TO: All KCQA Members

FR: KCQA Steering Committee—Ed Jones (Co-Chair), Allen Nissenson (Co-Chair), Scott Ash, Donna Bednarski, Barbara Fivush, Ray Hakim, Shari Ling, Chris Lovell, Tom Manley, Jason Spangler, Gail Wick

RE: Recommendation of Medication Management Measures for Testing

DA: 6 January 2016

Since the All-KCQA call on December 16 to review the draft medication management measure specifications, the Feasibility/Testing Workgroup[1] concluded its deliberations and the Steering Committee reviewed its recommendation for the 1-2 measures that should be advanced to testing. This memorandum summarizes the Workgroup's deliberations on the comments it received from Steering Committee and KCQA members, reviews the Workgroup's recommendation that the two medication reconciliation measures be advanced to testing, and presents the Steering Committee's recommendation for KCQA members' discussion.

**Workgroup Consideration of Comments**

The Workgroup discussed the following comments received from KCQA members and the Steering Committee:

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" home dialysis patients undergoing a care transition;
4. Use of LPNs for medication documentation; and
5. Utility/efficacy of medication reconciliation without review.

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. In the course of this discussion, the Workgroup also decided to eliminate the inclusion of orders as part of the specifications because they are not prescriptions, vary by treatment, and are recorded each time in the medical record; the specifications were modified to limit the scope to "medications that are not delivered intradialytically."
2. The Workgroup again discussed the feasibility of collecting detailed information vs. a pure check-box. It confirmed the need for an attestation given the many data elements related to the list of medications, but also noted the addition of additional auditable

[1] Mike Guffey (DPC); Richard Faris, PhD, MSs, RPh (DVA); Jeffrey Hymes, MD (FMC RTG); Don Molony, MD (Forum of ESRD Networks); Harold Manley, PharmD (DCI); Paul Miller, MD (RPA); Glenda Payne, MS, RN, CNN (ANNA); Sharon Perlman, MD (ASPN); Wendy St. Peter, PharmD (NKF); Len Usvyat, PhD (FMC); Gail Wick, MHSA, BSN, RN, CNN (AKF and Steering Committee Liaison)

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 undergoing a care transition 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. Workgroup members emphasized that if the reconciliation measures ultimately moved forward, it does not mean the documentation or review are not necessary and highly important. It also was noted medication review measures could be used for internal quality improvement, but the initial measures for accountability/the QIP should be medication reconciliation. The discussion informed Workgroup members' voting, which is summarized in the following section.

**Workgroup Recommendation**

Workgroup members ranked their top three choices via surveymonkey; there are 11 Workgroup members and all voted. The recommendation for the two medication reconciliation measures (general population and "high-risk") is clear (see Attachment A for specifications). Table 1 displays the raw counts, and Table 2 presents an analysis where the first choice=3 points, second=2 points, and third=1 points.

**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* |

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).

We also asked Workgroup members, "If X measure is among the top 2, but was not among your top 3 preferences, can you still support its advancement?" Table 3 presents these results, 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% |

Finally, Attachment B provides the comments five Workgroup members provided with their voting.

**Steering Committee Recommendation**

The results appear to indicate a few Workgroup members believe reconciliation might be a high bar (the votes for documentation), but also a few who would like the bar higher (the votes for review). Although concern has been expressed about the value of reconciliation without the more rigorous review component, the clear sentiment of the Workgroup is that measuring medication review *for accountability purposes* shouldn't be pursued at this time. We also note these results fit nicely with CMS' intent to pursue a medication reconciliation TEP—which it has not to date announced.

**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.***

**Next Steps**

Following the All-KCQA call to review the recommended draft specifications and to discuss the Steering Committee's recommendation, a 2-week review period will be provided for KCQA Lead Representatives to ensure support for 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.

# MM-2, MM-3: Medication Reconciliation

| MM-2: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities | |
|---|---|
| **Description** | Percentage of patient-months for which medication reconciliation was performed and documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of patient-months for which medication reconciliation was performed and documented by an eligible professional* during the reporting period.<br><br>The medication reconciliation MUST:<br>• Include the name of the eligible professional;[1]<br>AND<br>• Include the date of the reconciliation;<br>AND<br>• Address ALL known medications that are not administered intradialytically (prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Address for EACH medication: Medication name,[2] indication,[3,4] dosage,[12] frequency,[12] route of administration,[12] start and end date (if applicable),[12] discontinuation date (if applicable),[12] reason medication was stopped or discontinued (if applicable),[12] and identification of individual who authorized stoppage or discontinuation of medication (if applicable);[12]<br>AND<br>• List any allergies, intolerances, or adverse drug events experienced by the patient.<br><br>"Medication reconciliation" is defined as the process of creating the most accurate list of all medications that are not administered intradialytically that the patient is taking, including name, indication, dosage, frequency, and route, by comparing the most recent medication list in the dialysis medical record to one or more external list(s) of medications obtained from a patient or caregiver (including patient-/caregiver-provided "brown bag" information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider.<br><br>*For the purposes of medication reconciliation, "eligible professional" is defined as: physician, RN, ARNP, PA, pharmacist, or pharmacy technician. |
| **Denominator** | Total number of patient-months for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | Transient patients, defined as in-center patients who received <7 hemodialysis treatments in the facility during the month. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |



[1] The preliminary feasibility assessment reveals that "name of the eligible professional" may present a feasibility issue for testing purposes. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[2] For patients in a clinical trial, it is acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo.
[3] The preliminary feasibility assessment reveals that "indication" is not captured or not captured in a manner amenable to testing and so also is a feasibility issue. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[4] "Unknown" is an acceptable response for this field.

| MM-3: Medication Reconciliation at Care Transitions for Patients Receiving Care at Dialysis Facilities | |
|---|---|
| **Description** | Percentage of high-risk patient-events for which medication reconciliation was performed and documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of high-risk patient-events* for which a list of current medications was documented by an eligible professional** within 8 days of a transition event (returning to the dialysis facility due to a transition of care [e.g., discharge from hospital]) or admission for in-center patients and within 30 days for home patients during the reporting period.<br><br>The medication documentation MUST:<br>• Include the name of the eligible professional;[5]<br>AND<br>• Include the date of the reconciliation;<br>AND<br>• Address ALL known medications that are not administered intradialytically (prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Record for EACH medication: Medication name,[6] indication,[7,8] dosage,[8] frequency,[8] route of administration,[8] start and end date (if applicable),[8] discontinuation date (if applicable),[8] reason medication was stopped or discontinued (if applicable),[8] and identification of individual who authorized stoppage or discontinuation of medication (if applicable);[8]<br>AND<br>• List any allergies, intolerances, or adverse drug events experienced by the patient.<br><br>"Medication documentation" is defined as recording in a list the required data elements necessary to conduct the medication reconciliation and medication review processes.<br><br>*High-risk patient-events are defined as transitions between care settings (e.g., discharge from hospital or other care setting) and new admissions to the dialysis facility.<br><br>**For the purposes of medication documentation, "eligible professional" is defined as: physician, RN, ARNP, LNP, PA, pharmacist, or pharmacy technician. |
| **Denominator** | Total number of high-risk patient-events for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | 1. Transient patients, defined as in-center patients who received <7 hemodialysis treatments in the facility during the month.<br>2. In-center patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge.<br>3. Home patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

