NATIONAL QUALITY FORUM

This Word document of the NQF Measure Submission form is provided for use as a working file to prepare for entry into the online form. This document is arranged in the same order as the electronic version of the form to the process of data transfer. DO NOT ATTACH THIS FILE TO THE SUBMISSION FORM.

The evidence and measure testing attachments are separate Word documents that are attached to the online submission form where indicated. (Available on Submitting Standards Page)

For any technical assistance needed while completing this form please email info@qualityfourm.org for assistance.

Project Name: **Patient Safety 2015-2017.**
Measure #: **NQF 2988.**
Measure Title: *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities.*
Last Edit Date: **Not applicable; new measure.**
Last Edit By: **Not applicable; new measure.**
Measure: **Process.**
Status: **New measure.**

Contents

Introduction

Thank you for your interest in submitting a measure to NQF for possible endorsement.

What criteria are used to evaluate measures? Measures are evaluated on four standardized criteria: importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. For your measure to be evaluated against these measure evaluation criteria , you must complete the measure submission form.

Why do I have to complete a form? Due to the volume and/or complexity of proposed measures, NQF provides measure information to committee reviewers in a standardized format to facilitate their evaluation of whether the measure meets NQF's measure evaluation criteria. This form allows the measure steward to present information demonstrating that the proposed measure meets NQF's criteria.

What is on the form? The information requested in this form is directly related to NQF's measure evaluation criteria and is consistent with the data fields agreed upon in the *Common Data Fields Collaboration*.

Can't I just submit our files for consideration? No. Measures must be submitted through the online form to be considered. Requested information should be entered directly into this form.

Can I submit additional details and materials? Additional materials will be considered only as supplemental. Do NOT rely on material provided in attachments or in links to provide measure specifications or to demonstrate meeting the criteria. For example, definitions should be provided in the measure specification detail fields. Some examples of appropriate supplemental materials include code lists that exceed two pages, data collection tools, and methodology reports for complex measures. Even in these examples, the core information should be provided in the appropriate submission form fields. I f supplemental materials are provided, a link to a web page is preferred over attached materials. Be sure to indicate specific page numbers or web page locations for the relevant information. Please contact **the designated project staff** regarding questions about submitting supplemental materials.

What do I do first? When you first start a new submission or click on ''Begin Submission'', you will be directed to the "NQF Conditions" tab, which asks questions about several conditions that must be met before your proposed measures may be considered and evaluated for suitability as NQF-endorsed voluntary consensus standards:
- Is there a signed Measure Steward Agreement (applicable to all non-government organizations)?
- Have you identified the entity and process that will be used to maintain and update the measure?
- Does the intended use include both public reporting and quality improvement?
- Is the measure fully specified and tested for reliability and validity?
- Have you addressed harmonization of related measures and issues with competing measures?
- Is the measure submission information complete with all requested information entered in the form?

Once you have agreed that the four conditions have been met by answering all questions marked with an asterisk, you can begin completing the measure submission form.

Can I come back later to complete a submission once I have started? Yes. You can return to your submission at your
convenience to complete the form until the designated deadline for the specific project. To save and return, simply click on the save- draft option anytime during the submission process. When you want to continue, please login to the National Quality Forum website, go to your Dashboard, and click on submission.

Can I make changes to a form once I have submitted it? No. Once you submit your measure, you will NOT be able to return to this submission form to make further revisions.

What if I need additional help? Please contact the project director identified in the call for measures if you have questions regarding the information requested or submitting supplemental materials.

Please email us at web-help@qualityforum.org if you experience technical difficulties using the online submission form. Thank you for your interest in submitting measures to NQF.

NQF Conditions

Conditions that must be met for consideration by NQF
Several conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. I f any of the conditions are not met, the measure will not be accepted for consideration.

A. The measure is in the public domain or a Measure Steward Agreement is signed. (All non-government organizations must sign a Measure Steward Agreement even if measures are made publicly and freely available.)

B. The measure owner/steward verifies there is an identified responsible entity and a process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every three years.

C. The intended use of the measure includes both accountability applications (including public reporting) and performance improvement to achieve high-quality, efficient healthcare.

D. The measure is fully specified and tested for reliability and validity.

E. The measure developer/steward attests that harmonization with related measures and issues with competing measures have been considered and addressed, as appropriate.

F. The requested measure submission information is complete and responsive to the questions so that all the information needed to evaluate all criteria is provided.
Do you agree to the conditions?

☒**I have read and accept the conditions as specified above***

Specifications

Descriptive Information
De.1. Measure Type *(Patient-reported outcomes include HRQoL/functional status, symptom/burden, experience with care, health-related behavior.)***: Process.**

De.2. Measure Title*: *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities.*

De.3. Brief description of measure (*including type of score, measure focus, target population, timeframe, e.g., Percentage of adult patients aged 18-75 years receiving one or more HbA1c tests per year*): **Percentage of patient-months for which medication reconciliation* was performed and documented by an eligible professional.****

_____
* "Medication reconciliation" is defined as the process of creating the most accurate list of all home 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.

** For the purposes of medication reconciliation, "eligible professional" is defined as: physician, RN, ARNP, PA, pharmacist, or pharmacy technician.

