

# TECHNICAL EXPERT PANEL CHARTER

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**Project Title:**

End-Stage Renal Disease Medication Reconciliation & Management

**Dates:**

March – December 2017

**Project Overview:**

The Centers for Medicare & Medicaid Services (CMS) has contracted with the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) to develop a quality measure(s) related to medication reconciliation and management. The contract name is End Stage Renal Disease (ESRD) Quality Measure Development, Maintenance, and Support. The contract number is HHSM-500-2013-130171. As part of its measure development process, CMS asks measure developers to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure developer during measure development and maintenance.

Medication reconciliation is a process by which an accurate medication list can be created, whereas medication management optimizes drug therapy to improve patient outcomes and minimize drug related problems. In a dialysis facility, this can be a complex task given that there are often multiple prescribers involved and medication regimens are often changed during times of care transition such as at hospital discharge. The CMS Conditions for Coverage specify that it is incumbent upon facility staff to obtain an accurate medication history as part of the patient assessment, however medication discrepancies remain common and impact patient safety as well as cost of care.

**Project Objectives:**

The University of Michigan Kidney Epidemiology and Cost Center, through its contract with the Centers for Medicare and Medicaid Services, will convene a technical expert panel (TEP) to inform the development of a quality measure(s) related to medication reconciliation and management in dialysis facilities.

Clinicians need to be aware of what medications a patient is prescribed before any changes can be made or new medications initiated. This can be a challenge since individuals with end stage renal disease who are receiving dialysis have a high medication burden with an average of 12 different prescriptions per day<sup>1</sup>. The financial burden, both for patients and payers is also substantial; with 77% of ESRD patients enrolled in Medicare part D, total estimated expenditures for enrollees

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<sup>1</sup> Manley et al. Nephrol Dial Transplant 19:1842– 1848, 2004.

reached \$2.7 billion in 2014 for prescription medications<sup>2</sup>. Medication related problems, such as adverse drug reactions or over/under utilization, occur frequently in the dialysis setting and are often related to gaps in medical information transfer. Identifying these issues has the potential to reduce hospitalizations, improve quality of life, and use health care resources more efficiently. In a randomized controlled trial, dialysis patients assigned to receive medication reconciliation and management of medication related problems by a clinical pharmacist used 14% fewer medications and had almost half as many hospitalizations at the end of the two year intervention compared to the usual-care group<sup>3</sup>. However, systematic medication reconciliation is not routinely performed in most dialysis clinics due to lack of staff training, limited interfaces in electronic health information between care facilities (outpatient dialysis facilities, hospitals, skilled nursing facilities, and rehabilitation centers), and absence of clinical pharmacists in most dialysis facilities<sup>4</sup>. Because of the frequent contact between dialysis facilities and patients, medication reconciliation and management as a means to reduce medication related problems may represent an opportunity to improve quality of care.

Specific objectives include:

- Review of existing NQF endorsed measures that incorporate Medication Reconciliation in this or other care settings (e.g. Medication Reconciliation for Patients Receiving Care at Dialysis Facilities, NQF #2988; Medication Reconciliation Post-Discharge (MRP), NQF #0554)
- Examination of data sources and availability
- Consideration of the components of the reconciliation process including frequency that it is performed, providers who are eligible to complete the task, and the necessary steps to do so.
- Consideration of medication management as it relates to the reconciliation process and how that might be incorporated into a measure.
- Develop one or more measures of medication reconciliation and management with attention to any adjustment or exclusion criteria that may be needed and harmonization with existing measures.

### **TEP Objectives:**

The TEP will use existing data and their expert opinion to formulate recommendations to UM-KECC regarding the development of new measures that address important quality gaps in medication reconciliation and management. Recommended measures should be evidence based, scientifically acceptable (reliable and valid), feasible, and usable by CMS, providers, and the public. Key objectives include obtaining TEP input on the following:

- Draft measures including defining denominator, numerator and potential exclusion criteria
- Consideration of risk adjustment (e.g., certain chronic conditions)
- Determine to what extent a new measure(s) can be harmonized with existing measures.

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<sup>2</sup> United States Renal Data System. 2016 USRDS annual data report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2016.

<sup>3</sup> Pai et al. *Pharmacotherapy* 2009;29(12):1433–1440

<sup>4</sup> Pai et al. *CJASN* 2013 as doi: 10.2215/CJN.01420213

## Scope of Responsibilities:

The role of each TEP member is to provide advisory input to UM-KECC.

*Role of UM-KECC:* As the CMS measure developer contractor, UM-KECC has a responsibility to support the development of quality measures for ESRD patients. The UM-KECC moderators will work with the TEP chair(s) to ensure the panel discussions focus on the development of draft measure specifications, as recommended to the contractor. During discussions, UM-KECC moderators may advise the TEP and chair(s) on the needs and requirements of the CMS contract and the timeline, and may provide specific guidance and criteria that must be met with respect to CMS and NQF review of revised candidate measures reflecting prevalent comorbidities.

*Role of TEP chair(s):* Prior to the in-person TEP meeting, one or two TEP members are designated as the chair(s) by the measure contractor and CMS. The TEP chair(s) are responsible, in partnership with the moderator, for directing the TEP to meet the expectations for TEP members, including provision of advice to the contractor regarding measure specifications.

*Duties and Role of TEP members:* According to the CMS Measure Management System Blueprint, TEPs are advisory to the measure contractor. In this advisory role, the primary duty of the TEP is to review any existing measures, provide input as to data sources and feasibility, and to suggest measure specifications. TEP members are expected to attend conference calls in 2017, and attend one in-person meeting in June of 2017 (specific dates to be determined) in Baltimore, MD, and be available for additional follow-up teleconferences and correspondence as needed in order to support the submission and review of the candidate measure(s) by NQF. Some follow up activities may be needed after testing has occurred.

The TEP will review, edit (if necessary), and adopt a final charter at the first teleconference. A discussion of the overall tasks of the TEP and the goals/objectives of the ESRD Medication Reconciliation quality measurement project will be described. TEP members will be provided with a summary of peer reviewed literature and other related quality measures prior to the in-person meeting. TEP members will have the opportunity to submit additional studies to be included in the literature review. A review of the CMS and NQF measure development criteria will also be covered during the teleconference.

During the In-Person Meeting: The TEP will review evidence to determine the basis of support for proposed measure(s). The key deliverables of the TEP at the in-person meeting include:

- Recommending draft measure specifications,
- Assisting in completing the necessary documentation forms to support submission of the measures to CMS for review, and to the NQF for endorsement
- As needed TEP members may be asked to provide input to UM-KECC as they prepare responses to NQF and public comments

At the end of the in-person meeting the TEP chair(s) and TEP members will prepare a summary of recommendations. As necessary, the TEP chair(s) will have additional contact with UM-KECC moderators to work through any other issues. This will include votes for draft and final measures. After the In-Person Meeting (approximately June 2017): TEP members will review a summary

report of the TEP meeting discussions, recommendations, draft measure specifications, and other necessary documentation forms required for submission to the NQF for endorsement.

**Guiding Principles:**

Potential TEP members must be aware that:

- Participation on the Technical Expert Panel is voluntary.
- Input will be recorded in the meeting minutes.
- Proceedings of the in-person meeting will be summarized in a report that is disclosed to the general public.
- Potential patient participants may keep their names confidential, if they wish to do so.
- If a TEP member has chosen to disclose private, personal data, that material and those communications are not covered by patient-provider confidentiality.
- All questions about confidentiality will be answered by the TEP organizers.
- All potential TEP members must disclose any current and past activities that may pose a potential conflict of interest for performing the tasks required of the TEP.
- All potential TEP members must commit to the expected time frame outlined for the TEP.
- All issues included in the TEP summary report will be voted on by the TEP members
- Counts of the votes and written opinions of the TEP members will be included, if requested.

**Estimated Number and Frequency of Meetings:**

- TEP members should expect to come together for one to three (1 – 2 hour) teleconference calls prior to the in-person meeting held June 2017, in Baltimore, MD.
- One one-day in-person meeting (June 2017)
- After the in-person meeting, additional conference calls may be needed.

**Date Approved by TEP:** TBD

**TEP Membership:** TBD

**Expiration Notice:** This notice expires on December 31, 2017