Dialysis Facility Compare (DFC) National Provider Call
June 20, 2018

Moderator: Hello, and thank you for joining today's Dialysis Facility Compare National Provider Call. Today, our presenters are Elena Balovlenkov, technical lead of Dialysis Facility Compare in the division of quality measurement at CMS, Jesse Roach, end-stage renal-disease measure-development lead in the division of quality measurement at CMS, and Scott Scheffler, ICH CAHPS survey-sampling task leader at RTI International. Elena will begin the presentation with background information and provide us a review of DFC. Jesse will then provide a measures update, a Star Ratings update, an update on new quality measures to be reported on DFC, and information on facility-patient-list requests. Scott will then give an update on the Star Ratings of CAHPS survey results. Elena will then conclude the webinar, focusing on how to include the patient voice in everyday patient care, as well as next steps on how to continue this effort. Following the presentation, subject-matter experts will be available to address questions. You can ask your questions throughout the presentation by using the chat box. Subject-matter experts will address as many questions as time allows. If your question is not answered during the call, CMS will address any remaining questions following the call. Now I would like to introduce Elena Balovlenkov. Elena, you may begin.

Elena Balovlenkov: Thank you very much. Hi. So, I just wanted to thank you all before we started for taking time out of what I know is a very busy day to join us so that we can talk about what will be occurring with the October refresh. And we also know that oftentimes there is turnover in the community in terms of senior leadership so that we are going to do a little bit of a background on Dialysis Facility Compare so that everybody starts on the same page. So, for those of you who have been with us for a while, congratulations for still being part of the team. And for those of us that are new, welcome. Next slide, please.

So, why did we bother with all of this? One of the reasons that CMS developed Dialysis Facility Compare Star Ratings is that as a community at large, people are very used to using visual presentation to understand quality. So that what this allows us to do is to provide greater transparency to the renal community as to how CMS evaluates quality based on certain select measures, and patients have asked for information to help them in decision making and to educate them in terms of asking questions of their facilities so that they can understand what's going on about their care. Next slide, please.

So, I'm not going to read out loud, but as review for you all, let's just talk about the key points. So, basically, we announced in June of 2014 that we heard the call from the community about looking for a simple way for people to understand measures because they didn't want to get into the math. All they wanted to do was understand how does CMS say this is a good facility

or an average facility or an above-average facility? So, that what happened is, in January of 2015, the program started. And over the time, since then, we have had multiple technical-expert panels, where we've included subject-
matter experts such as patient advocates, patients from the community, statisticians, academicians, physicians, to help us get guidance from the community, but it's a scientific community, the academic community, and the patient community, to help us design a program that meets the needs of those individuals that use it. So, that while the Dialysis Facility Compare site is intended as a patient information, patient clearinghouse for information, it is also used by providers and facilities and academics and scientists in terms of looking at developing different journal articles and things. So,

this basically is kind of just a brief overview of who we are and what we've done over the past several years. Next slide, please.

So, again, what we've done is people want a scale that's simple. So, we chose a scale that's 1 to 5 that helps people understand quickly what's going on, as opposed to using a scale of 1 to 10 or to use half numbers. We only use whole numbers on a scale of 1 to 5 to identify differences in healthcare quality and also to look at areas for improvement. Star Ratings help consumers, advocates, healthcare providers because people can understand stars without having to do an awful lot of reading. But it also gives them an opportunity so if they want to drill down and get into the nitty-gritty, they also have that opportunity, as well. Next slide, please.

So, I'm going to turn part of the presentation over to Dr. Jesse Roach. He's our ESRD measure development lead in the division of quality measurement, and he will go over several things, and then we'll continue to move on according to the agenda. Jesse?

Jesse Roach: Thank you, Elena.

Next slide.

So, this is -- I'm here to talk about the measures that are involved with this Dialysis Facility Compare and Star Ratings. So, what we had planned for in the preview period that runs July 15th to August 15th is public reporting for 2018. So, we will show the updated Dialysis Facility Compare Measure Set. We will also preview the Dialysis Facility Compare Clinical Quality Star Ratings. And that will use updated methodology, which we will talk about in a later slide. There will also be a new measures table, which will provide a preview for the October 2019 measure candidates. This information will only be available to facilities, starting with the preview period. Next slide, please.