[5] The preliminary feasibility assessment reveals that "name of the eligible professional" may present a feasibility issue for testing purposes. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[6] For patients in a clinical trial, it is acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo.
[7] The preliminary feasibility assessment reveals that "indication" is not captured or not captured in a manner amenable to testing and so also is a feasibility issue. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[8] "Unknown" is an acceptable response for this field.

# MM-1, MM-6: Medication Documentation

| MM-1: Medication Documentation for Patients Receiving Care at Dialysis Facilities | |
|---|---|
| **Description** | Percentage of patient-months for which a list of current medications was documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of patient-months for which a list of current medications was documented by an eligible professional* during the reporting period.<br><br>The medication documentation MUST:<br>• Include the name of the eligible professional;[9]<br>AND<br>• Include the date of the reconciliation;<br>AND<br>• Address ALL known medications that are not administered intradialytically (prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Record for EACH medication: Medication name,[10] indication,[11,12] dosage,[4] frequency,[4] route of administration,[4] start and end date (if applicable),[4] discontinuation date (if applicable),[4] reason medication was stopped or discontinued (if applicable),[4] and identification of individual who authorized stoppage or discontinuation of medication (if applicable);[4]<br>AND<br>• List any allergies, intolerances, or adverse drug events experienced by the patient.<br><br>"Medication documentation" is defined as recording in a list the required data elements necessary to conduct the medication reconciliation and medication review processes.<br><br>*For the purposes of medication documentation, "eligible professional" is defined as: physician, RN, ARNP, LPN, PA, pharmacist, or pharmacy technician. |
| **Denominator** | Total number of patient-months for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | Transient patients, defined as in-center patients who received <7 hemodialysis treatments in the facility during the month. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

[9] The preliminary feasibility assessment reveals that "name of the eligible professional" may present a feasibility issue for testing purposes. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[10] For patients in a clinical trial, it is acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo.
[11] The preliminary feasibility assessment reveals that "indication" is not captured or not captured in a manner amenable to testing and so also is a feasibility issue. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[12] "Unknown" is an acceptable response for this field.

| MM-6: Medication Documentation at Care Transitions for Patients Receiving Care at Dialysis Facilities | |
|---|---|
| **Description** | Percentage of high-risk patient-events for which a list of current medications was documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of high-risk patient-events* for which a list of current medications was documented by an eligible professional** within 8 days of a transition event (returning to the dialysis facility due to a transition of care [e.g., discharge from hospital]) or admission for in-center patients and within 30 days for home patients during the reporting period.<br><br>The medication documentation MUST:<br>• Include the name of the eligible professional;[13]<br>AND<br>• Include the date of the reconciliation;<br>AND<br>• Address ALL known medications that are not administered intradialytically (prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Record for EACH medication: Medication name,[14] indication,[15,16] dosage,[8] frequency,[8] route of administration,[8] start and end date (if applicable),[8] discontinuation date (if applicable),[8] reason medication was stopped or discontinued (if applicable),[8] and identification of individual who authorized stoppage or discontinuation of medication (if applicable);[8]<br>AND<br>• List any allergies, intolerances, or adverse drug events experienced by the patient.<br><br>"Medication documentation" is defined as recording in a list the required data elements necessary to conduct the medication reconciliation and medication review processes.<br><br>*High-risk patient-events are defined as transitions between care settings (e.g., discharge from hospital or other care setting) and new admissions to the dialysis facility.<br><br>**For the purposes of medication documentation, "eligible professional" is defined as: physician, RN, ARNP, LNP, PA, pharmacist, or pharmacy technician. |
| **Denominator** | Total number of high-risk patient-events for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | 1. In-center patients who received <7 hemodialysis treatments in the facility during the month (i.e., transient patients).<br>2. In-center patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge.<br>3. Home patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

[13] The preliminary feasibility assessment reveals that "name of the eligible professional" may present a feasibility issue for testing purposes. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[14] For patients in a clinical trial, it is acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo.
[15] The preliminary feasibility assessment reveals that "indication" is not captured or not captured in a manner amenable to testing and so also is a feasibility issue. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[16] "Unknown" is an acceptable response for this field.

# MM-4, MM5: Medication Review

| MM-4: Medication Review for Patients Receiving Care at Dialysis Facilities | |
|---|---|
| **Description** | Percentage of patient-months during which a medication review was performed and documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of patient-months during which a medication review was performed and documented by an eligible professional* during the reporting period.<br><br>The medication review MUST:<br>• Include the name of the eligible professional;[17]<br>AND<br>• Include the date of the reconciliation;<br>AND<br>• Address ALL known medications (orders, prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Address for EACH medication:<br>○ Medication name,[18] indication,[19,20] dosage,[21] frequency,[21] route of administration,[21] start and end date (if applicable),[21] discontinuation date (if applicable),[21] reason medication was stopped or discontinued (if applicable),[21] and identification of individual who authorized stoppage or discontinuation of medication (if applicable).[21]<br>○ Is the indication valid for each medication?[20]<br>○ Are there duplications of therapy?<br>○ Are there any potential clinically relevant drug-drug, drug-food, or drug-disease interactions?<br>○ Is the patient experiencing any adverse effect from any drug? If yes, document drug, adverse event, and date.<br>○ Is the drug dose and frequency appropriate for the patient? Factors that should be considered include, but are not limited to: residual kidney function, method of dialysis, frequency and type of dialysis membrane, presence of other organ dysfunction (e.g., liver), patient weight (overweight, underweight, amputation, muscle wasting), laboratory values, other relevant patient factors such as gender, race/ethnicity, concomitant disease.<br>○ Can the patient take the medication as prescribed?<br>○ Is the appropriate monitoring being conducted for each medication?<br>AND<br>• List any allergies, intolerances, or adverse drug events experienced by the patient.<br><br>"Medication review" is defined as a process of evaluating a patient's medications and confirming them as being appropriate, safe, and convenient for |