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?: **Not applicable.**

De.5. Subject/Topic Areas (Check all the areas that apply):

☐ Behavioral Health: Behavioral Health

☐ Behavioral Health: Alcohol, Substance Use/Abuse

☐ Behavioral Health: Attention Deficit Hyperactivity Disorder (ADHD)

☐ Behavioral Health: Depression

☐ Behavioral Health: Post-Traumatic Stress Disorder (PTSD)

☐ Behavioral Health: Screening

☐ Behavioral Health: Serious Mental Illness

☐ Behavioral Health: Suicide

☐ Behavioral Health: Tobacco Use

☐ Infectious Diseases: Hepatitis

☐ Infectious Diseases: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

☐ Infectious Diseases: Immunization

☐ Infectious Diseases: Respiratory

☐ Infectious Diseases: Sexually Transmitted

☐ Infectious Diseases: Tuberculosis

☐ Infectious Diseases: Screening

☐ Mental Health: Mental Health

☐ Mental Health: Alcohol, Substance Use/Abuse

- ☐ Cancer: Cancer
- ☐ Cancer: Bladder
- ☐ Cancer: Breast
- ☐ Cancer: Colorectal
- ☐ Cancer: Gynecologic
- ☐ Cancer: Hematologic
- ☐ Cancer: Liver
- ☐ Cancer: Lung, Esophageal
- ☐ Cancer: Pancreatic
- ☐ Cancer: Prostate
- ☐ Cancer: Screening
- ☐ Cancer: Skin
- ☐ Cardiovascular: Cardiovascular
- ☐ Cardiovascular: Acute Myocardial Infarction
- ☐ Cardiovascular: Atrial Fibrillation
- ☐ Cardiovascular: Congestive Heart Failure
- ☐ Cardiovascular: Hyperlipidemia
- ☐ Cardiovascular: Hypertension
- ☐ Cardiovascular: Ischemic Heart Disease, Coronary Artery Disease
- ☐ Cardiovascular: Percutaneous Coronary Intervention (PCI)
- ☐ Cardiovascular: Screening
- ☐ Endocrine: Endocrine
- ☐ Endocrine: Diabetes
- ☐ Endocrine: Screening
- ☐ Endocrine: Thyroid Disorders
- ☐ Gastrointestinal (GI): Gastrointestinal (G)
- ☐ Gastrointestinal (GI): Appendicitis
- ☐ Gastrointestinal (GI): Cirrhosis
- ☐ Gastrointestinal (GI): GI Bleeding
- ☐ Gastrointestinal (GI): Gall Bladder Disease
- ☐ Gastrointestinal (GI): Gastroenteritis
- ☐ Gastrointestinal (GI): Gastro-Esophageal Reflux Disease (GERD)
- ☐ Gastrointestinal (GI): Polyps
- ☐ Gastrointestinal (GI): Screening
- ☐ Gastrointestinal (GI): Peptic Ulcer
- ☐ GU/GYN: GU/GYN
- ☐ GU/GYN: Incontinence

- ☐ Mental Health: Depression
- ☐ Mental Health: Domestic Violence
- ☐ Mental Health: Serious Mental Illness
- ☐ Mental Health: Suicide
- ☐ Musculoskeletal: Musculoskeletal
- ☐ Musculoskeletal: Osteoarthritis
- ☐ Musculoskeletal: Rheumatoid Arthritis
- ☐ Musculoskeletal: Hip/Pelvic Fracture
- ☐ Musculoskeletal: Joint Surgery
- ☐ Musculoskeletal: Low Back Pain
- ☐ Musculoskeletal: Osteoporosis
- ☐ Neurology: Neurology
- ☐ Neurology: Brain Injury
- ☐ Neurology: Cognitive Impairment/Dementia
- ☐ Neurology: Delirium
- ☐ Neurology: Stroke/Transient Ischemic Attack (TIA)
- ☐ Perinatal and Reproductive Health: Perinatal and Reproductive Health
- ☐ Perinatal and Reproductive Health: Gynecology
- ☐ Perinatal and Reproductive Health: Newborn
- ☐ Perinatal and Reproductive Health: Perinatal
- ☐ Perinatal and Reproductive Health: Screening
- ☐ Prevention: Prevention
- ☐ Prevention: Development/Wellness
- ☐ Prevention: Immunization
- ☐ Prevention: Malnutrition
- ☐ Prevention: Obesity
- ☐ Prevention: Physical Activity
- ☐ Prevention: Screening
- ☐ Prevention: Tobacco Use
- ☐ Pulmonary/Critical Care: Pulmonary/Critical Care
- ☐ Pulmonary/Critical Care: Asthma
- ☐ Pulmonary/Critical Care: Chronic Obstructive Pulmonary
- ☐ Disease (COPD)
- ☐ Pulmonary/Critical Care: Critical Care
- ☐ Pulmonary/Critical Care: Dyspnea
- ☐ Pulmonary/Critical Care: Pneumonia
- ☐ Pulmonary/Critical Care: Sleep Apnea
- ☒ **Renal: Renal**

☐ GU/GYN: Screening

☐ Head, Eyes, Nose, Throat (HEENT): Head, Eyes, Ears, Nose, Throat (HEENT)

☐ Head, Eyes, Ears, Nose, Throat (HEENT): Dental

☐ Head, Eyes, Ears, Nose, Throat (HEENT): Ear Infection

☐ Head, Eyes, Ears, Nose, Throat (HEENT): Hearing

☐ Head, Eyes, Ears, Nose, Throat (HEENT): Pharyngitis

☐ Head, Eyes, Ears, Nose, Throat (HEENT): Screening

☐ Head, Eyes, Ears, Nose, Throat (HEENT): Vision

☐ Infectious Diseases: Infectious Diseases

☐ Renal: Chronic Kidney Disease (CKD)

☒ **Renal: End Stage Renal Disease (ESRD)**

☐ Surgery: Surgery

☐ Surgery: Cardiac Surgery

☐ Surgery: General Surgery

☐ Surgery: Perioperative

☐ Surgery: Thoracic Surgery

☐ Surgery: Vascular Surgery

De.6. Cross Cutting Areas (Check all the areas that apply):