Last year, in 2017, we had a Star Ratings technical-expert panel, and there were a number of recommendations that came from that. This panel consisted of physicians, patients, other dialysis-facility representatives, and it was a cross-section of people involved in the dialysis community. So, their recommendations were to update the standardized mortality ratio, standardized hospitalization ratio, the standardized transfusion ratio, and the hypercalcemia quality measures to reflect updated NQF-endorsed specifications. So, they recommended updating those to new measures that have been recently endorsed by NQF, by the National Quality Forum. Replace the current vascular-access measures with the Standardized Fistula Rate and the Long-Term Catheter Rate measures. They recommended including pediatric peritoneal dialysis as Kt/V in the Star Ratings. They provided input on potential next steps for resetting the Star Ratings. And they recommended adding the ICH-CAHPS survey as a separate Star Rating from the DFC Clinical Quality Star Ratings. And this technical-expert panel report is available online. Next slide.

So, the October 2018 Clinical Quality Star Ratings will be released in October. They will be calculated using updated methodology. And the details about this methodology can be found at the website listed on this slide. Next slide.

So, updates for the Star Ratings. The new Star Ratings will include updated versions of the following measures -- the SMR, the SHR, the STrR, and

Hypercalcemia. The current vascular-access measures will be replaced with the Standardized Fistula Rate and the Long-Term Catheter Rate. The new measures will be the standardized readmission ratio and the pediatric peritoneal dialysis Kt/V. The pediatric PD Kt/V will be combined to total Kt/V measure, and the ICH CAHPS Star Rating will be added as a separate Star Rating. So, these were all recommendations from the TEP. Of note, the Standard Infection Ratio from NHSN will remain on the DFC website but will not be included in the Star Ratings. Next slide, please.

So, updated new measures to be included in the October 2018 release. You can see these here, just to run through them again. The Mortality Ratio, the Standardized Hospitalization Ratio, the Standardized Transfusion Ratio, the Standardized Fistula Rate, the Long-Term Catheter Rate, the portion of patients with hypercalcemia, and measurement of Normalized Protein Catabolic Rate for pediatric hemodialysis patients. Next slide, please.

This is a list of the quality measures used in the Star Ratings for the October 2018 release. Included in these are the ones that I have just gone over that were updated. Of note, we have a total Kt/V measure, which includes the pediatric Kt/V measure, in addition to pediatric hemodialysis and adult hemodialysis compared to renal dialysis. So, those are also all available online, and the methodologies used to compute them are available online. Next slide, please. The October 2018 release will use the April 2018 DFC release data and Star Ratings Distribution to establish a new set of final-score cutoffs to be applied to the Star Ratings calculated in the October 2018 release. So, basically, what we're doing is we're using the results from the April release to set a baseline for the October 2018 release. Next slide.

So, the clinical Star Ratings will be evaluated once three years have passed since the last reset. After those three years have passed, the clinical Star Rating distribution will be evaluated for a reset when 15% or less facilities are receiving 1 or 2 stars. This goes along with the TEP recommendations for CMS to evaluate resetting at predictable time intervals so that the community will be able to anticipate them. The resetting of the Star Ratings distribution will also include the establishment of a new baseline this year. Next slide.

There will be a new measures table that will be introduced. This table will allow facilities to preview their measures before the start of public reporting in the October 2019 DFC release. The facilities will be able to ask questions and request patient lists for these measured calculations. The table for this year will be calculated with calendar-year 2017 data and be available for each quarterly preview period leading up to the July 2019 preview for the release that's in October of 2019. Next slide.

Included in the new measures table will be new measures. So, the percentage of prevalent patients waitlisted using calendar-year 2017 data and a standardized first kidney-transplant waitlist ratio for incident dialysis patients using calendar years 2014 through 2016. To go over what these are --these are both measures that measure access to transplantation. The percentage of prevalent patients waitlisted is percentage of all patients in your facility that have been waitlisted for transplants. And the standardized first kidney transplant waitlist is the percentage of patients that are waitlisted within the first year of starting dialysis. Next slide.