[17] The preliminary feasibility assessment reveals that "name of the eligible professional" may present a feasibility issue for testing purposes. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[18] For patients in a clinical trial, it is acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo.
[19] The preliminary feasibility assessment reveals that "indication" is not captured or not captured in a manner amenable to testing and so also is a feasibility issue. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[20] "Unknown" is an acceptable response for this field.

| | |
|---|---|
| | the patient; a review with the patient may be included.<br><br>*For the purposes of medication review, "eligible professional" is defined as: physician, ARNP, PA, or pharmacist. |
| **Denominator** | Total number of patient-months for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | Transient patients, defined as in-center patients who received <7 hemodialysis treatments in the facility during the month. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

| **MM-5: Medication Review at Care Transitions for Patients Receiving Care at Dialysis Facilities** | |
|---|---|
| **Description** | Percentage of high-risk patient-events for which a medication review was performed and documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of high-risk patient-events* for which a medication review was performed and documented by an eligible professional** within 8 days of a transition event (returning to the dialysis facility due to a transition of care [e.g., discharge from hospital]) or admission for in-center patients and within 30 days for home patients during the reporting period.<br><br>The review MUST:<br>• Include the name of the eligible professional;[21]<br>AND<br>• Include the date of the reconciliation;<br>AND<br>• Address ALL known orders, prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana.<br>AND<br>• Address for EACH medication:<br>○ Medication name,[22] indication,[23,24] dosage,[25] frequency,[25] route of administration,[25] start and end date (if applicable),[25] discontinuation date (if applicable),[25] reason medication was stopped or discontinued (if applicable),[25] and identification of individual who authorized stoppage or discontinuation of medication (if applicable).[25]<br>○ Is the indication valid for each medication?[24]<br>○ Are there duplications of therapy?<br>○ Are there any potential clinically relevant drug-drug, drug-food, or drug-disease interactions?<br>○ Is the patient experiencing any adverse effect from any drug? If yes, document drug, adverse event, and date.<br>○ Is the drug dose and frequency appropriate for the patient? Factors that should be considered include, but are not limited to: residual kidney function, method of dialysis, frequency and type of dialysis membrane, presence of other organ dysfunction (e.g. liver), patient weight (overweight, underweight, amputation, muscle wasting), laboratory values, other relevant patient factors such as gender race/ethnicity, concomitant disease. |

[21] The preliminary feasibility assessment reveals that "name of the eligible professional" may present a feasibility issue for testing purposes. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[22] For patients in a clinical trial, it is acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo.
[23] The preliminary feasibility assessment reveals that "indication" is not captured or not captured in a manner amenable to testing and so also is a feasibility issue. Accordingly, this data element may be removed from the specifications if the measure is advanced for testing.
[24] "Unknown" is an acceptable response for this field.

| | |
|---|---|
| | ○ Can the patient take the medication as prescribed?<br>○ Is the appropriate monitoring being conducted for each medication?<br>AND<br>• List any allergies, intolerances, or adverse drug events experienced by the patient.<br><br>"Medication review" is defined as a process of evaluating a patient's medications and confirming them as being appropriate, safe, and convenient for the patient; a review with the patient may be included.<br><br>*High-risk patient-events are defined as transitions between care settings (e.g., discharge from hospital or other care setting) and new admissions to the dialysis facility.<br><br>**For the purposes of medication review, "eligible professional" is defined as: physician, ARNP, PA, or pharmacist. |
| **Denominator** | Total number of high-risk patient events for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | 1. In-center patients who received <7 hemodialysis treatments in the facility during the month (i.e., transient patients).<br>2. In-center patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge.<br>3. Home patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

| |
|---|
| I do believe that MM-1 and MM-2 will be hard to operationalize / sell to the consumer community without MM-6 and MM-3 respectively, even if MM-1 and MM-2 are easier for the providers to fulfill. I placed MM-3 / MM-6 above MM-2 since the former two are probably done less well currently and might have the largest net beneficial impact on outcomes if performed better and more universally. |
| I think the time our patients are most vulnerable is on transition between care sites. That is why I list MM-3 as my top. Beyond that, having a medication list is incredibly important, as is some level of review. I would rate review higher, but we do need the review first. Unfortunately, all our indicators are "check box" that they were done, but it is a good place to start for medication use and then needs to move to more specifics. |
| I feel that establishing MM-1 as a baseline provides a measure of protection to all patients, and while it may not be earth-shattering, it also is something that should be doable. I also like MM-3 because it provides the next level of protection for transitional patients. I also voted for MM-1 because these measures appear to be stepping stones, and I didn't want to hear MM-2 could not be done because MM-1 was not in place. |
| Whereas I think the review process is the most meaningful, I have concerns about feasibility, and therefore concerns that facilities will fail because of the complexity of the process behind the measures. Thus, reconciliation is likely more practical, and gets us started. |
| Medication reconciliation is important as it impacts all patients. Medications can only be reviewed if they are reconciled first. During care transitions, all medications (to include HOME and IN-CENTER) should be reconciled. Medication review should also occur at care transitions. |

**SUMMARY**
**Kidney Care Quality Alliance Conference Call**
**December 16, 2015**

A conference call of the Kidney Care Quality Alliance (KCQA) was convened on Wednesday, December 16, 2015. Representatives of the following organizations participated: AbbVie, American Kidney Fund, American Nephrology Nurses' Association, DaVita Healthcare Partners Inc., Dialysis Patient Citizens, Dialysis Clinic Inc., Fresenius Medical Care North America, Kidney Care Partners, National Forum of ESRD Networks, National Kidney Foundation, National Renal Administrators Association, Northwest Kidney Centers, NxStage Medical, Renal Physicians Association, Rogosin Institute.

**OPENING REMARKS**
Following the roll call, Dr. Ed Jones, KCQA Steering Committee Co-Chair, 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 to update KCQA members on the work of the KCQA Medication Management Feasibility/Testing Workgroup. She noted the Workgroup has been extremely engaged throughout the process, and referred participants to materials distributed in advance of the call: a background memorandum on the Workgroup's deliberations and a table of draft specifications for the candidate medication management measures. She indicated rather than reviewing the specifications in great detail during the call, she would like to spend the bulk of the time providing a high-level overview of the Workgroup's discussions, answering any questions participants may have, and receiving any comments/feedback participants wish to convey to the Workgroup and Steering Committee. She noted the Workgroup is still formulating its recommendation to the Steering Committee of the 1-2 measures (of the six currently under consideration) that should be tested, comments in this regard also are welcome.

**SUMMARY OF WORKGROUP PROGRESS**
Dr. Nishimi informed participants the Feasibility/Testing Workgroup has held twice (generally) weekly, 1.5-hour conference calls since November 13 to identify the top 4-5 measure concepts, and from there specifications, from which KCQA can select the 1-2 related measures for testing for the purpose of submitting to NQF for endorsement consideration.