☐ Health and Functional Status: Health and Functional Status

☐ Health and Functional Status: Development/Wellness

☐ Health and Functional Status: Functional Status

☐ Prevention: Prevention

☐ Prevention: Immunization

☐ Prevention: Nutrition

☐ Prevention: Obesity

☐ Prevention: Physical Activity

☐ Prevention: Screening

☐ Prevention: Social Determinants

☐ Access

☒ **Care Coordination: Care Coordination**

☐ Care Coordination: Readmissions

☐ Disparities

☐ Functional Status

☐ Overuse

☐ Palliative Care and End of Life Care

☐ Patient and Family Engagement

☒ **Safety: Safety**

☐ Safety: Complications

☐ Safety: Healthcare Associated Infections

☒ **Safety: Medication Safety**

☐ Safety: Venous Thromboembolism

☐ Safety: Readmissions

☐ Safety: Workforce

Measure Specifications

S.1. Measure-specific Web Page *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)***: http://www.kidneycarepartners.com/files2/94**

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)**: Not applicable.**

☐ Available in attached file
☒ **No HQMF specs**

S.2b. Data Dictionary Code Table, *or value sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)*

     ○ Available in attached Excel or csv file
     ⊙ **No data dictionary/code table – all information provided in the submission form**

S.3. <u>For endorsement maintenance</u>, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons. **Not applicable.**

S.4. Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome). <u>IF an OUTCOME MEASURE</u>, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm:* **Number of patient-months for which medication reconciliation was performed and documented by an eligible professional during the reporting period.**

The medication reconciliation MUST:
- **Include the name or other unique identifier of the eligible professional;**
AND
- **Include the date of the reconciliation;**
AND
- **Address ALL known home medications (prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana);**
AND
- **Address for EACH home medication: Medication name,[1] indication,[2] 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]**
AND
- **List any allergies, intolerances, or adverse drug events experienced by the patient.**

_____

[1] 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.

[2] "Unknown" is an acceptable response for this field.

S.5. Time Period for Data *(What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)* **12 months.**

S.6. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b). <u>IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.</u>*

<u>NUMERATOR STEP 1</u>. **For each patient meeting the denominator criteria in the given calculation month, identify all patients with <u>each</u> of the following three numerator criteria (a, b, and c) documented in the facility medical record to define the numerator for that month:**

    a. **Facility <u>attestation</u> that during the calculation month:**

        1. **The patient's most recent medication list in the dialysis medical record was reconciled to one or**

more external list(s) of medications obtained from the patient/caregiver (including patient-/caregiver-provided "brown-bag" information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider AND that ALL known medications (prescriptions, OTCs, herbals, vitamin/mineral/dietary [nutritional] supplements, and medical marijuana) were reconciled;

AND

2. ALL of the following items were addressed for EACH identified medication:
   a) Medication name;
   b) Indication (or "unknown");
   c) Dosage (or "unknown");
   d) Frequency (or "unknown");
   e) Route of administration (or "unknown");
   f) Start date (or "unknown");
   g) End date, if applicable (or "unknown");
   h) Discontinuation date, if applicable (or "unknown");
   i) Reason medication was stopped or discontinued, if applicable (or "unknown"); and
   j) Identification of individual who authorized stoppage or discontinuation of medication, if applicable (or "unknown");

AND

3. Allergies, intolerances, and adverse drug events were addressed and documented.

   b. Date of the medication reconciliation.

   c. Identity of eligible professional performing the medication reconciliation.

NUMERATOR STEP 2. Repeat "Numerator Step 1" for each month of the one-year reporting period to define the final numerator (patient-months).

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*
IF an OUTCOME MEASURE, state the target population for the outcome. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.18). **Total number of patient-months for all patients permanently assigned to a dialysis facility during the reporting period.**

S.8. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

☐ Children's Health

☐ Maternal Health

☒ **Populations at Risk: Populations at Risk**

☐ Populations at Risk: Dual eligible beneficiaries

☒ **Populations at Risk: Individuals with multiple chronic conditions**

☐ Populations at Risk: Veterans

☐ Senior Care

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*:

DENOMINATOR STEP 1. Identify all in-center and home hemodialysis and peritoneal dialysis patients permanently assigned to the dialysis facility in the given calculation month.

DENOMINATOR STEP 2. For all patients included in the denominator in the given calculation month in "Denominator Step 1", identify and remove all in-center hemodialysis patients who received < 7 dialysis treatments in the calculation month.

DENOMINATOR STEP 3. Repeat "Denominator Step 1" and "Denominator Step 2" for each month of the one-year reporting period.

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*: **In-center patients who receive < 7 hemodialysis treatments in the facility during the reporting month.**

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*: **As detailed in "Denominator Step 2" above, transient patients, defined as in-center patients who receive < 7 hemodialysis treatments in the facility during the reporting month, are excluded from the measure.**

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*: **Not applicable.**

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

- ⊙ **No risk adjustment or risk stratification**
- ○ Statistical risk model
- ○ Stratification by risk category/subgroup
- ○ Other (specify)

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*: **Not applicable.**

S.15. Detailed risk model specifications *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*
Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b. **Not applicable.**

- ○ Available in attached Excel or csv file
- ○ Provided in response box S.15a

S.16. Type of score: (Please select one of the following options)

    ○ Count
    ⊙ **Rate/proportion**
    ○ Ratio
    ○ Categorical, e.g., yes/no
    ○ Continuous variable, e.g. average
    ○ Other (specify):

S.17. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

    ⊙ **Better quality = higher score**
    ○ Better quality = lower score
    ○ Better quality = score within a defined interval
    ○ Passing score defines better quality

S.18. Calculation Algorithm/Measure Logic *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.):* **Scores are calculated using the following algorithm. For each calculation month in the one-year reporting period:**

1. **IDENTIFY THE "RAW DENOMINATOR POPULATION"**
   Identify all in-center and home hemodialysis and peritoneal dialysis patients permanently assigned to the dialysis facility during the given calculation month.

2. **REMOVE PATIENTS MEETING MEASURE EXCLUSION CRITERIA TO DEFINE THE "FINAL DENOMINATOR POPULATION" FOR THE CALCULATION MONTH**
   For all patients included in the denominator during the given calculation month in Step 1 above, identify and remove all in-center patients who received < 7 hemodialysis treatments during the given calculation month.