During the quarterly preview periods, users are able to request their facility's patient list. The protocol for this will be facilities will be

encouraged to request patient lists in the first 5 days of the 15-day preview period and the first 10 days of a 30-day preview period. So, the first third of the preview period. Patient-list requests in the first 5 to 10 days of a preview period will receive top priority in response time. And after this period, DFC will continue to fulfill patient-list requests, but the response time will be greater. Next slide.

So, now I'm gonna turn it over to Scott Scheffler to go over the Star Ratings and ICH CAHPS.

Scott Scheffler: Hi. I am Scott Scheffler. I am one of the statisticians on ICH CAHPS at RTI and primarily work in the sampling, but I also help out and assist in the analytic activities, as well. And today we're going to be talking a little bit about the ICH CAHPS survey, the measures we capture and report, as well as the Star Ratings and how we calculate those Star Ratings. So, next slide, please.

The ICH CAHPS survey is currently being conducted twice a year, in the spring and fall. National implementation of ICH CAHPS began in the fall of 2014, and we are currently in data-collection mode for the spring 2018 survey. The survey questionnaire contains 62 items, and of those 43 of those items are considered core CAHPS. And there are several processes that help ensure that the quality and the data meets a high standard. The first is that we used independent survey vendors and all survey vendors maintain ongoing training. There are in-person oversight meetings with the vendors, and there is an ICH CAHPS website that provides announcements and updates. And, finally, there is a constant, ongoing QC review of the data is collected. And this is just really the tip of the iceberg. There's a lot of time and effort that goes into maintaining and ensuring that our data is really good. Next slide, please.

CMS began reporting results from the ICH survey on the Dialysis Facility Compare, also called the DFC, in October of 2016. The results are updated twice a year as new data becomes available. And the data that we used are
from the two most recent survey periods. For an ICH facility to be displayed, they need to have 30 or more complete across the two survey periods. In this instance, it's 30 total. So, it's not 30 in each period. So, it's 30 across the two. And the DFC displays top-box scores, which are the most positive ratings for an item. But I did want to say that on the DFC, there's a button that says "view more details." And if you click on that, not only do you get the top box, but you can get the middle and bottom-box results, as well. Next slide, please.

The DFC reports on six measures from the ICH CAHPS survey. Three of those measures are based on a single item from the survey -- the rating of the kidney doctor, the rating of the staff, and the rating for the center. And then three of the measures are composites, meaning that several survey items go into constructing that particular measure. They're the kidney doctors' communication and caring -- that has six items that go into it. We have staff, care, and operations, which has 17 items, and providing information to patients, which has nine. And periodically we have a psychometrician that evaluates these composite measures to make sure that the items that go into are correlated with the measure that we're tracking, and then we look for whether any items need to be added or removed. And to date, I don't think any items have been replaced. Next slide, please.

And so, a natural question is, why do we need Star Ratings? And this is very similar to what Elena was describing earlier. Star Ratings are summarized on a 1-to-5 scale. They are a familiar visual tool that consumers can quickly and easily to use to understand complex data. And they allow you to spotlight differences in healthcare quality relative to other facilities' peers. And they also allow consumers and advocates and providers to seek areas for improvement. Next slide, please.

Star Ratings are currently being used on other CAHPS surveys, including Hospital CAHPS and Home Health CAHPS and CMS Parts C and D. We will begin using Star Ratings on ICH CAHPS in October of this year, and they'll be using data from the spring 2017 and fall 2017 data. The Star Ratings will be used on the same six measures that we discussed on the previous slide. Next slide, please.

