workgroup added LPNs as eligible professionals for the documentation measure, acknowledging this was an oversight.
5. Workgroup members again discussed at length the merits of only advancing a medication reconciliation measure vs. the importance of the review process. Some members felt medication review was too high a bar and that medication documentation and/or medication reconciliation were the places to start. Others felt medication review was the ultimate endpoint and so measures in this area should be promoted. It was noted that medication review measures could be used for internal quality improvement, but that the initial measures for accountability/the QIP should be medication reconciliation.

Dr. Nishimi also noted that, on its final call, the Workgroup decided to modify the specifications and focus the documentation and reconciliation measures to "home" medications and not those provided at each treatment—i.e., the measures do not apply to orders for medications delivered intradialytically.

Workgroup Recommendation

Dr. Nishimi reported Workgroup members were asked to rank their top three choices from among the six they had specified. Dr. Nishimi noted the recommendation for the two medication reconciliation measures (general population and "high-risk") is clear. She referred participants to Tables 1 and 2 in the memo distributed in advance of the call, which display the raw counts and a weighted analysis of the votes (i.e., first choice=3 points, second=2 points, and third=1 points), respectively.

Table 1. Raw Vote Counts

	1st	2nd	3rd	TOTAL VOTES RANKING IN TOP 3
MM-1	1	2	1	4
MM-6	0	1	4	5
MM-2	2	5	1	**8 (72.7%)**
MM-3	7	2	1	**10 (90.9%)**
MM-4	1	0	2	3
MM-5	0	1	2	3
	11	11	11	15

MM-1: Medication Documentation
MM-6: Medication Doc, High-Risk
MM-2: Medication Reconciliation
MM-3: Medication Rec, High-Risk
MM-4: Medication Review
MM-5: Medication Rev, High-Risk

Table 2. Votes Weighted

	1st	2nd	3rd	TOTAL POINTS
MM-1	1X3 = 3	2X2 = 4	1X1 = 1	8
MM-6	0	2	4	6
MM-2	6	10	1	**17**
MM-3	21	4	1	**26**
MM-4	3	0	2	5
MM-5	0	2	2	4
				Highest possible = 33

Dr. Nishimi informed participants the highest preference is MM-3, medication reconciliation within 8 days for in-center or 30 days for home patients upon a care transition (e.g., post-hospitalization or upon admission). MM-2, the next highest preference, is the general medication reconciliation measure (every 30 days).

Dr. Nishimi informed participants that Workgroup members were also asked, "If X measure is among the top 2, but was not among your top 3 preferences, can you still support its advancement?" She referred participants to the results presented in Table 3 of the memo, which reveal only MM-2 and MM-3 are supported by all Workgroup members.

Table 3. Can support measure even if not among her/his top 3

	Could Support	Could Not Support	Could %	Could Not %
MM-1	10	1	90.9%	9.1%
MM-6	10	1	90.9%	9.1%
MM-2	11	0	**100.00%**	0.00%
MM-3	11	0	**100.00%**	0.00%
MM-4	6	5	54.6%	45.5%
MM-5	7	4	63.6%	36.4%

Steering Committee Recommendation

Dr. Nishimi informed participants the Steering Committee concurs with the Workgroup's deliberations and recommends KCQA members approve testing of the two medication reconciliation measures—MM-2: *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities* and MM-3: *Medication Reconciliation at Care Transitions for Patients Receiving Care at*

Dialysis Facilities. With no questions or comments on the background material, she opened the call to general discussion.

DISCUSSION

Ms. Tonya Saffer of NKF requested clarification on how transient patients are defined, and asked whether established patients who were hospitalized for the majority of a given month who then received fewer than 7 treatments during the month would be excluded. Dr. Nishimi responded the exclusion language is used in other measures. She noted the focus should be on the term-of-art "transient"—i.e., the exclusion only applies to "visiting" patients; patients who are established in a facility are included in the measure, regardless of whether they receive fewer than 7 treatments during the month or not. Ms. Saffer remarked that it is confusing not having that clarification in the specifications and suggested it be incorporated so it will be clear prior to testing. Dr. Nishimi responded this is approved KCP policy and mirrors language currently used by CMS, so she advises against changing it. Dr. McGonigal noted the transient exclusion is explicitly defined in the measure testing protocol to indicate only visiting patients are encompassed by the exclusion. Ms. Saffer said this addresses her concern. Another participant asked if there is a definitions section anywhere. Dr. Nishimi responded these types of detailed specifics appear when a measure's testing protocol, microspecifications, and implementation guidance are developed, and are not incorporated into specifications at this level.