3. **IDENTIFY THE "NUMERATOR POPULATION" FOR THE CALCULATION MONTH**
   For each patient remaining in the denominator during the given calculation month after Step 2, identify all patients with each of the following three numerator criteria (a, b, and c) documented in the facility medical record to define the numerator for that month:

   a. **Facility attestation that during the calculation month:**

       1. **The patient's most recent medication list in the dialysis medical record was reconciled to one or more external list(s) of medications obtained from the patient/caregiver (including patient-/caregiver-provided "brown-bag" information), pharmacotherapy information network (e.g., Surescripts®), hospital, or other provider AND that ALL known medications (prescriptions, OTCs, herbals, vitamin/mineral/dietary [nutritional] supplements, and medical marijuana) were reconciled;**

       AND

       2. **ALL of the following items were addressed for EACH identified medication:**
           a) **Medication name;**
           b) **Indication (or "unknown");**
           c) **Dosage (or "unknown");**
           d) **Frequency (or "unknown");**
           e) **Route of administration (or "unknown");**
           f) **Start date (or "unknown");**
           g) **End date, if applicable (or "unknown");**

      h)   **Discontinuation date, if applicable (or "unknown");**

      i)   **Reason medication was stopped or discontinued, if applicable (or "unknown"); and**

      j)   **Identification of individual who authorized stoppage or discontinuation of medication, if applicable (or "unknown");**

      AND

      3.   **Allergies, intolerances, and adverse drug events were addressed and documented.**

   b. **Date of medication reconciliation.**

   c. **Identity of eligible professional performing medication reconciliation.**

4. **CALCULATE THE PERFORMANCE SCORE FOR THE CALCULATION MONTH**
Calculate the facility's performance score for the given calculation month as follows:

Month's Performance Score = Month's Final Numerator Population ÷ Month's Final Denominator Population

5. **CALCULATE THE ANNUAL PERFORMANCE SCORE**
Calculate the facility's annual performance score as follows:

Facility's Annual Performance Score = (Facility's Month 1 Score + Month 2 Score +..... + Month 12 Score) ÷ 12

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment *(You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix)*

    ○ Available at measure-specific web page URL identified in S.1
    ○ Available in attached appendix
    ◉ **No diagram provided**

S.20. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)* <u>IF a PRO-PM</u>, identify whether (and how) proxy responses are allowed. **Not applicable.**

S.21. Survey/Patient-reported data *(If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)* <u>IF a PRO-PM</u>, specify calculation of response rates to be reported with performance measure results. **Not applicable.**

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.) <u>Required for Composites and PRO-PMs</u>. *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities* **is constructed as an "all or nothing" measure, such that a medication reconciliation event for which <u>any</u> of the numerator data elements are missing does not meet the measure criteria and is counted as a measure "fail" for that calculation month. Consequently, there is no missing data to report on this measure.**

S.23. Data Source *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in 2a1.26.

☐ Administrative claims

☒ **Electronic Clinical Data: Electronic Clinical Data**

☒ **Electronic Clinical Data: Electronic Health Record**

☐ Electronic Clinical Data: Imaging/Diagnostic Study

☐ Electronic Clinical Data: Laboratory

☐ Electronic Clinical Data: Pharmacy

☐ Electronic Clinical Data: Registry

☐ Healthcare Provider Survey

☐ Management Data

☐ Paper Medical Records

☐ Patient Reported Data/Survey

☐ Other

S.24. Data Source or Collection Instrument *(Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)*. IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration. **Dialysis facility medical record; intended for use by CMS in its CROWNWeb ESRD Clinical Data Repository.**

S.25. Data Source or Collection Instrument *(available at measure-specific Web page URL identified in S.1 OR in attached appendix)*

      ○ Available at measure-specific web page URL identified in S.1
      ○ Available in attached appendix
      ◉ **No data collection instrument provided**

S.26. Level of Analysis *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*

☐ Clinician: Individual

☐ Clinician: Group/Practice

☐ Clinician: Team

☒ **Facility**

☐ Health Plan

☐ Integrated Delivery System

☐ Population: Community

☐ Population: County or City

☐ Population: National

☐ Population: Regional

☐ Population: State

S.27. Care Setting *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*

☐ Ambulatory Care: Ambulatory Surgery Center (ASC)

☐ Ambulatory Care: Clinician Office/Clinic

☐ Ambulatory Care: Outpatient Rehabilitation

☐ Ambulatory Care: Urgent Care

☐ Behavioral Health/Psychiatric: Inpatient

☐ Behavioral Health/Psychiatric: Outpatient

☒ **Dialysis Facility**

☐ Emergency Medical Services/Ambulance

☐ Home Health

☐ Hospice

☐ Hospital/Acute Care Facility

☐ Imaging Facility

☐ Laboratory

☐ Pharmacy

☐ Post Acute/Long Term Care Facility: Nursing Home/Skilled

☐ Nursing Facility

☐ Post Acute/Long Term Care Facility: Inpatient

☐ Rehabilitation Facility

☐ Post Acute/Long Term Care Facility: Long Term Acute Care

☐ Hospital

☐ Other

S.28. COMPOSITE Performance Measure - Additional Specifications *(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)* **Not applicable.**

Importance

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence.