And so, these next three to four slides give us an overview of how Star Ratings are created. This will just be a general overview. We're not going to get into the statistical details. And essentially there are two main steps in this process for creating the Star Ratings. The first is creating the linear scores for each survey response. And then the second big step is using the linear means of these scores to create the Star Ratings. And so, just to kind of pause here for a moment. The linear mean is very different from top box. If there's a survey item that can be rated from 0 to 10, the top box will only assign two levels based on a person's response. It will either be 0 or 100%. And so, if a person rated an item a 9 or 10, then the top box gets 100%. And if they marked it 0 to 8, then the top box gets assigned a 0%. Well, the linear mean is different. It utilizes all the coded responses that go into that score. So, using the same example, where we've got an item that goes from 0 to 10, if somebody rated an item a 0, then it gets a 0%. And if they rated it a 10, it gets 100%. But if they give an item an 8, then it will be given an 80%. So, unlike the top box, where it will be a 0 or a 100, you can have all levels in between. And for composites, composites are a little bit more complex. Basically, you take each item that goes into that composite and convert it to a 0% to 100% score, and then you take the average of those items to create the composite score. So, does this mean that top box is inferior to Star Ratings because it utilizes all the responses? And the answer to that is not at all. Both sets of scores have their purpose. They simply look at the data in different ways. So, depending on questions that you were asking, one measure may be more useful than the other. Next slide, please.

Now, once we calculate the linearized scores for our six ICH CAHPS measures, we patient-mix adjust them in a similar manner that we do for the top-box scores. Patient-mix adjustment evens the playing field among the providers that are known to have different mixes of patient characteristics. Patient-mix adjustment factors include age, gender, self-reported overall-health status, education, years on dialysis, and selected diseases and conditions. And most of these items come from the survey itself. Next slide, please.

And now that we have linear means at the provider level for each of the six ICH CAHPS measures, we can create the Star Ratings. This is the second main step in the process. And we do this using a cluster analysis. Once again, we're only using facilities where we have 30 or more responses across the two survey periods. The clustering forms five groups which corresponds to our five stars. The difference between the five groups are maximized. So, a 1-star group is optimized to be different from 2-star groups and so on. But the differences within a group, they are optimized to be minimized. So, providers

within a 5-star group are made to be as similar as possible. And as a general comment, there are no quotas when creating these cluster groups. So, if you have this conception where a 1-star might be the lower 20% and the 2-stars might be the 21% to 40% -- it's not like that at all. There's an algorithm that goes into assigning these. There's no bell-shaped distribution. You can have as few or as many facilities within a given ratings for any of these. And it can vary from reporting period to reporting period. Next slide, please.

Also note these cluster groups have what are called "cut points." And this is the range of scores that define the Star Ratings for a given measure. These are non-overlapping. So, to use an example, say, the rating for the kidney doctor, the clustering analysis may determine that for this particular rating, a facility with a mean score between 0 and 65 would get a 1-star rating. And if the score was between 66 and 70, it might get a 2-star rating. And then you could have a wide range. So, you could have a 3-star that is from 71% to 85% and so on. If you're looking at different measures, then you will have different cut points. So, it's not generating cut points that are sent across all measures. So, if you were looking at the ratings for the facility, it can have an entirely different set of cut points. These cut points will be re-estimated from reporting period to reporting period. So, what may be a set of cut points for October may be different in the following years. And, lastly, we will be creating an overall Star Ratings, and it's based on the simple average of the Star Ratings for the six measures. So, just to use an example, if we have a facility that has an equal mix of 3- and 4-star ratings for the measures, the simple average will be 3.5. And you take that 3.5, and you round it to 4, and so that overall Star Ratings facility would be 4 stars. And that basically concludes the overview for how we generate the Star Ratings on ICH CAHPS. And next slide, and I believe I'll be turning it back over to Elena.

Elena Balovlenkov: Hi. Thank you. Yes. So, one of the things that we really want to emphasize is that Dialysis Facility Compare as a website is intended -- I guess the best description is as a clearinghouse for information for patients to help them not only make decisions but also to think about what kind of questions they may have. And it's incredibly important to CMS and everyone within the community to dialogue back and forth so that we're sure that we are getting, as I say, the pulse of a community. So, let's look at the next slide, and let's talk about some of the things that we've been doing. So, I'm going to only bring up the key things that we've been going on, and I actually will bring up some of the stuff that we're doing in 2018. But where a lot of this came from, for example, putting Star Ratings for patient-reported outcomes such as the CAHPS survey, is patients asking for information not just on clinically, what their blood showed, but they wanted to find out how patients felt about how they were treated. So, that came from a meeting that we had, an all-day discussion, that was facilitated by the American Association of Kidney Patients. We also had representation from dialysis-patient citizens, NKF. We had patients. We had family members. And this was the first time that we had actually reached out individually to each of the patient organizations to say, "Hey, everybody represents different types of groups. Let's bring everybody together and really look at what's going on on the website, what kind of information sharing is going on, and what can we do to drive more patients to the site? Next slide, please.