**Scope of Consideration**
Dr. Nishimi reminded participants that because the *Medication Management* domain is of wide-ranging scope, five subdomains were identified around which to organize the Workgroup's discussions:

- *Medication Documentation;*
- *Medication Reconciliation/Review;*
- *Medication Adherence;*
- *Medication Safety;* and
- *Therapeutic Appropriateness.*

She noted that, as was done with *Fluid Management* for KCQA's Cycle 1 work, the consultants performed an environmental scan (of public databases [NQF, AHRQ], literature, and Avalere's

proprietary database), surveyed KCQA member dialysis organizations for applicable internal quality improvement measures, and conducted a Call for Concepts from KCQA members. Through these mechanisms, she indicated 57 measures/measure concepts were identified for the Workgroup's review. Over the two initials calls, the Workgroup agreed to focus on the *Medication Documentation* and *Medication Reconciliation/Review* subdomains, setting aside the other three subdomains for the following reasons:

- *Medication Adherence.* Dr. Nishimi indicated Workgroup members had noted the measures identified through the environmental scan focused on medication availability, rather than adherence—i.e., whether the patient is actually taking the prescribed medication. The Workgroup felt monitoring labs and/or medication levels would provide a more meaningful assessment in this regard. Given there are no existing medication management measures developed specifically for dialysis facilities, the Workgroup also agreed there were more important areas that should be addressed prior to adherence. It also was noted the data for these types of measures generally reside in pharmacies and are not readily available to all dialysis facilities.
- *Medication Safety.* Dr. Nishimi informed participants Workgroup members agreed the more narrow types of safety measures identified through the environmental scan (e.g., the percentage of dangerous drug-drug interactions identified; medication review specifically by pharmacists; avoidance of specific high-risk drugs) were not suitable candidates for further consideration for numerous reasons—small numbers considerations, lack of pharmacists in most facilities, their belief facilities should not be penalized for identifying potential drug-drug interactions, the inherent difficulties of identifying specific medications that should *never* be prescribed for *any* patient, etc. Workgroup members also noted medication documentation and medication reconciliation can be considered safety measures.
- *Therapeutic Appropriateness.* Dr. Nishimi noted existing *Therapeutic Appropriateness* measures identified through the environmental scan were largely of similar construct—i.e., the percentage of patients with a given clinical condition who were prescribed a particular, clinically appropriate medication. Workgroup members felt some medications that could be candidates likely would be prescribed by other physicians and are thus not attributable to the dialysis facility. Similarly, by its very nature, "appropriateness" measures apply to a subset of patients and KCQA should pursue measures applicable to as large a number of patients as possible.

**Current Status**

Dr. Nishimi informed participants the Workgroup has identified three sets of measures for consideration: *Medication Documentation, Medication Reconciliation*, and *Medication Review*:

- **"Medication documentation"** is defined as recording in a list the required data elements necessary to conduct the medication reconciliation and medication review processes.
- "**Medication reconciliation**" is defined as the process of creating the most accurate list of all medications that the patient is taking, including name, indication, dosage, frequency, and route, by comparing the most recent medication list in the dialysis medical record to one or more external list(s) of medications obtained from a patient or caregiver (including patient-/caregiver-provided "brown bag" information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider.

- **"Medication review"** is defined as a process of evaluating a patient's medications and confirming them as being appropriate, safe, and convenient for the patient; a review with the patient may be included.

Dr. Nishimi indicated that for each area, two measures have been identified—one for the general population and one for "high-risk" patients, defined as patients who have undergone a care transition or newly admitted patients. She noted the general population measures require the action within 30 days, but the specifications for the "high-risk" patients require the action within 8 days for in-center patients or 30 days for home patients. She referred members to Attachment A of the memo, which sets forth the current draft specifications as of the Workgroup's call on December 15.

**DISCUSSION**

One KCQA member expressed concern the six measures developed by the Workgroup focus on attestation and asked how they differ from simple "check-box "measures. Dr. Nishimi responded the measures are not of a simple yes/no construction—rather, each requires multiple attestations addressing multiple explicit data elements. Additionally, the Workgroup ensured there are auditable fields within each measure, making the attestations verifiable.

Another participant asked whether patients on chemotherapy are included in the measures. Dr. Nishimi responded she believes chemotherapeutic agents would be addressed by the medication list, as defined in the specifications, but indicated she would specifically raise the question to the Workgroup for confirmation during its call on December 18. Also raised was whether patients enrolled in clinical trails would be included in the measures. It was noted the dialysis facility would not know whether the patient is receiving the therapeutic agent or a placebo, and so could not attest the medication list is complete. Dr. Nishimi said this scenario had not been discussed, and she would have the Workgroup consider it on the next call.

Another member asked why the allotted timeframe within which the medication documentation, reconciliation, or review can be performed within 30 days for home patients following high-risk events. Dr. Nishimi responded the Workgroup noted home patients are typically only seen in the facility monthly and, as such, might not be seen for up to 30 days following the care transition event. The participant acknowledged this is not an unusual scenario, but noted home patients are generally seen at home by multiple healthcare providers during the course of a typical month, most of whom qualify as an "eligible professional" as specified by the measures. He maintained the medication management processes could be performed more expeditiously than 30 days. Dr. Nishimi agreed to raise the issue for reconsideration by the Workgroup on its next call.

**NEXT STEPS**

Dr. Nishimi thanked participants for their time and input. She noted KCQA member input from today's call will be reported to the Workgroup and Steering Committee, after which the Workgroup will finalize its recommendation to the Steering Committee on which 1-2 measures should be tested. The Steering Committee will review the Workgroup's recommendation and will seek KCQA member input through another All-KCQA conference call in early January. Additionally, the specifications will be circulated so KCQA member organizations have the opportunity to review them prior to the testing phase.