Opportunity for Improvement (Measure evaluation criterion 1a)

1a. Attach evidence submission form (Click here to download Evidence Submission Form Template): **Attached.**

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure). IF a COMPOSITE (e.g. combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1d.3 on the composite tab: **Medication management is a critical safety issue for all patients, but especially so for patients with ESRD, who often require 10 or more medications and take an average of 17-25 doses per day, have numerous comorbid conditions, have multiple healthcare providers and prescribers, and undergo frequent medication regimen changes.[1,2,3,4] Medication-related problems (MRPs) contribute significantly to the approximately $40 billion in public and private funds spent annually on ESRD care in the United States,[5,6] and it is believed that medication management practices focusing on medication documentation, review, and reconciliation could systematically identify and resolve MRPs, improve ESRD patient outcomes, and reduce total costs of care. As most hemodialysis patients are seen at least thrice weekly and peritoneal dialysis patients monthly, the dialysis facility has been suggested as a reasonable locale for medication therapy management.[7]**

1b.2. Provide performance scores on the measure as specified (**current and over time**) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use: *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities* **is new measure that is not yet in use, so performance scores over time are not available. However, the measure was tested using data from three KCQA member dialysis organizations, each with the capacity to provide retrospective analyses from a data warehouse/repository. All pertinent data from all eligible (i.e., adult and pediatric in-center and home hemodialysis and peritoneal dialysis) patients of the participating organizations during the testing period were included in the dataset. The number of patients and contributing facilities varied by month, but approximately 325,000 patients and 5,292 facilities across the three organizations were included in each of the six months of the study. The study was conducted on data from April 1-September 30, 2015.**

Performance scores obtained during testing are as follows:
- **Mean Performance Score = 52.62%**
- **Standard Deviation = 32.83**
- **Standard Error = 0.197**
- **95% Confidence Interval = 52.24 to 53.01**
- **Median Score = 48.18**
- **Mode of Scores = 100**
- **Range of Scores = 0 to 100**
- **Interquartile Range = 27.59 to 87.62**

Results show a significant spread between both the minimum and maximum scores, as well as the median and minimum and maximum scores, indicating there is significant room for improvement in this aspect of care and that the measure identifies clinically and practically meaningful differences in performance among the measured entities.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance **on the specific focus of measurement.** Include citations. **Testing data are presented in 1b.2. Contemporary literature supports our findings documenting variations in performance and room for improvement in medication management practices in dialysis facilities.**

As previously noted, ESRD patients often are prescribed 10 or more medications, have multiple comorbidities and numerous healthcare providers, and undergo frequent medication regimen changes, putting them at high risk for medication errors, discrepancies, and other medication-related problems (MRPs).[1,2,3,4] While there is a paucity of peer-reviewed empirical studies addressing medication

management specifically in dialysis facilities, those that have been published provide convincing evidence for the need for increased focus in this area.

One small prospective observational study (2003) in a single outpatient hemodialysis center identified discrepancies in 60% of participating patients' home medications lists when compared to those documented in the dialysis facility medical record.[8] A 2009 randomized controlled trial demonstrated an association between increased focus on medication management in dialysis facilities and the identification of real and potential MRPs, as well as a decrease in the numbers of drugs taken by ESRD patients and a reduction in all-cause hospitalization rates and hospital lengths-of-stay.[1,9,10] Likewise, the *Identifying Best Practices in Dialysis (IBPiD) Study*, a cross-sectional staff survey of three dialysis organizations comparing the perceived quality of patient-, provider-, and facility-level practices with Standardized Mortality Ratio (SMR) scores from U.S. Renal Data Service (USRDS) facility reports, found units with lower-than-expected mortality rates convene multidisciplinary conferences sooner after dialysis patients return to the facility after hospitalization and perform medication reconciliation more frequently than high-mortality units.[11]

1b.4. Provide disparities data from the measure as specified (<u>current and over time</u>) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (<u>This is required for endorsement maintenance.</u> Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use. **Not applicable—new measure; not yet in use.**

1b.5. <u>If no or limited data on disparities from the measure as specified is reported in 1b4</u>, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations: **Again, empirical studies addressing medication management remain limited, and those focusing on dialysis patients or on sociodemographic discrepancies even more so. Two publications tangentially addressing such disparities among population groups were identified; only one was specific to the dialysis setting. Specifically, the previously mentioned 2003 observational study by Manley et al. reported a negative correlation between age and the number of drug record discrepancies identified (r = -0.27, p = 0.04) in hemodialysis patients.[8] The authors noted this was a reversal from what had previously been reported in medication adherence studies,[14,15] and speculated sample size, follow-up period, or random phenomenon might apply. The other publication reported findings from a small 2014 Duquesne University study at an urban indigent primary care clinic, wherein medication discrepancies were more likely to persist in Caucasian subjects when compared to African Americans, despite pharmacist-led medication reconciliation. The authors theorized this finding might stem from variations in providers' communication styles with the two patient groups, but noted additional investigations in this area are needed.[13]**

High Priority (Measure evaluation criterion 1c)

1c.1. Demonstrated high priority aspect of healthcare

☒ **Affects large numbers**

☒ **A leading cause of morbidity/mortality**

☒ **Frequently performed procedure**

☒ **High resource use**

☒ **Patient/societal consequences of poor quality**

☒ **Severity of illness**

☐ Other

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare). List citations in 1c.4: **Medication management is a widely acknowledged problem in health care, generally,[12-17] but is especially important for patients with ESRD, who often require 10 or more medications and take an average of 17-25 doses per day.[1] Reducing MRPs has the potential to significantly reduce morbidity and mortality in dialysis-dependent patients. While there is a general paucity of pertinent randomized controlled trials (RCTs) in this area, one such study demonstrated an association between an increased focus on medication management practices and the identification of actual and potential MRPs, a decrease in the mean numbers of drugs taken by patients, and a reduction in all-cause hospitalization rates and hospital lengths-of-stay.[1,9] Likewise, the *IBPiD Study*, a cross-sectional staff survey of three dialysis organizations comparing the perceived quality of patient-, provider-, and facility-level practices with SMR scores from USRDS facility reports, revealed units with lower-than-expected mortality rates convene multidisciplinary conferences sooner after dialysis patients return to the facility after hospitalization and perform medication reconciliation more frequently than high-mortality units.[9] Finally, improved medication management practices will likely reduce healthcare costs. For example, a 2002 report estimated that every dollar spent on detecting and addressing MRPs in the dialysis population might ultimately save the healthcare system four dollars.[10] More recently, a Minnesota study observed the reduction in total annual health expenditures exceeded the cost of providing MTM services by more than 12 to 1 in the general population. These savings would accrue from decreased prescription costs, from avoidance of unnecessary and/or inappropriate medications, and fewer hospitalizations.[11]**