So, what we heard. One of the first things we heard, which I hadn't really even thought about until that time is that patients felt that the pictures that we use, which were the canned pictures that you find on the Internet,

did not really reflect the community at large. The feeling was that we always used a sick patient in a chair with somebody standing next to them in a white lab coat and that we needed to represent patients as people who took trains, who run businesses, who drive trucks, who teach children, who babysit, who have a life as everybody else in their community does and that one of the things we heard is that "I don't live to dialyze. I dialyze to live, that I'm more than one particular thing." One of the other things that we heard about is that people wanted us to figure out a way to provide information to patients who may be too scared to look for information, may not know where to look for information, may not be computer-savvy, may be getting misinformation so that I guess the colloquial phrase said is, like, "Give it to the people who need it and don't realize that they do." The other things that we heard loud and clear is people are in different stages of kidney disease and that we should not just focus on those individuals with end-stage renal disease, that we needed to include some information about chronic kidney disease, all the five stage, as well as AKI. AKI, by the way, I'm sorry, is acute kidney injury. What we also heard, we felt, was very important, as people believe that Medicare is a trusted source of information. Next slide, please.

So, we have changed our pictures. We've changed our information. Patients also asked to review language and content to make sure that it's easy to use. We've been conducting usability testing of the website to make sure that it's easy to use, and what we also learned is that most people do not access the Dialysis Facility Compare website through a computer in their home, that what they do is they use their smartphone, and most patients have a smartphone, whether it's an Android or an iPhone, because there are not phones in their communities. They're pretty much at a position where they have to have a cellphone in order to keep in touch with their community, with their doctors and so that they use the data feature on their phone to be able to look up information to help them figure out how to get the best care. So, that with the adding of the Star Ratings for CAHPS, our first patient-reported outcome measure, that you can also filter results by the stars for CAHPS in addition to be able to filter by clinical results. Next slide, please.

So, we continue to reach out to the community on I guess trying to figure out how to build a better mousetrap. What's the best way to get information into the hands of patients, so that we also have been doing more focus groups -- and I'll tell you about one in just a few minutes -- more listening sessions. We've been looking at our checklist. We've been looking at and working with the community on developing a tool kit that goes down to the patient level to be able to describe the maps behind the measures that currently exist. Also, to look at what we can do for patient caregivers, that we have a large focus on helping health professionals understand measures. We're focusing on patients understanding measures. But what we heard loud and clear from the community is that oftentimes it's the husband, the wife, the grandparent who is making decisions. So, we are looking at ways to help the caregivers, as well. The other thing we're working on is actually developing a how-to guide for the DFC handbook to help patients figure out a better way to navigate the DFC website. Next slide, please.

So, we are looking, also, to figure out how to get more information out through social media. We've met with the social influencers -- people who have blogs, people who have Facebook pages -- to figure out what's the best way to partner with them to get information out to patients. Again, looking at sensitivities about terminology and pictures. The first thing we did was change the pictures on all the websites and on the information that we're

giving out. We are also looking at incorporating feedback into DFC's future development. And one of the things we did -- and I'm really excited about it; we're not quite finished yet -- is that we've heard from the really engaged patients, the patients that go onto Capitol Hill, the ones who write letters. We also had the focus group in 2017, which what I call our midlevel patients, patients who have pretty solid knowledge about their kidney disease and what questions they need to ask and how they can help CMS change what we're doing, what direction we're going in. And so, those patients said we need to reach out to people who don't have computers, who don't have a comfort level with computers, even if they take their child to the library to use computers, that they need help navigating around and that what about those people who are in the rural community who don't use computers at all? How are we going to get information for them? So, we recently did a focus group in three separate states with patients, including pediatric patients, as well as caregivers, and we're in the process of synthesizing that information and to report recommendations to help drive our direction for future development of the site. So, we're really excited about having feedback from a more diverse community and look at the opportunity, continue to partner with patients. I just heard from one of the patient-community groups yesterday, saying that they want to partner with CMS on developing ways, how to get to the patients that we don't traditionally hear from. So, I'm really excited about developing that partnership with them. Next slide, please.