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

**KCQA MEDICATION MANAGEMENT MEASURE FEASIBILITY/TESTING WORKGROUP**
**Conference Call #8 Summary**
**December 18, 2015**

**Attendees:** Richard Faris, PhD, MSc, RPh; Mike Guffey; Jeffrey Hymes, MD; Harold Manley, PharmD, FASN, FCCP; Paul Miller, MD; Glenda Payne, MS, RN; Sharon Perlman, MD; Wendy St. Peter, PharmD, FCCP, FASN, FNKF; Gail Wick, MHSA, BSN, RN, CNN; Robyn Y. Nishimi, PhD; Lisa McGonigal, MD, MPH; Craig Solid, PhD; Dave Gilbertson, PhD

**Not present:** Donald Molony, MD; Len Usvyat, PhD;

**Members of the public:** Claudia Dahlerus, PhD, MA (UM KECC); Joseph Messana, MD (UM KECC)

## AGENDA

After roll call, Dr. Nishimi reviewed the agenda for the call, noting she anticipates this will be the final call prior to measure testing. She advised Workgroup members the call would be used to review the revised measure specifications that incorporate the changes agreed to on the prior call and to discuss issues raised on the recent Steering Committee and All-KCQA calls and by email from Dr. Miller. She noted, however, the call primarily will be devoted to a Workgroup discussion on which 1-2 measures it believes should be recommended to the KCQA Steering Committee for testing. She reminded the Workgroup each member will be asked to make his/her case for preferences to fellow Workgroup members. Of note, although the Workgroup has been reviewing the measures essentially in "pairs," each is considered an individual measure and a maximum of two can be recommended to move forward; any combination of two measures can be recommended since we consider them all related. She informed the Workgroup that after the call, a surveymonkey link will be sent to record actual votes. Finally, she noted the summary for Call #7 had been distributed in advance of the call.

## REVIEW OF MEASURE SPECIFICATION REVISIONS

### MM-1: Medication Documentation for Patients Receiving Care at Dialysis Facilities
### MM-6: Medication Documentation at Care Transitions for Patients Receiving Care at Dialysis Facilities

Dr. Nishimi reviewed the revised MM-1 and MM-6 measure specifications:

| MM-1: Medication Documentation for Patients Receiving Care at Dialysis Facilities | |
|---|---|
| **Description** | Percentage of patient-months for which a list of current medications was documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of patient-months for which a list of current medications was documented by an eligible professional* during the reporting period.<br><br>The medication documentation MUST:<br>• Include the name of the eligible professional[1] and date of the documentation;<br>AND<br>• Address ALL known medications (orders, prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana); |

[1] Preliminary feasibility assessments suggest that "name of the eligible professional" might be difficult to extract from organizations' EMRs at a corporate level during testing, and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.

| | |
|---|---|
| | AND<br>• Record for EACH medication:<br>o Medication name, indication,[2,3] dosage,[2] frequency,[2] route of administration,[2] start and end date (if applicable),[2] discontinuation date (if applicable),[2] reason medication was stopped or discontinued (if applicable),[2] and identification of individual who authorized stoppage or discontinuation of medication (if applicable).[2]<br><br>"Medication documentation" is defined as recording in a list the required data elements necessary to conduct the medication reconciliation and medication review processes.<br><br>*For the purposes of medication documentation, "eligible professional" is defined as: physician, RN, ARNP, LPN, PA, pharmacist, or pharmacy technician. |
| **Denominator** | Total number of patient-months for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | Transient patients, defined as in-center patients who received <7 dialysis treatments in the facility during the month. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

| **MM-6: Medication Documentation at Care Transitions for Patients Receiving Care at Dialysis Facilities** | |
|---|---|
| **Description** | Percentage of high-risk patient-events for which a list of current medications was documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of high-risk patient-events* for which a list of current medications was documented by an eligible professional** within 8 days of the applicable event for in-center patients and within 30 days for home patients during the reporting period.<br><br>The medication documentation MUST:<br>• Include the name of the eligible professional[4] and date of the documentation;<br>AND<br>• Address ALL known medications (orders, prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Record for EACH medication:<br>o Medication name, indication,[5,6] dosage,[5] frequency,[5] route of administration,[5] start and end date (if applicable),[5] discontinuation date (if applicable),[5] reason medication was stopped or discontinued (if applicable),[5] and identification of individual who authorized stoppage or discontinuation of medication (if applicable).[5]<br><br>"Medication documentation" is defined as recording in a list the required data elements necessary to conduct the medication reconciliation and medication review processes.<br><br>*High-risk patient-events are defined as transitions between care settings (e.g., discharge from hospital |

[2] "Unknown" is an acceptable response for this field.
[3] Preliminary feasibility assessments suggest that medication "indication" is not routinely recorded in organizations' EMRs and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.
[4] Preliminary feasibility assessments suggest that "name of the eligible professional" might be difficult to extract from organizations' EMRs at a corporate level during testing, and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.
[5] "Unknown" is an acceptable response for this field.
[6] Preliminary feasibility assessments suggest that medication "indication" is not routinely recorded in organizations' EMRs and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.

| | |
|---|---|
| | or other care setting) and new admissions to the dialysis facility.<br>**For the purposes of medication documentation, "eligible professional" is defined as: physician, RN, ARNP, LPN, PA, pharmacist, or pharmacy technician. |
| **Denominator** | Total number of high-risk patient-events for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | 1. In-center patients who received <7 hemodialysis treatments in the facility during the month (i.e., transient patients).<br>2. In-center patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge.<br>3. Home patients discharged from hospital or other care setting who are readmitted within 30 days of the discharge. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

Dr. Nishimi reminded the Workgroup the latest revisions to the MM-1 and MM-6 specifications involved adding LPNs to the list of eligible professionals.

### MM-2: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
### MM-3: Medication Reconciliation at Care Transitions for Patients Receiving Care at Dialysis Facilities

Dr. Nishimi reviewed the revised MM-2 and MM-3 measure specifications:

| **MM-2: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities** | |
|---|---|
| **Description** | Percentage of patient-months for which medication reconciliation has been performed and documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of patient-months for which medication reconciliation was performed and documented by an eligible professional* during the reporting period.<br><br>The medication reconciliation MUST:<br>• Include the name of the eligible professional[7] and date of the reconciliation;<br>AND<br>• Address ALL known medications (orders, prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Address for EACH medication:<br>o Medication name, indication,[8,9] dosage,[8] frequency,[8] route of administration,[8] start and end date (if applicable),[8] discontinuation date (if applicable),[8] reason medication was stopped or discontinued (if applicable),[8] and identification of individual who authorized stoppage or discontinuation of medication (if applicable).[8]<br><br>"Medication reconciliation" is defined as the process of creating the most accurate list of all medications that the patient is taking, including name, indication, dosage, frequency, and route, by comparing the most recent medication list in the dialysis medical record to one or more external list(s) of medications obtained from a patient or caregiver (including patient-/caregiver-provided "brown bag" information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider. |

[7] Preliminary feasibility assessments suggest that "name of the eligible professional" might be difficult to extract from organizations' EMRs at a corporate level during testing, and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.
[8] "Unknown" is an acceptable response for this field.
[9] Preliminary feasibility assessments suggest that medication "indication" is not routinely recorded in organizations' EMRs and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.