Ms. Saffer also requested clarification on the rationale for why intradialytic medications are not addressed in the reconciliation measure. Ms. Payne, a member of the Workgroup, responded that the point of the reconciliation measures is to verify the medications patients are responsible for taking themselves. She noted intradialytic medications are important, but they are not the focus of these particular measures. She said the Workgroup wanted to eliminate the additional burden that would be required trying to verify medications that are given by protocol and can vary by treatment. Ms. Wick, a member of the Workgroup and Steering Committee, concurred with Ms. Payne's response.

Ms. Saffer responded she doesn't understand why the whole comprehensive list is not included as a matter of practicality. She noted it is reasonable to think this information might be shared with a patient, and if intradialytic medications aren't included, the patient wouldn't see the entirety of his/her medications list. She added the entire list would be helpful for patients if they have to go to another care setting. Ms. Payne responded it is the responsibility of the facility to send all information on all prescribed and intradialytic medications to the new setting if a patient transfers care. However, the point of the reconciliation measures is to focus on self-administered, home medications. Ms. Saffer clarified that by "another care setting" she had meant hospitalization, not a transfer to another dialysis facility. Ms. Payne noted the transfer of information should be the same in both scenarios—i.e., all information on all prescribed and intradialytic medications would be shared by the facility. She noted when a patient visits another physician, the information provided for the visit probably varies greatly. Ms. Wick concurred with Ms. Payne and also noted there is a point where too much information can be included in a list and providers become overwhelmed and "snow blind." She remarked the reality of what would be required to first gather, then organize the information for medications that vary from treatment to treatment (i.e., intradialytic) is significant. Ms. Wick said the reconciliation measures as currently proposed are already ambitious and that complicating the measures further might result in unintended consequences. Ms. Payne further clarified that, while not a part of the medications being addressed by the reconciliation measures, orders and

protocols addressing intradialytic medications are recorded and accessible elsewhere in the medical record. Dr. Palevsky expressed concern that if medications given during treatment are not included, there could be overlap on some medications that will be missed, such as oral and intravenous Vitamin D. Ms. Payne noted the Workgroup had specifically discussed Vitamin D and part of the rationale for being comfortable with what has been proposed is that the same staff responsible for the medication reconciliation process is also responsible for administering medications during dialysis. Ms. Wick agreed these issues were considered. She stressed the Workgroup and Steering Committee recommendation is not meant to suggest medication review should not still occur and be tracked for internal quality purposes. She noted, however, these reconciliation measures are appropriate and being proposed in the context of use on a national level for public reporting and payment.

Dr. Nishimi asked if there were any additional comments on the recommendation, the specifications, or whether other measures among the six were preferred. There were no additional comments or questions.

PUBLIC COMMENT

A public listener, Dr. Lou Diamond, wanted to note his general understanding of medication reconciliation is that all medications a patient is receiving are reconciled. He remarked that earlier comments speak to the fundamental issue of eliminating medications administered intradialytically from the specifications. He suggested, at a minimum, the specifications should clearly indicate that intradialytic medications have been excluded from the reconciliation process. He opined he felt it is unusual to exclude medications from these processes and expressed concern there could be some issues that arise from this decision. He noted medication reconciliation and documentation are defined in the specifications, but asked if medication review is defined anywhere. Dr. Nishimi responded the specifications for the documentation and reconciliation do indicate intradialytic medications are excluded. She also noted medication review is defined in the MM-4 and MM-5 specifications, the measures addressing medication review in the general and high-risk populations, respectively. She noted the two review measures do include orders/intradialytic medications, and indicated the definitions for review and reconciliation are reversed by some providers/organizations, which she also inferred from his comments. Dr. Diamond indicated this appropriately addressed his concern. Ms. Payne added that, currently, if facility staff were to be queried, reconciliation would be indicated as focusing primarily on home medications and would not include medications administered during dialysis.

NEXT STEPS

Dr. Nishimi thanked participants for their time and input. She informed participants that, following the call, a 2-week review period will be provided for KCQA Lead Representatives to ensure support for the measures within their organizations. The specifications for all six measures will be sent out to the Lead Representatives and other KCQA contacts within each organization. This review period will be followed by a formal vote via survey monkey, asking specifically for approval to advance the measures to the testing phase. She noted there will be an opportunity to provide comments in the survey. Questions and comments in advance of the vote can also be submitted by replying to the email.

Drs. Jones and Nissenson also thanked participants, and the conference call was adjourned.