So, what we're going to do now is I'm going to turn the presentation back over so that we can have the question-and-answer period, and I wanted to let you know who our subject-matter experts are. We have representation from RTI, from CMS, and from UM-KECC, our contractor with measure developments. So, I think you'll be getting the answers from the best of the best. I turn it back over to you.

Moderator: Okay, great. Thanks, Elena. So, as a reminder, please enter your questions through the chat box, and subject-matter experts will address as many questions as time allows. If your question is not answered during the call, CMS will address any remaining questions via e-mail following this call. Okay, so, our first question is, "How is the PPPW calculated for patients that go on and off the waitlist due to factors such as DMI, cancer, et cetera?"

Elena Balovlenkov: One minute, please.

Jesse Roach: I'm just going to refer... So, instead of going through the details of how the measure's calculated for every specific purpose, there's a link to all of the methodologies on dialysisdata.org that everyone can take a look at.

Elena Balovlenkov: Additionally, the website -- feel free to submit any clarifying questions that you need through the help desk, and we'll be sure to get back to you.

Moderator: Okay. Our next question -- "Where on the website can you retrieve the latest report? I looked yesterday, and there were only old reports on the website."

Elena Balovlenkov: I'm assuming -- I need some more information, what kind of reports we're talking about. Are we talking about the latest data to the last refresh? Are we talking about old reports? If you can clarify your question, I might be able to get you a little bit more information, exactly which reports you're looking for that you can't find. Let's take the next question while we're waiting for them to type that in.

Moderator: Sure thing. So, our next question is, "Can you clarify how we request patient lists?"

Jesse Roach: Facilities can request patient lists through dialysisdata.org when they're logged in during the preview period under the "comments" tab.

Moderator: Okay, thank you. Our next question -- "If a facility has an attestation due to low volume of patients and does not participate in ICH CAHPS, how do they get the Star Rating?"

Scott Scheffler: They simply would not. I'm sorry. This is Scott Scheffler with RTI. So, if a facility has a low patient volume, then they wouldn't receive a CAHPS Star Rating, at least on the survey side, because they have 30 or fewer respondents.

Moderator: All right. Thank you, Scott. Our next question -- "Is 30 survey responses enough to draw a valid conclusion about patient satisfaction? Why not use a minimum percentage of responses? Does public report indicate what the percentage of responses is?"

Scott Scheffler: That is a very good and a very tough question. So, there are a lot of factors that go into why we use the threshold of 30. One of the issues that goes into this -- there's a lot of factors. So, one of the issues is that we have thousands, probably 6,000 dialysis facilities across the nation, and the vast majority of these facilities are relatively small. So, they might have somewhere in the neighborhood of 50-ish patients within a given year. And so, if we set the threshold too high -- so, ideally, we like as much data as possible. So, the problem is, is that if we set the threshold too high on the number of responses that we have, we will end up excluding probably half the facilities in the country. So, we're fighting a battle between representing as many facilities as we can in the country, while as also having a statistically reliable estimate. With regards to the percentage responses, that's also tricky because due to the varying sizes of the facilities. We tend to rely on a fixed number of completes that we get. But I believe on the DFC, we report the response rate that we do get from the facility. And I'm sorry. That was a rushed answer, but it's a really tough question to answer.

Moderator: Okay. Thank you, Scott. Our next question is --

Elena Balovlenkov: Before we go onto the next question, I'm sorry to interrupt. So, I wanted to go back to the individual who asked the question about the reports. If they're looking for the new preview-period reports, they should check back on July 15th, okay? If that's not the reports they were talking about, the other thing is that they can look for the methodology reports from dialysisdata.org under the "measures" tab. So, I wanted them to understand that we did hear their question. So, if that's not the right answer to the right question, please submit it through the question-and-answer guidelines, and we'll respond in writing.