| | |
|---|---|
| | *For the purposes of medication reconciliation, "eligible professional" is defined as: physician, RN, ARNP, PA, pharmacist, or pharmacy technician. |
| **Denominator** | Total number of patient-months for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | Transient patients, defined as in-center patients who received <7 dialysis treatments in the facility during the month. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

| **MM-3: Medication Reconciliation at Care Transitions for Patients Receiving Care at Dialysis Facilities** | |
|---|---|
| **Description** | Percentage of high-risk patient-events for which medication reconciliation was performed and documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of high-risk patient-events* for which medication reconciliation was performed and documented by an eligible professional** within 8 days of the applicable event for in-center patients and within 30 days for home patients during the reporting period.<br><br>The medication reconciliation MUST:<br>• Include the name of the eligible professional[10] and date of the reconciliation;<br>AND<br>• Address ALL known medications (orders, prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Address for EACH medication:<br>o Medication name, indication,[11,12] dosage,[11] frequency,[11] route of administration,[11] start and end date (if applicable),[11] discontinuation date (if applicable),[11] reason medication was stopped or discontinued (if applicable),[11] and identification of individual who authorized stoppage or discontinuation of medication (if applicable).[11]<br><br>If a facility has been unable to procure the discharge medications list from the discharging facility within the defined 8 days of the applicable event for in-center patients or 30 days for home patients, the facility must indicate the following to receive credit for the measure:[13]<br><br>☐ Attempted but unable to obtain discharge medications list from discharging facility within 8 days of discharge for in-center patient or 30 days for home patient.<br>• Date of attempt to obtain discharge medications list: _____<br>• Name of person who attempted to obtain discharge medications list: _____<br>• Name of discharging facility: _____<br><br>"Medication reconciliation" is defined as the process of creating the most accurate list of all medications that the patient is taking, including name, indication, dosage, frequency, and route, by comparing the most recent medication list in the dialysis medical record to one or more external list(s) of discharge, care transition, or admission medications (as applicable) obtained from a patient or caregiver (including |

[10] Preliminary feasibility assessments suggest that "name of the eligible professional" might be difficult to extract from organizations' EMRs at a corporate level during testing, and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.
[11] "Unknown" is an acceptable response for this field.
[12] Preliminary feasibility assessments suggest that medication "indication" is not routinely recorded in organizations' EMRs and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.
[13] Preliminary feasibility assessments suggest that data elements required for this "failed attempt" attestation are not readily collectible in some organizations' EMRs and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the attesting must be removed from the specifications.

| | |
|---|---|
| | patient-/caregiver-provided "brown-bag" information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider.<br><br>*High-risk patient-events are defined as transitions between care settings and new admissions to the dialysis facility.<br>**For the purposes of medication reconciliation, "eligible professional" is defined as: physician, RN, ARNP, PA, pharmacist, or pharmacy technician. |
| **Denominator** | Total number of high-risk patient events for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | 1. In-center patients who received <7 hemodialysis treatments in the facility during the month (i.e., transient patients).<br>2. In-center patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge.<br>3. Home patients discharged from hospital or other care setting who are readmitted within 30 days of the discharge. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

Dr. Nishimi indicated the latest revisions to MM-2 and MM-3 involved adding pharmacy technicians to the list of eligible professionals.

### MM-4: Medication Review for Patients Receiving Care at Dialysis Facilities
### MM-5: Medication Review at Care Transitions for Patients Receiving Care at Dialysis Facilities

Dr. Nishimi reviewed the MM-4 and MM-5 measure specifications:

| MM-4: Medication Review for Patients Receiving Care at Dialysis Facilities | |
|---|---|
| **Description** | Percentage of patient-months during which a medication review was performed and documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of patient-months during which a medication review was performed and documented by an eligible professional* during the reporting period.<br><br>The medication review MUST:<br>• Include name of eligible professional[14] and date of the review;<br>AND<br>• Address ALL known medications (orders, prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);<br>AND<br>• Address for EACH medication:<br>o Medication name, indication[15,16] dosage,[15] frequency,[15] route of administration,[15] start and end date (if applicable),[15] discontinuation date (if applicable),[15] reason medication was stopped or discontinued (if applicable),[15] and identification of individual who authorized stoppage or discontinuation of medication (if applicable).[15]<br>o Is the indication valid for each medication?[16] |

[14] Preliminary feasibility assessments suggest that "name of the eligible professional" might be difficult to extract from organizations' EMRs at a corporate level during testing, and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.
[15] "Unknown" is an acceptable response for this field.
[16] Preliminary feasibility assessments suggest that medication "indication" is not routinely recorded in organizations' EMRs and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.

| | |
|---|---|
| | ○ Are there duplications of therapy?<br>○ Are there any potential clinically relevant drug-drug, drug-food, or drug-disease interactions?<br>○ Is the patient experiencing any adverse effect from any drug? If yes, document drug, adverse event, and date.<br>○ Is the drug dose and frequency appropriate for the patient? Factors that should be considered include, but are not limited to: residual kidney function, method of dialysis, frequency and type of dialysis membrane, presence of other organ dysfunction (e.g., liver), patient weight (overweight, underweight, amputation, muscle wasting), laboratory values, other relevant patient factors such as gender, race/ethnicity, concomitant disease.<br>○ Can the patient take the medication as prescribed?<br>○ Is the appropriate monitoring being conducted for each medication?<br>AND<br>• List any allergies, intolerances, or adverse drug events experienced by the patient.<br><br>"Medication review" is defined as a process of evaluating a patient's medications and confirming them as being appropriate, safe, and convenient for the patient; a review with the patient may be included.<br><br>*For the purposes of medication review, "eligible professional" is defined as: physician, ARNP, PA, or pharmacist. |
| **Denominator** | Total number of patient-months for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | Transient patients, defined as in-center patients who received <7 dialysis treatments in the facility during the month. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

| **MM-5: Medication Review at Care Transitions for Patients Receiving Care at Dialysis Facilities** | |
|---|---|
| **Description** | Percentage of high-risk patient-events for which a medication review was performed and documented by an eligible professional. |
| **Measure Type** | Process. |
| **Data Source** | Facility medical record. |
| **Level of Analysis** | Dialysis facility. |
| **Numerator** | Number of high-risk patient-events* for which a medication review was performed and documented by an eligible professional** within 8 days of the applicable event for in-center patients and within 30 days for home patients during the reporting period.<br><br>The review MUST:<br>• Include name of eligible professional[17] and date of the review.<br>AND<br>• Address ALL known orders, prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana.<br>AND<br>• Address for EACH medication:<br>○ Medication name, indication,[18,19] dosage,[18] frequency,[18] route of administration,[18] start and end date (if applicable),[18] discontinuation date (if applicable),[18] reason medication was stopped or discontinued (if applicable),[18] and identification of individual who authorized stoppage or discontinuation of medication (if |