1c.4. Citations for data demonstrating high priority provided in 1a.3

1. Hakim RM, Collins AJ. Reducing avoidable rehospitalization in ESRD: A shared accountability. *JASN.* 2014;25(9):1891-1893.
2. Cardone KE, Bacchus S, Assimon MM, Pai AB, Manley HJ. Medication-related problems in CKD. *Adv Chronic Kidney Dis.* 2010;17(5):404-412.
3. Shoemaker SJ, Hassoi A. Understanding the landscape of MTM programs for Medicare Part D: Results from a study for the Centers for Medicare & Medicaid Services. *J Am Pharm Assoc.* 2011;51(4):520-526.
4. Forum of ESRD Networks' Medical Advisory Council. *Medication Reconciliation Toolkit.* 2009. Available at: http://esrdnetworks.org. Accessed March 22, 2016.
5. Parker WM and Cardone KE. *Medication Management Services in a Dialysis Center: Patient and Dialysis Staff Perspectives.* Albany College of Pharmacy and Health Services. January 2015. Available at: http://www.acphs.edu. Accessed March 22, 2016.
6. National Kidney and Urologic Diseases Information Clearinghouse. *Kidney Disease Statistics for the United States.* June 2012.
7. Pai AB, Cardone KE, Manley HJ, St. Peter WL, Shaffer R, Somers M, Mehrotra R. Dialysis Advisory Group of American Society of Nephrology. Medication reconciliation and therapy management in dialysis-dependent patients: Need for a systematic approach. *CJASN.* 2013;8(11):1988-1999.
8. Manley HJ, Drayer DK, McClaran M, Bender W, Muther RS. Drug record discrepancies in an outpatient electronic medical record: Frequency, type, and potential impact on patient care at a hemodialysis center. *Pharmacotherapy.* 2003;23(2):231-239.
9. Pai AB, Boyd A, Depczynski J, Chavez IM, Khan N, Manley H. Reduced drug use and hospitalization rates in patients undergoing hemodialysis who received pharmaceutical care: A 2-year, randomized, controlled study. *Pharmacotherapy.* 2009; 29: 1433–1440.
10. Spiegel B, Bolus R, Desai AA, Zagar P, Parker T, Moran J, Solomon MD, Khawar O, Gitlin M, Talley J, Nissenson A. Dialysis practices that distinguish facilities with below- versus above-expected mortality. *CJASN.* 2010;5:2024-2033.
11. Manley HJ, Carroll CA. The clinical and economic impact of pharmaceutical care in end-stage renal disease patients. *Semin Dial.* 2002;15:45–49.
12. Isetts BJ, Schondelmeyer SW, Artz MB, Lenarz LA, Heaton AH, Wadd WB, Brown LM, Cipolle RJ. Clinical and economic outcomes of medication therapy management services: The Minnesota

experience. *J Am Pharm Assoc.* 2008;48:203–211.

13. Stewart AL, Lynch KJ. Medication discrepancies despite pharmacist led medication reconciliation: The challenges of maintaining an accurate medication list in primary care. Pharm Pract. 2014;12(1)360.

14. Bedell SF, Jabbour S, Goldberg R et al. Discrepancies in the use of medications: Their extent and predictors in an outpatient practice. *Arch Intern Med.* 2000;160:2129-2134.

15. Wagner MM, Hogan WR. The accuracy of medication data in an outpatient electronic medical record. *J Am Med Inform Assoc.* 1996;3:61-68.

16. Cipolle RJ. Clinical and economic outcomes of medication therapy management services: The Minnesota experience. *J Am Pharm Assoc.* 2008;48:203–211.

17. Tache SV, Sonnichsen A, Ashcrof, DM. Prevalence of adverse drug events in ambulatory care: A systematic review. *The Annals of Pharmacotherapy.* 2001; 45(7-8):977-989.

1c.5. IF a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.) **Not applicable.**

Scientific Acceptability

Testing Attachment

2.1. Attach measure testing form (Click to here to download the Measure Testing Submission Form OR the Composite Measure Testing Form.) **Attached.**

Feasibility

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

Data Elements Generated as Byproduct of Care Processes (Measure evaluation criterion 3a)

3a.1. How are the data elements needed to compute measure scores generated? (Check all that apply.) Data used in the measure are:

☒ **Generated "or collected" by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, "depression score")**

☐ Coded by someone other than person obtaining original information (e.g., DRG, I CD-9 codes on claims)

☐ Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

☐ Other

Electronic Sources (Measure evaluation criterion 3b)

3b.1. To what extent are the specified data elements available electronically in defined fields (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

    ⊙ **ALL data elements are in defined fields in electronic health records (EHRs)**
    ○ ALL data elements are in defined fields in electronic claims
    ○ ALL data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS)
    ○ ALL data elements are in defined fields in a combination of electronic sources
    ○ Some data elements are in defined fields in electronic sources
    ○ No data elements are in defined fields in electronic sources

3b2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. **Not applicable; all data elements are from electronic sources.**

3b.3. <u>If this is an eMeasure</u>, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. **Not applicable.**

    ○ Available at measure-specific web page URL identified in S.1
    ○ Available in attached file
    ○ No feasibility assessment

Data Collection Strategy (Measure evaluation criterion 3c)

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues. <u>IF a PRO-PM</u>, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

MEDICATION MANAGEMENT DEFINITIONAL DISCREPANCIES. When developing the measure specifications and operationalizing the specifications for testing, it was noted while all three dialysis organizations that participated in testing have identified and engage in the same three components of medication management—i.e., documentation, reconciliation, and review—one organization defined reconciliation and review in reverse to those detailed in the KCQA measure specifications. Specifically, "medication <u>reconciliation</u>" is defined within that organization as "the process of creating the most accurate list of all medications that the patient is taking by comparing the most recent medication list in the medical record to one or more external list(s) of medications obtained from a patient or caregiver," while "medication <u>review</u>" 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."   Based on other KCQA Workgroup member input and our outreach to the other two testing organizations and KCQA members, however, this appeared to be an outlier situation—albeit a significant one.   Our final approach to the medication management definitions was ultimately agreed upon because the majority of dialysis organizations use this convention, as do hospitals, pharmacists, and the existing NQF-endorsed measures in the area.