Moderator: Okay. Thanks, Elena. We'll move on to our next question. "My understanding of DFC and Star Ratings is to provide a higher level of transparency for Medicare beneficiaries. How does reporting ICH CAHPS scores one way and then having this complicated Star Ratings for the scores help to meet that goal? Can you please tell me how this supports our patients with this level of complexity?"

Debra Dean-Whittaker: Hi. This is Debra Dean-Whittaker. I'm with CM, and I work with ICH CAHPS. The reason that we have a different calculation for the Star Ratings than we have for the DFC presentation on Compare is that for Compare, we wanted to present numbers that are very easy to understand, and we thought that the top box, meaning the percentage of patients who gave the most favorable response, would be very easy for everybody to understand when they looked at percentages. The Star Ratings, on the other hand, we wanted to use the full range of data. Scott mentioned this before. If you would only use the top

box, then people are either in the top box, or they aren't. Here, with using the more complex system, we take into account the full range of data that we can then enter into our statistical program to generate the five stars. And,
also, we are hoping that these will make these stars more reliable and more valid for people to use. Thank you.

Moderator: All right. Thank you. Our next question -- "Over 90% of our patients are from nursing homes. How are we getting Star Ratings with ICH CAHPS results?"

Debra Dean-Whittaker: That's an interesting question, and it would have to do with sampling, I think. Perhaps we should ask you to go ahead and send that question in and maybe even give us some of the CCMs involved for us to take a look at it in more detail.

Scott Scheffler: Yes, and I'll answer that -- I'll try to answer it partially. There's a wide range of facilities out there at the national level. So, the patients that are getting surveyed, they have to meet a certain eligibility criteria. And so, depending on the mix of patients that you have within a given facility, it could be that not everyone gets surveyed. It could be that only half of a facility's population is in that eligible criteria. And so, the results that you may get, the results represent the eligible population and not the ineligible population.

Moderator: Okay. Our next question -- "Did you hear from the patient community about survey burnout?"

Debra Dean-Whittaker: Yes, we did. This is Debra again. We certainly did. And we are concerned about survey burnout. We've been thinking about things that we can do about it. It is a serious problem. It is particularly true because this is a chronic condition. One of the other CAHPS surveys, for example, hospitals. Well, you do a hospital survey this month. Next month, they're a different patient. Next month after that, different patient. That's not true here. Here you have a lot of patients the same over and over and over. Now, one of the things we thought about doing is just doing a survey once a year. Well, if you do it once a year, and everybody knows it's gonna be done at this time of the year, then it is possible -- and I'm not saying this would happen -- but it is possible that facilities would change their behavior to improve their survey score right before the survey occurred. On the other hand, if you try to do too much a year -- we were originally thinking this would happen maybe every month -- you're just completely ruining it because it's just too much. So, right now what we're doing is twice a year. We have had response saying it's too much, and we are looking at varieties and ways to handle it, and it is an ongoing issue for us.

Elena Balovlenkov: Hi. This is Elena. I'd like to respond, as well. What we heard from patients, and as I said, we just recently did three focus groups, in addition to the very large focus group last year. And then I just presented and had the wonderful opportunity at the American Association of Kidney Patients national meeting to meet with patients over a 3-day period, and that was one

of the things we talked about was information sharing and surveys and things like that. And the general feeling from the patient is they don't mind filling out a survey as long as they know what we're doing with information. They do not want to complete a survey, whether it's for DFC, whether it's for a restaurant or anybody, if they think that it falls into the black hole. They want to be given the opportunity to give true, valid feedback so that it's not slanted. As one of the patients said to me, "Your concept of what's going on and my concept of what's going on sitting in that chair three days a week could be really different. So, I don't mind filling something out, but I want to be sure that you're reading it and that you're using it and that things are changing." And I think that ties into what Debra was talking about is that we continue to reach out and talk to people and say, "Okay, when is too much too much? What is a way that we can make it easier for you and still hear from you?" So, it is an ongoing thing that CMS is looking at.

Scott Scheffler: And to piggyback on Elena's comments, we've done a nonresponse analysis, and our results mirror exactly what Elena is talking about. The surprising thing that came out of that is that the group that is most likely to continue responding or to fill out the survey are those that have responded previously. We were expecting to see some type of burnout effect, but if somebody has responded to the survey once, they are highly likely, more than any other demographic characteristic, to respond again in future surveys.