[17] Preliminary feasibility assessments suggest that "name of the eligible professional" might be difficult to extract from organizations' EMRs at a corporate level during testing, and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.
[18] "Unknown" is an acceptable response for this field.
[19] Preliminary feasibility assessments suggest that medication "indication" is not routinely recorded in organizations' EMRs and thus might present a feasibility issue. Feasibility will be further assessed during measure testing to determine if the data element should be removed from the specifications.

| | |
|---|---|
| | applicable).[18]<br>o Is the indication valid for each medication?[19]<br>o Are there duplications of therapy?<br>o Are there any potential clinically relevant drug-drug, drug-food, or drug-disease interactions?<br>o Is the patient experiencing any adverse effect from any drug? If yes, document drug, adverse event, and date.<br>o Is the drug dose and frequency appropriate for the patient? Factors that should be considered include, but are not limited to: residual kidney function, method of dialysis, frequency and type of dialysis membrane, presence of other organ dysfunction (e.g. liver), patient weight (overweight, underweight, amputation, muscle wasting), laboratory values, other relevant patient factors such as gender race/ethnicity, concomitant disease.<br>o Can the patient take the medication as prescribed?<br>o Is the appropriate monitoring being conducted for each medication?<br>AND<br>• List any allergies, intolerances, or adverse drug events experienced by the patient.<br><br>"Medication review" is defined as a process of evaluating a patient's medications and confirming them as being appropriate, safe, and convenient for the patient; a review with the patient may be included.<br><br>*High-risk patient-events are defined as transitions between care settings and new admissions to the dialysis facility.<br><br>**For the purposes of medication review, "eligible professional" is defined as: physician, ARNP, PA, or pharmacist. |
| **Denominator** | Total number of high-risk patient events for all patients assigned to a dialysis facility during the reporting period. |
| **Exclusions** | 1. In-center patients who received <7 hemodialysis treatments in the facility during the month (i.e., transient patients).<br>2. In-center patients discharged from hospital or other care setting who are readmitted within 8 days of the discharge.<br>3. Home patients discharged from hospital or other care setting who are readmitted within 30 days of the discharge. |
| **Reporting and Stratification** | No risk adjustment or risk stratification. |

Dr. Nishimi indicated no revisions were made to MM-4. She noted, however, that for all three "high-risk" measures (MM-6, MM-3, and MM-5), the "applicable event" language in the numerator statements was clarified (i.e., changing it to "transition event" and providing an example to make it clear when the "clock starts"). An exclusion for patients who experience a subsequent event (e.g., return to the hospital) within 8 days of the initial event also was added to the high-risk measures; as agreed, the exclusion is an 8-day return for *both* in-center and home patients. Finally, she indicated those data elements that might need to be removed for feasibility issues (eligible professional, indication, and the "attempted to obtain discharge information" attestation) have been footnoted to indicate such.

**ISSUES IDENTIFIED BY STEERING COMMITTEE ON DECEMBER 14 CALL**

Dr. Nishimi informed the Workgroup that the Steering Committee had reviewed the measure specifications, as well as outstanding issues identified by the Workgroup. The additional concern raised by a Steering Committee member is the value of pursuing reconciliation measures—particularly for the "high-risk" patients—if a subsequent review is not also verified by measurement. The Steering Committee member noted readmissions are less likely to be prevented if there is no review of issues identified during the reconciliation process.

Workgroup members responded that if the reconciliation measures are ultimately recommended, it does not imply either documentation or review are not considered highly important by the Workgroup. Rather, Workgroup members expressed concern the documentation measures set too low a bar and the review measures are likely unfeasible until further advances are made in EMR systems—the reconciliation measures offer a middle ground that will promote rigor in dialysis facility medication management processes. The measures also necessitate that appropriate documentation occur prior to the reconciliation and will promote a subsequent review of medication discrepancies identified during the reconciliation.

**ISSUES IDENTIFIED BY ALL-KCQA MEMBERS ON DECEMBER 16 CALL**

Dr. Nishimi informed the Workgroup that one KCQA member expressed concern the six measures developed by the Workgroup focus on attestation and asked how they differ from simple check-box measures. Dr. Nishimi noted she had responded the measures are not of a simple yes/no construction; rather, each requires multiple attestations addressing multiple explicit data elements. Additionally, the Workgroup had ensured there are auditable fields within each measure, making the attestations verifiable.

Dr. Nishimi noted one KCQA member asked whether patients on chemotherapy are included in the measures; she had responded she believes chemotherapeutic agents would be addressed by the medication list as specified in the measures, but would raise the question with the Workgroup for confirmation. One Workgroup member remarked "fixed interval" chemotherapies are manageable, but that chemotherapy "roadmaps" will be challenging and should be excluded. Another disagreed, noting she was aware of a dialysis patient who had died following a chemotherapy overdose that had been erroneously based on the patient's creatinine value. She opined this is an important issue that must be addressed by the measures. Another Workgroup member agreed all attempts should be made to include all patients, but it would be very time consuming to track patients on different chemotherapeutic regimens. He noted, however, the specifications imply "to the best of our ability" and the attempt should be made. Dr. Nishimi suggested the current specifications, which use "all known medications," includes chemotherapies, and there is no need to specifically address these medications. The Workgroup agreed and concluded no exclusion or other change is necessary.

Dr. Nishimi informed the Workgroup a KCQA member questioned whether patients enrolled in clinical trails would be included in the measures, noting the dialysis facility would not know whether the patient is receiving the therapeutic agent or a placebo, and so could not attest the medication list is complete. Dr. Nishimi had noted this scenario had not been specifically discussed, but she would have the Workgroup consider the issue. Workgroup members opined that medical records generally only indicate a patient is in a trial, and there is no way to know if the medication or a placebo is being administered. Some suggested this information could be entered in the "other" field, but others noted this might not be feasible in all EMR systems. Dr. Nishimi proposed adding a footnote to the measures acknowledging that when a patient is in a clinical trial, it will be unknown whether the medication or placebo is being taken. The Workgroup agreed to this plan of action.

Dr. Nishimi informed the Workgroup another KCQA member had asked why the allotted timeframe within which the medication documentation, reconciliation, or review can be performed following high-risk events was specified as 30 days for home patients. Dr. Nishimi had explained the Workgroup noted home patients are typically only seen in the facility once monthly and, as such, might not be seen for up to 30 days following the care transition event. The member noted, however, home patients often are seen at home by multiple healthcare

providers during the course of a typical month, most of whom qualify as an "eligible professional" as specified by the measures. He maintained the medication management processes could be performed more expeditiously than 30 days; Dr. Nishimi had agreed to raise the issue for reconsideration by the Workgroup on its next call. Workgroup members agreed the exclusion timeframe had been carefully considered and expressed the continued concern about the feasibility of performing the processes for home patients within 8 days. The Workgroup determined that the exclusion should not be revised.

