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.