DATA SYSTEM DISCREPANCIES. Again, when developing the measure specifications and operationalizing the specifications for testing, variations between the electronic medical record systems of the three large dialysis organizations that participated in testing were identified. For instance, a given data element (e.g., indication, start date, name of eligible professional) might not be present or might be available only as a free text field. It was further noted that this variability might be even greater in the medium and small dialysis organizations. Given the variability among electronic systems and because some medications are prescribed by other entities for which "indication" may be unknown, for example, it was determined that "unknown" must be an allowable response to many data elements so as to maintain the measure's feasibility.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified

(e.g., value/code set, risk model, programming code, algorithm)? Not applicable.

Usability and Use

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making.
NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

4.1. Current <u>and</u> Planned Use *(check all the current and planned uses; for any current uses that are checked, provide a program name and URL for the specific program)*

Use	Planned	Current	For current use, provide Program Name and URL
a. **Public Reporting**	◉	○	
b. Public Health/Disease Surveillance	○	○	
c. **Payment Program**	◉	○	
d. Regulatory and Accreditation Programs	○	○	
e. Professional Certification or Recognition Program	○	○	
f. **Quality Improvement with Benchmarking (external benchmarking to multiple organizations)**	◉	○	
g. **Quality Improvement (Internal to the specific organization)**	◉	○	
h. Not in use	◉	○	**This is a new measure that is not yet in use as specified. Variants of the measure are currently in use by KCQA member dialysis organizations for internal quality improvement, prompting KCQA to develop this measure to standardize the specifications and definitions for accountability purposes.**

4a.1. For each CURRENT use, checked above, provide:
- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

Not applicable; new measure undergoing initial endorsement assessment.

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (*e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?*) **Not applicable; new measure undergoing initial endorsement assessment.**

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*): **The measure was developed for use by CMS for its accountability initiatives. We note the measure requires a number of data fields not currently available in the CROWNWeb ESRD clinical data repository, and would require a system update for implementation. As we have done for other KCQA measures, we intend to commence discussions with CMS in this regard, specifically to request that the measure be included in the *Measures Under Consideration for Use in Federal Programs List* submitted to NQF's Measure Applications Partnership (MAP) in an upcoming cycle and that a CROWNWeb System Change form be created to commence building the necessary data elements into the system.**

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)
Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:
- **Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)**
- **Geographic area and number and percentage of accountable entities and patients included**

Not applicable; new measure undergoing initial endorsement review.

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations. The measure is new and is not yet in use. However, variants of the measure are currently in use

by KCQA member dialysis organizations for internal quality improvement. Standardizing specifications and definitions for accountability purposes will improve and expedite identification and resolution of real and potential medication-related problems (MRPs) in ESRD patients. Associated hospitalization, readmissions, mortality, and health care costs should consequently be minimized.

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them. No unintended consequences were identified during testing.

Related and Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

Relation to Other NQF-endorsed® Measures (Measure evaluation criterion 5)
If there are related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population), list the NQF # and title of all related and/or competing measures. (Can search and select measures.)

⊙ Yes
- **NQF 0097: Medication Reconciliation Post-Discharge (NCQA)**
- **NQF 0554: Medication Reconciliation Post-Discharge (MRP) (NCQA)**
- **NQF 2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (Brigham and Women's Hospital)**

○ No

Harmonization (Measure evaluation criterion 5a)

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized?
○ Yes
⊙ **No**

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden. *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities* **is harmonized with existing NQF-endorsed medication reconciliation measures in that all similarly specify that the medication reconciliation must address ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route.**

The KCQA measure, however, is unique among the currently endorsed medication reconciliation measures in that the level of analysis is the dialysis facility. The KCQA measure also moves beyond a single "check-box", specifying multiple components that must be met to be counted as a "success." It requires the following additional information on each medication, where applicable and known: indication, start and end date, discontinuation date, reason the medication was stopped or discontinued, and identification of individual who authorized stoppage or discontinuation of medication. Additionally, given the increasing frequency with which medical marijuana is prescribed, the KCQA measure specifies that this pharmacotherapeutic agent must be addressed during the

reconciliation. Finally, the KCQA measure requires that allergies, intolerances, and adverse drug events be addressed during the reconciliation process.

KCQA believes these additional foci are necessary to ensure the medication reconciliation process is as comprehensive as possible to better identify and effectively addresses potential sources of adverse drug-related events and not merely a single "check box" measure. Testing demonstrated these data elements are effectively captured and recorded in facility's electronic medical record systems during the routine medication reconciliation process.

Competing Measure(s) (Measure evaluation criterion 5b)

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.): **Not applicable; this medication management measure is unique in its specific focus on the ESRD population.**

Additional

Authorized Users

Steward Developer Username: Kidney Care Partners (KCP) for Kidney Care Quality Alliance (KCQA)
First Name: Lisa
Last Name: McGonigal
Organization: Kidney Care Quality Alliance (KCQA)

Appendix-Attachment

A.1. Supplemental materials may be provided in an appendix.

All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number that should be indicated. Requested information should be provided in the submission form and measure testing attachment. There is no guarantee that supplemental materials will be reviewed.