Moderator: Okay, great. We'll move on to our next question. "When do you anticipate pediatric facilities having to complete the ICH CAHPS and report it?"

Debra Dean-Whittaker: We do not currently not have a timeline for that.

Moderator: Our next question -- "Will the way CAHPS is incorporated into QIP change with the move to ICH CAHPS Star Ratings and linearization of the scores?"

Debra Dean-Whittaker: I'm not sure who's supposed to answer that question.

Elena Balovlenkov: That may be something that we need to meet with the QIP team about. I don't think that necessarily we can just give an off-the-cuff answer. I don't know the answer. Jesse?

Jesse Roach: No, I would -- why don't you submit that question, and we can send it to the QIP team?

Moderator: All right, we'll go on to our next question. "For units with less than 30 patients that are not required to do the ICH CAHPS survey, where will their Star Ratings for a survey come from?"

Scott Scheffler: If they're not participating, they simply will not have a Star Rating or any results on the DFC.

Moderator: Okay. Our next question -- "With the focus on increasing these at-home modalities, when will there head CAHPS for home PD?"

Debra Dean-Whittaker: We are looking at that now. We don't have a specific time frame, but we are actively interested in this, talking to the community about it and working on it among ourselves.

Moderator: Okay. And our next question is for Jesse. And they're asking if you can explain a little more on how the DFC preview period will work this year.

Elena Balovlenkov: We'll ask UM-KECC to respond to the question.

Karen Wisniewski: Hi. This is Karen from UM-KECC. The preview period occurs quarterly for Dialysis Facility Compare. The next one coming up will start on July 15th, as Jesse said. It's a monthlong preview period. You will be able to log onto dialysisdata.org to view your report starting on July 15th. During that time, you can submit questions and comments to the help desk. You can also request patients' lists of patients included in the calculations for the measure and submit suppression requests if that's something you want to do, as well. That's it.

Okay.

Moderator: Okay, great. Moving on to our next question. "Are AKI non-ESRD patients included in any measures? If so, what measures are most used in reflecting their quality of care?"

Jesse Roach: So, the measures only include ESRD patients. So, they do not include acute-kidney-injury patients. We are looking at ways to find specific measures that reflect the differences between AKI and ESRD patients to monitor their quality of care, but as of right now, the DFC only includes ESRD patients.

Moderator: Okay, and I believe we have time for one more question. "So, what is the timeline for including the transplant measures in 5-star ratings? Is UM-KECC incorporating feedback that was provided by the community?"

Jesse Roach: So, as of now, there is no plan to include the transplant measures in the 5-star ratings. If we do do that, they would be previewed to facilities prior to that happening. And typically we have not added measures to the Star Ratings until after at least a year of public reporting.

Moderator: Okay, great. And, Elena, I will turn it back over to you to close out the call.

Elena Balovlenkov: Thank you very much. Wow, we got some great questions, and I just wanted you all to know that we will create a question-and-answer document that will be posted along with the slides and the transcript, and it's basically on the CMS.gov/Medicare/End-Stage-Renal-Disease general information page, and those of you who have attended before have seen the slides up there. So, it does take us a little bit of time to take and research all the questions because we feel that if you have a question that we didn't get to, other people in the community probably have the same question. So, want to be able to be sure that we have an answer that is generalizable enough to all the facilities. And in addition to those questions that are more pointed, as long as we're not revealing somebody's data that is covered under privacy acts, then that question will be included. If it does require sensitivity, the facility will be answered individually. So, I just wanted you to know that. But I want to thank you guys so much, and for additional questions, always remember that you can e-mail the UM-KECC help desk all year round. For questions about CROWNWeb, we also note that you can send it to mycrownweb.org. And for CAHPS questions, you can also send it to ichcahps.org. I want to thank you all for joining us. Next slide, please.

And basically thank you, and we look forward to our next survey and also to feedback that we get from the preview period. Thank you so much for joining today. Haley, up to you.

Great, and that concludes today's call. Thanks, all.