**ISSUES RAISED BY DR. MILLER VIA EMAIL**

Dr. Nishimi advised the Workgroup that Dr. Miller had sent an email in advance of today's call raising several concerns with the measures as currently specified. She indicated the first issue was whether "orders" should be included, given orders will include immunizations, saline, heparin, etc. Dr. Nishimi noted that immunizations is a broad category the Workgroup could choose to specifically add. The other items would go to the level of measure microspecifications, in her opinion, but the Workgroup could make a comment on these, if desired.

Dr. Miller added that when a list is constructed, it needs to be meaningful, but there is a limit to how "complete" that list can be—i.e., there is a purpose for understanding patterns, signals, and frequency of medications, but there is a point where providers will become "snow blind" by the sheer volume of what is included. He urged that lists be structured and include categorization, or the Workgroup won't achieve what it hoped with these measures. Other Workgroup members responded that while categorization of lists is helpful, it is not realistic to try to dictate how facilities list their medications. One noted this level of categorization cannot be accomplished with the EMR systems in use within her organization at this time.

One Workgroup member questioned whether medications administered during dialysis should be included, noting focusing on agents such as ESAs is not unreasonable, but going to the level of saline is more prescriptive than the Workgroup would want to be with the measures. One member noted she felt the purpose of the list is to verify what the patient is taking compared to what the facility believes he or she is taking. She recommended medications administered during dialysis not be included; these change from treatment to treatment and would be too overwhelming to monitor within the medications list. She noted the purpose of this entire effort is to increase patient safety with respect to what patients are administering to themselves at home, rather than what is being used intradialytically. Others agreed, but one Workgroup member suggested that oral Vitamin D be included; if there is no record of IV Vitamin D being administered during treatment, this could become a safety issue.

Dr. Miller remarked that, in raising the issue, he was not advocating everything be included in the list, but is rather asking that the Workgroup clarify specifically what should and should not be included. Workgroup members agreed saline and mannitol should not be included, but some again questioned whether Vitamin D analogs and perhaps diphenhydramine should be. One Workgroup member urged that all medications—home and intradialyic—be listed in the same place. Another noted she believes there should be oversight of medications administered during dialysis, but that it is a different process—the medical personnel administering a Vitamin D analog is in communication with the nephrologist who ordered it. She noted facility personnel have a list of what is administered during dialysis; if the home list is accurate, a comparison can be made. Others agreed both lists are readily available so as to allow a comparison, such that the list of home medications informs what is administered intradialytically. One Workgroup member noted that while it is vitally important to address medications prescribed while in the hospital or administered during an emergency department

visit, these drugs should not be added to the patient's medications list; this would unnecessarily "muddy the waters" and would make it difficult to determine the next month what the patient is currently on. The comparison should take place during the transition medication review, but the medications should not be included in the main list.

The Workgroup ultimately concluded the medications list addressed by the documentation and reconciliation measures should be limited to "home" medications and not include those received during dialysis. Members also agreed the review measures, however, should address intra-treatment medications, so as to allow identification of incompatible or contraindicated medications that might have been administered while hospitalized or during an emergency department visit.

Dr. Nishimi indicated Dr. Miller's second and third issues—use of the phrases "per approved protocol" and "standing orders" to indicate intradialytic medication administration—appeared to have been effectively addressed through the clarification the list applies only to home medications. Dr. Miller and other Workgroup members concurred.

**INDIVIDUAL WORKGROUP RECOMMENDATIONS**

Dr. Nishimi then asked Workgroup members to identify their top two choices and provide a rationale for their decision. The Workgroup's responses follow:

- ***Glenda Payne:*** Ms. Payne advocated for MM-2 and MM-3, noting the reconciliation measures will necessarily require that documentation had occurred in advance and that a review should be completed to address identified discrepancies. She added many facilities already do this, but not all do so at transitions. She believes the reconciliation measures will result in safer care and are more feasible than the review measures and more rigorous than the documentation measures.
- ***Sharon Perlman:*** Dr. Perlman selected MM-2 and MM-3, for similar reasons to Ms. Payne. Documentation is too simple and review, while the "brass ring," is more than most facilities can handle at this point.
- ***Richard Faris:*** Dr. Faris felt MM-3 is critical, since it addresses a "hand-off" issue. He believes, however, that MM-2 is not practical on a monthly basis and instead suggested MM-1, the general population medication documentation measure.
- ***Harold Manley:*** Dr. Manley identified MM-4 and MM-5, as review to resolve identified discrepancies is of the highest priority. He noted the general population measure (MM-4) is of a higher priority than the high-risk measure (MM-5).
- ***Mike Guffey:*** Mr. Guffey advocated for MM-1 and MM-3, the general population documentation and high-risk reconciliation measures, respectively. He said MM-3 will help with the disadvantaged high-risk patients, while MM-1 will build a baseline for reference.
- ***Jeff Hymes:*** Dr. Hymes identified his preferences as MM-2 and MM-3. He noted he prefers the review measures (MM-4 and MM-5), but believes they are too aspirational at this time and the reconciliation measures are the way to go. He stated his preference for MM-3 over MM-2.
- ***Wendy St. Peter:*** Dr. St. Peter selected MM-2 and MM-4, the general population reconciliation and review measures, respectively). She noted since most facilities are already doing documentation, she is not sure these measures would improve quality.

She stated her belief a revolution is needed, not baby steps. (NOTE: Dr. St. Peter subsequently revised her selection to MM-2 and MM-3.)

- ***Paul Miller:*** Dr. Miller identified his preferences as MM-1 and MM-2, the general population documentation and reconciliation measures, respectively. He noted he believes these are what is feasible in a timely fashion and meaningful, without having to hire additional dedicated staff.
- ***Gail Wick:*** Ms. Wick said she favored the reconciliation measures, MM-2 and MM-3. She added this will be a "stretch", but will be doable and meaningful, without requiring that already limited staff be pulled away from other aspects of care.

**PUBLIC COMMENT**
The audience members offered no public comments, but thanked the Workgroup for the opportunity to listen in on its calls.

**NEXT STEPS**
Dr. Nishimi advised the Workgroup this would be the final conference call until after measure testing. She reminded the Workgroup that Dr. McGonigal would forward a surveymonkey link shortly after the call to record Workgroup members' formal votes on which measures to advance to testing; the deadline with be December 23. She noted the Workgroup would be informed of the results, as would the Steering Committee and All-KCQA. She reminded the Workgroup there would be an All-KCQA conference call in January to discuss results and invited Workgroup members to attend if so inclined.

Dr. Nishimi thanked Workgroup members for their time and efforts and adjourned the call.