○ Available at measure-specific web page URL identified in S.1
⊙ **Available in attached file**
○ No appendix

Contact Information

Co.1. Steward Point of Contact: Lisa McGonigal, MD, MPH
Co.1.1. Organization: Kidney Care Quality Alliance (KCQA)
Co.1.2. First Name: Lisa
Co.1.3. Last Name: McGonigal
Co.1.4. Email Address: lmcgon@msn.com
Co.1.5. Phone Number: 203-530-9524

Co.2. Developer Point of Contact
☒ **Same as Measure Steward Point of Contact**

Additional Information

Ad.1. Workgroup/Expert Panel Involved in Measure Development: List the workgroup/panel members' names and organizations. Describe the members' role in measure development.

The KCQA Steering Committee guides the measure development process. Steering Committee members are:
- **Edward Jones, MD; KCQA Co-Chair—Renal Physicians Association**
- **Allen Nissenson, MD; KCQA Co-Chair—DaVita**
- **Jason Spangler, MD, MPH—Amgen**
- **Donna Bednarski, RN, MSN—American Nephrology Nurses Association**
- **Barbara Fivush, MD—American Society of Pediatric Nephrology**
- **Raymond Hakim, MD, PhD—American Society of Nephrology**
- **Scott Ash, MHA—Fresenius Medical Care North America**
- **Chris Lovell, RN, MSN—Dialysis Clinics, Inc.**
- **Thomas Manley, RN, BSN—National Kidney Foundation**
- **Gail Wick, MHSA, BSN, RN—American Kidney Fund**
- **Shari M. Ling, MD, Chief Medical Officer, Centers for Medicare and Medicaid Services, Center for Clinical**

Standards and Quality (CCSQ)–CMS Liaison Member

The KCQA Measure Feasibility/Testing Workgroup provided technical expertise and guidance to develop the specifications. Workgroup members were:
- Richard Faris, PhD, MSc, RPh—DaVita
- James Guffey—Dialysis Patient Citizens
- Jeffrey Hymes, MD—Fresenius Medical Care North America
- Len Usvyat, PhD—Fresenius Medical Care Renal Therapies Group
- Harold Manley, PharmD, FASN, FCCP—Dialysis Clinics, Inc.
- Paul Miller, MD—Renal Physicians Association
- Donald Molony, MD—Forum of ESRD Networks
- Glenda Payne, MS, RN, CNN—American Nephrology Nurses Association
- Sharon Perlman, MD—American Society of Pediatric Nephrology
- Wendy St. Peter, PharmD, FASN, FCCP, FNKF—National Kidney Foundation
- Gail Wick, MHSA, BSN, RN; KCQA Steering Committee Liaison—American Kidney Fund

KCQA Lead (Voting) Representatives identify KCQA's measure development foci, review the Workgroup's output and testing results, and approve major milestones during the development of the process, including and assessment of the face validity of the measure and submission to NQF. KCQA Lead Representatives are:
- Michael Heiffets, MD—AbbVie
- Qing Zuraw, MD, MBA—Akebia Therapeutics, Inc.
- Gail Wick, MHSA, BSN, RN—American Kidney Fund
- Glenda Payne, MS, RN, CNN—American Nephrology Nurses' Association
- Richard Cronin, MD—American Renal Associates, Inc.
- Raymond Hakim, MD, PhD—American Society of Nephrology
- Barbara Fivush, MD—American Society of Pediatric Nephrology
- Jason Spangler, MD, MPH—Amgen
- Maggie Gellens—Baxter Healthcare Corporation
- RJ Picciano—Board of Nephrology Examiners and Technology
- Peter DeOreo, MD—Centers for Dialysis Care
- LeAnne Zumwalt—DaVita Healthcare Partners, Inc.
- James Michael Guffey—Dialysis Patient Citizens
- Doug Johnson, MD—Dialysis Clinic, Inc.
- Jeffrey Hymes, MD—Fresenius Medical Care North America
- Robert Kossman, MD—Fresenius Medical Care Renal Therapies Group
- Jennifer Holcomb/William Poire—Greenfield Health Systems
- Thomas Nusbickel—Hospira
- Greg Madison—Keryx Biopharmaceuticals, Inc.
- Cherilyn Cepriano—Kidney Care Council
- Linda Keegan—Kidney Care Partners
- Donald Molony, MD/Andrew Howard, MD—The National Forum of ESRD Networks
- Tonya Saffer—National Kidney Foundation
- Deb Cote—National Renal Administrators Association
- Nancy Gallagher—Nephrology Nursing Certification Commission
- Tosha Whitley—Northwest Kidney Centers
- Leslie Spry, MD—NxStage Medical
- Paul Palevsky, MD—Renal Physicians Association
- Jonathan Lorch, MD—Rogosin Institute
- Sara Froelich—Sanofi
- Brigitte Schiller—Satellite Healthcare
- Stan Lindenfeld, MD—U.S. Renal Care

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2. Year the Measure Was First Released: 2016.

Ad.3. Month and Year of Most Recent Revision: Not applicable; new measure.

Ad.4. What is your frequency for review/update of this measure? Annually, and as needed with changes or additions to the evidence base.

Ad.5. When is your next scheduled review/update for this measure? May 2017.

Ad.6. Copyright Statement:
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Ad.7. Disclaimers:
Dialysis facility performance measures (Measures) and related data specifications, developed by the Kidney Care Quality Alliance (KCQA), primarily funded by Kidney Care Partners, are intended to facilitate quality improvement activities by dialysis providers.

These Measures are intended to assist dialysis facilities in enhancing quality of care. Measures are designed for use by any dialysis facility. These performance Measures are not clinical guidelines and do not establish a standard of medical care. KCQA has not tested its Measures for all potential applications. KCQA encourages the evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by KCQA. The Measures may not be altered without the prior written approval of KCQA. Measures developed by KCQA, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by dialysis providers in connection with their care delivery or for research. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and Kidney Care Partners, on behalf of KCQA.

Neither KCQA nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Ad.8. Additional Information/Comments: