WEBINAR

Please note: The webinar transcript begins on slide 2.

JOEL ANDRESS: Dialysis Facility Compare (DFC) will be refreshed in October 2017, and will be previewed to facilities from July 15 to August 15 on dialysisdata.org. The new and modified measures table will be part of the July Preview Period, and available in the same document as the rest of the measures–there are not two different documents for facilities to keep track of. The extended preview of these measures allows facilities to review the calculations and ask questions ahead of the measures being reported on DFC in October 2018.

The measures currently publically reported on DFC cover facility best treatment practices, as well as survival and hospitalization. Information about each measure can be found on DFC and dialysisdata.org.

As part of our efforts to increase transparency, we will begin providing a New and Modified Measures Table in your preview reports in advance of each October release. These tables will preview measures that are either new to DFC, or that have been substantially modified in some way, one year before they will become publicly reported. The intent is to give you the opportunity to review the new data, and be familiar with the measures before they become publicly reported.

You will have the opportunity – with other measures that are included in the report to provide us with questions, to provide comment or to seek more information about the measures on the table. Could you move the slide to five please?

The data presented in this year's new and modified measures table in July will largely reflect measures that we intend to begin publicly reporting in October of 2018. As we've said, you will have the opportunity to review these data in advance and request patient lists as you are currently able to for the measures and productions.

So I want to stress that again. The measures that are included in the new and modified measures table are available in the form of – I should say we are going to make available to you patient lists for these measures as with those that are publicly reported and this is part of our attempt to provide you with the capacity to review these measures and consider their implications for your facilities.

You will also will have the opportunity to point out where our presentation of these data might be improved upon to support your own review in the preview report. And so we encourage that you reach out to us regarding these measures and the format of the new and modified measures table, as we are interested in ensuring that these data are as helpful to you as they possibly can be.

The data on the new and modified measures table will be available for review until July 2018 when you will receive preview reports in which these measures will be fully integrated with the

others. Now what that means is that the data for the new and modified measures table will be available throughout the coming year, and you will have the opportunity to review them at any time or to request patient lists for these measures at any time.

When we go into production for October of 2018, then they will be removed from the new and modified measures table and they will simply become a part of the standard preview report that you already received.

The new and modified measures table for this year will include measured data largely from calendar year 2016 as with the other measures that are on DFC. And when the measures are at least in October 2018, they will be calculated using calendar year 2017 data, again, in accordance with the measures that we already publicly report on DFC.

And to repeat Elena's caveat earlier, and I think you'll hear us repeat this frequently because we know it's an issue of some concern, none of the data that you see in the new and modified measures table will have any effect on the Star Ratings and it will not be publicly reported in October of 2017. Please go to the next slide. Thank you.

This slide you see the list of updated and of modified and new measures that will be included on the new and modified measures table. In the case of hypercalcemia, we have updated the measures specifications to include missing values in the numerator where previously our calculation of hypercalcemia was only – we only included the missing values in the measure

denominator. This aligns us with the ESRD QIP and also brings us in line with the updates to the NQF measure endorsement.

The standardized mortality ratio and the standardized hospitalization ratio on the new and modified measures table, reflect the newly endorsed measures which incorporate risk adjustment for prevalent comorbidities captured through Medicare claims data. So these reflect a more robust risk adjustment than the measures that are currently publicly reported on DFC.

I would also note as a consequence of incorporating claims data for the risk adjustment for these measures, the standardized mortality ratio, as presented in the new and modified measures table, is applicable only to the Medicare fee-for-service population, and that's a change from the previous measure which incorporates data for all patients.

The standardized transfusion ratio has also been updated to reflect a more conservative method of identifying transfusions. This is consistent with the newly endorsed specifications for the standardized transfusion ratio at NQF.

And then the intention for the standardized fistula rate and long term catheter rate measures is to replace on DFC the currently reported vascularize access type measures. So when these measures go into production and public reporting for October of 2018, we expect that they will be reported in place of the measures with which you are currently familiar. These measures were revised in several ways, or I should say these measures represent a number of revisions to the

previous measures. They are now based on CROWNWeb data, and both measures contain exclusions for patients with limited life expectancy.

Additionally, the fistula measure now includes risk adjustment for factors that are associated with decreased likelihood of AV fistula success. And this is intended to account for circumstances in which application of a fistula may not be a more appropriate course of action than a provision of a graft in a particular patient.

The single new measure on this list is the measurement of nPCR or Normalized Protein Catabolic Rate for pediatric hemodialysis patients. This measure is endorsed by NQF and will add to our portfolio of measures that incorporate pediatric patients including measures of HD and PD, Kt/V, standardized mortality and standardized hospitalization.

More information on these measures can be found on dialysisdata.org, and again, we stress that while some of these measures are similar to those that are found in the Star Ratings currently, none of the data you find in the new and modified measures table will affect the Star Ratings in 2017. And to the next slide please.

So, again, the measures that are used in – well, we're going to transitional a little bit to talk about the Star Ratings for 2017 and the recommendations that have come out of the 2017 Star Ratings TEP and what you can expect in terms of what they recommended and what our next steps are for addressing those recommendations within the Star Ratings.

So, again, to repeat, the same measures that were used in last year's Star Ratings will again be used in this year's Star Ratings and the scoring methodology will not be changed. The reason for this – please go to the next slide.

The reason for this is that we convened the Technical Expert Panel with the purpose of reviewing and providing recommendations on a number of methodological and measure set issues related to the Star Ratings. These include consideration of measures to add or retire as well as considerations for the scoring methodology and the presentation of the Star Ratings on the Dialysis Facility Compare website. The TEP included both patient and provider subject matter experts and provided us with a number of recommendations which we will be reviewing on this presentation.

The TEP is building on the work from the original Star Ratings TEP which was convened in 2015 and led to the revisions that you saw in October of 2016. The intention of CMS is that the recommendations is that we will seek to reflect the recommendations from this TEP in the Dialysis Facility Compare Star Ratings release for 2018. So that is why – so we're taking the time to consider the recommendations and develop a responsive methodology for 2018 rather than trying to rush those changes into effect for 2017, which is why you won't see any changes this year. Next slide please.

So among the key TEP recommendations. The TEP recommended that we consider replacing the current Vascular Access measures, the Hypercalcemia measure, the Standardized Mortality

and Hospitalization Ratios and the Standardized Transfusion Ratio measures in the Star Ratings with the versions that we were discussing for the new and modified measures table.

Now what that means is that they're recommending that these measures would take the place of the versions that are currently within the Star Ratings on a one for one basis. So we would be pulling out the old version of Hypercalcemia including the new version that we are previewing in the new and modified measures table, for example.

The TEP also recommended that we incorporate our measure of Pediatric Peritoneal Dialysis Kt/V in the Star Ratings. Currently, this subpopulation is not incorporated in the assessments of a dialysis adequacy for the Star Ratings and so this would have the effect of including these patients within that calculation for purposes of considering dialysis adequacy within the Star Ratings.

The TEP also recommended that we add an additional Star Rating that exists separate from the current Star Rating that incorporates the ICH-CAHPS data. So to stress here, the ICH-CAHPS will result in a Star Rating that lives separately from the current Star Rating you possess and you would be able to review – and patients will be able to review both Star Ratings – one based upon patient feedback from the ICH-CAHPS and another rating which is based upon the set of quality measures that currently inform the Star Ratings.

The TEP also provided some input on potential next steps for rebaselining and for defining when it is appropriate to do so and what the appropriate process would be for doing so. Again, that

won't have any consequence for the 2017 Star Ratings so we're not going to go into great detail of what that would look like, but we intend to provide detail at a later date. Next slide please.

The TEP also considered two additional measures for which they did not achieve a consensus and consensus here was defined within the context of the TEP as receiving 60% support among the TEP members. These include – so the two measures that were considered, but did not receive consensus support were the Standardized Readmission Ratio, which received 54% support among TEP members, and the National Healthcare Safety Network Bloodstream Infection measure which received 38% support among TEP members.

We will be providing, as you can see here – we are providing here a link between the Technical Expert Panel summary report where you can review the recommendations that were made, as well as the deliberations that led to those recommendations.

I'd reiterate that these are TEP recommendations, they are not final methodological decisions made by CMS. We anticipate that we'll be addressing the final methodological changes for 2018 in the Star Ratings at a later National Provider Call this fall. Next slide please. Thank you.

So as we've stated, the Dialysis Facility Compare 2017 Star Ratings will not be changed from those released in October 2016, simply refreshed with updated data. The same measures will be used, the scoring methodology will be the same as used previously, and again, there will be no rebaselining occurring, and what that means is that the standards of defining a one star versus a two star facility versus a three star facility will remain the same.

At the same time, we'll be updating the performance period and the data. Some facilities will have the opportunity to improve against those standards depending upon their performance on the set of quality measures for the Star Ratings. Next slide please.

For DFC 2018 as we have stated, CMS is currently considering the TEP's recommendations. Any modifications to a measures set, scoring methodology or to a process for rebaselining the Star Ratings will be announced at another National Provider Call, which we expect to occur in the fall of this year. Those changes would then be expected to take effect for the Dialysis Facility Compare 2018 Star Ratings released in October 2018.

I should note also that once we have made those announcements, we also anticipate providing you with the opportunity to submit comments with regard to any of the methodological changes, and we anticipate a robust engagement from the community as you consider the implications and other opportunities for improvement within the Star Ratings.

And I just want to lay out to all of you that, first of all, that we've appreciated it very much for the engagement we received from the TEP and I think that has resulted in a number of improvements in Star Ratings already and we expect that we'll continue to do so.

I also want to stress that your continued engagement through public comments, through letters to us and through considerations of additional methodological issues and issues of making the Star

Ratings more accessible to patients has been extremely helpful, and we certainly hope that you continue to provide us with that kind of input going into the future.

As we've stated before with previous updates to the Star Ratings, we don't consider this to be an endpoint and we expect there are still improvements that can be made to the Star Ratings to make them more useful to the community at large. Next slide please.

Here we provide a link to the ESRD Measures Manual. The ESRD Measures Manual will be updated prior to the end of this year, or should I say we expect to update it prior to the end of this year, to reflect all new measures going into effect in 2018. And the reason this is important is that we think it's necessary to provide you with the information on the measures that you will be assessed against before we are reporting them.

We received a number of comments in this area because our prior manual did not provide this information, and so we want to make clear that we have taken steps to ensure that the manual will be updated prior to public reporting of new measures on DFC. Next slide please.

And then, finally, what I can only apologize for appearing to be something of a non sequitur, we are making a change to our process for requesting patient lists, and the purpose of this is to try to get your engagement in requesting patient lists as early as possible within the preview period to allow us to meet your request needs and ensure that the data are going out as equitably as possible and to also ensure that you have those data available while you're previewing the data in the reports.

So to clarify here, starting with the November 2017 preview period, and this will be for the January 2018 refresh of DFC, we've put into place the following protocol. First, facilities will be encouraged to request patient lists in the first five days of a 15-day preview period and the first 10 days of a 30-day preview period. Now typically the way that we've worked this is that there is a 30-day preview period in advance of the October release and then a 15-day preview period in ahead of each of the subsequent quarters for that year.

And the rationale for this is that we intend to load our major changes to the website, updates the measures and updates the Star Ratings within the October releases, which means that we believe there should be a longer preview period available for that release. However, for the other quarters, we will be refreshing the data, but don't anticipate major changes to the measures sets or other types of information that are made available to you for those preview reports.

Patient lists typically – patient lists requests in the first five to ten days of a preview period will receive top priority in response time, but I do want to stress that we will continue to send out those patient lists if requested and this is going to give us the ability to more efficiently game out when we need – where we need to be allocated in our resources. So we certainly encourage you to request the patient lists early and we will pursue providing those to you as quickly and efficiently as possible.

If you have any questions, please feel free to contact our help desk and we will help you with the process. And now I think we're going to the next slide and I will turn the conversation back over to my colleague Elena. Elena?

ELENA BALOVLENKOV: Okay, thank you Joel. One of the things that we've learned as we continued our work on the Dialysis Facility Compare website is that nothing worth doing should be done in a vacuum, and that's why we continued to reach out to the community to get your ideas and your suggestions on how to improve the website, how to make it more user friendly.

And the idea is that not only do we want to educate patients, but we also want to educate healthcare professionals, providers, social workers and caregivers about having the opportunity to use Dialysis Facility Compare not just to find a facility as a newly diagnosed patient, but to assist patients who may relocate for jobs or patients who may travel, decide to go on vacation, that this information is available to them and we're trying to continue to look at ways to make it as easily accessible and understandable to patients as we can. Next slide please.

So one of the things that we've continued to do over the past three years is to meet with different populations within the patient care community to get feedback on the, as I call it the State of the Union of Dialysis Facility Compare website that first went live in January of 2015. We've met with what we call our highly engaged patients, who are the ones who would meet with staff here at CMS, officials at CMS, government officials, are very comfortable with talking with their physicians and have a reasonable understanding of how to partner in improving their outcomes.

So we thought we would take an opportunity to look at meeting with another group, patients again that have a level of understanding about the disease process and information about the website. And so what we did is on April 3rd of this year, NORC at the University of Chicago partnered with the America Association of Kidney Patients and we had a day where we actually spoke with patients from across the various dialysis organizations and dialysis facilities and we had patients representing the five national organizations – NKF, AAKP, Dialysis Patient Citizens and so forth.

And while we had 12 patients who actively participated in the question and answer period, we did have two patients who were there who were listen only, and in addition, we were kind of disappointed, but we understand that we had some patients that had to cancel at the last minute due to either family or healthcare issues. Because we really were looking at trying to get as robust of a site visit as possible in terms of the number of patients who could participate.

And this session was the first time that we actually went out and really wanted to leverage meeting with patients that were part of the advocacy committee because these are the individuals who also lobby not just for improvements that will help their own healthcare, but also lobby on behalf of others.

So we thought that it was really important to receive this broad patient input on the website and also we were fortunate we had the opportunity to have a caregiver as part of this group as well. Next slide please.

So we listened and we learned and we found that this is really – I mean, I always say no matter how many focus groups I go to I always walk away with something that I never knew before. And one of the things that patients shared with us, and we all know when patients are first diagnosed that often times that's not the best time to do patient education and sharing, because people are very overwhelmed in the disease process.

And so what people were saying is that patients wanted to seek resources specific to the disease state that they're in. CKD patients look for things relative to the prevention and prolongation remaining in a, quote/unquote, healthy state in their chronic kidney disease and try to delay the time by which they would have to start dialysis when they reach CKD5.

Patients who have been on dialysis for a year may have other questions than patients who have been on dialysis for three years. That one of the things that we need to look at as CMS and also as other groups that we work with that the current presentation of ESRD patients is not always representative of the range of patients' experience and that they may be too negative. That we have a population that has jobs, that goes – rides bicycles, takes care of families, takes trips and that we cannot continue to just use photographs of medical models of the doctors standing next to the elderly patient on the dialysis machine and that we have to consider how it is that we are going to change to be reflective of the community that's changing around us.

The other thing that's important is that information about treatment options and quality of care in patient outcomes should be proactively provided directly into the hands of patients who might not otherwise seek it out. And this is a real eye opener for us. One of the phrases that were used

by multiple patients within the group was that we needed to push this out whether people felt they needed it or not and that we had an obligation to assist those patients who maybe they were frightened, maybe there was an issue with health literacy, maybe patients were hopeless.

But that by providing the information to them they could decide when they would be ready to read it. But by not providing it and not making it available and finding a way to get to patients who may not be those that actively seek information that that was the percent of the population that we were not taking care of.

The other thing that we learned which was very exciting to hear is that and we've heard this at multiple other focus groups is that CMS is a trusted source of information and that was very helpful to have that reiterated by the group. Next slide please.

So one of the things that we heard from patients is a focus group is only as good as when you close the circle because giving information and not coming back and telling people what you did with the information is very discouraging. So we wanted to be sure that we brought the information from the patient summit to you and talk about some of the other things that we're going to do and that we're going to be working on moving forward to, again, incorporate the suggestions that we got from this and other patient groups.

One is that we're looking, again, to reorganize the existing content to address the different stages of kidney disease. This site primarily has focus on end stage renal disease, but we are also looking at ways to incorporate information of AKI and the other stages of chronic kidney

disease, and while it's not going to be ready for the October refresh, it is on the work that we will continue to go forward with.

We also are looking about making sure that we address patient sensitivity about the terminology that we use when we describe patients that we want patient-centric words and that we also need to look at, when we do videos, when we do graphics, what types of patients we're portraying and are we portraying what is currently going on in the community? As it was very adequately said to us that patients do not live to dialyze, they dialyze to live the life that they want to live and that needs to be reflected in the face that we show to the community.

The other thing that we need to consider to do is consider this feedback that we got from the summit, but also from the letters that you write and the articles that we get and the conversations that we have from the associations and from the patients in our future development. And one of the things that this led us to think about because the question came up at the summit and it has at other focus groups, what do you do for patients who don't use computers, who don't have access to computers or may be in underserved areas?

So one of the things that we're doing this summer is we are specifically focusing a patient focus group on less engaged patients, patients with less health literacy and less access to electronic information to get their understanding on their prospective for healthcare and how DFC can help engage them in partnering with what is the best thing for them to do to get – to have better outcomes. Next slide please.

So how can you help? One of the things that we've done in order to make it easier for providers and dialysis centers to educate patients on the Dialysis Facility Compare website and how it can be used to educate patients in their decision making, is we have created a toolkit that is available to the community, to providers, that is in both Spanish and English, and we encourage individuals who obtain these toolkits and you see that the address for requesting a toolkit is there, to use tweets and Facebook posts that are included that you could use within your emails, blogs, mailings to patients, articles.

Download and share the information, the social media graphics, include them in your newsletters, blogs, e-blasts, and you can also, if you have any questions relative to the best way you use the kits, can also use the same email to ask for any additional assistance and if you have any questions about the Star Ratings, about the toolkit – next slide please.

Please feel free to send any questions that you might have relative to the Star Ratings methodology, the measures specifications, to UM-KECC at the University of Michigan and also on the previous slide you had the information to ask questions about the toolkit, and as you know, Joel and I are always available. Most of you have our emails to answer any questions you may have.

At this time, I'm going to say thank you and I'm going to turn the presentation over to Jasmine who will be setting up the question and answer period. Thank you again.

MODERATOR: Thanks Elena. We will now start to take questions from the audience. As a reminder, please enter your questions into the Chat Box, subject matter experts from the CMS, DFC and ICH-CAHPS teams, as well as UM-KECC will address as many questions as time allows. Any questions not answered on the phone should be directed to CMSESRD@ketchum.com.

So we will now take the first question. Is there a discussion about revising the NHSN measure clinical and/or reporting?

JOEL ANDRESS: Thank you, this is Joel. So in response to that, so CMS is not the developer of the NHSN measure. The intentions for modifying, updating or otherwise revising the CDC's bloodstream infection measure should be directed to the CDC. I don't have their point of contacts just off the top of my head, but –

MODERATOR: But we'll refer the question to them.

JOEL ANDRESS: Yeah, but we will refer the question to them and then they can respond to your question. There is not currently any plan to modify the presentation of the measure on DFC however.

MODERATOR: Great. Thanks Joel. The next question is – would CMS consider releasing the patient level detail in a more user-friendly format?

JOEL ANDRESS: So I think the format we're currently using is a format that's used consistently across our programs. We'd certainly be willing to consider alternative formats. I think we'd be interested in hearing what formats might be considered more user-friendly for the audience. If you'd like to drop suggestions to us you can submit them to the help desk at dialysisdata@umich.edu or if you have our email you can just email it to Elena or myself and we'll take a look at it. That's actually – that's a new one, I don't think we've ever had anyone ask for a new format.

ELENA BALOVLENKOV: No, we never had a request before, but it's something that we can certainly consider as we continue to improve upon our work.

JOEL ANDRESS: Certainly. Does that answer the question?

MODERATOR: We'll have the person who asked the question submit a follow up if it doesn't.

JOEL ANDRESS: Okay, thank you.

MODERATOR: We'll go on to the next question. Can you clarify if the data and measures table will be available in aggregated Excel spreadsheet to LDOs. We request that you provide this information in an aggregated Excel format to facilitate data analysis.

JOEL ANDRESS: Thank you. So we currently provide the preview reports in tables that are set up for the population. We don't provide an aggregated Excel spreadsheet for the data for the

previews. We do provide an aggregated set of spreadsheets for performance of all facilities that's housed on the CMS data sites and there's a link to that through DFC.

I think the question seems to be can we provide that aggregated data file as part of the preview period. So I'd ask you to submit a follow up to let us know if that is correct. The answer to that is that we don't currently do that, but it's something that we could consider in the future. The caveat, of course, would be that if the data would not have gone through the preview period yet and so, of course, it would not reflect any corrections or, I should say, suppressions of the data. So that would be the first thing.

I think the second issue would be ensuring that the – any aggregate file that was only being provided to the – to say an LDO or a medium dialysis organization, we would need to develop a method for ensuring that we're only providing preview data for facilities that were actually owned by the provider. So that would probably need to be a source of discussion, but I think it's something we can consider.

ELENA BALOVLENKOV: Forecast for the future.

JOEL ANDRESS: Yep.

MODERATOR: Thanks Joel. The next question is, is the baseline data year still 2014 or does it change each year. So is it 2015 this year?

JOEL ANDRESS: Right. So under the current methodology, the baseline does not automatically change with each year. That was an intentional part of the revisions of the Star Ratings that were implemented in 2016, I believe. The purpose of this is that it allows facilities to improve in their performance relative to others prior to a rebaselining. And as we said before, the TEP had made some recommendations around rebaselining.

I expect we'll be providing more detail about when rebaselining occurs and what form it will take in a future call. But for the 2017 release, the baseline period is still the same and the standards that were calculated for that to define the cutoff points for the Star Ratings will still be the same as they were in the previous year.

MODERATOR: Thank you. The next question is – are the DFC's Star Ratings changing in 2017?

JOEL ANDRESS: No. So to clarify, the methodology is not changing, the measures set are not changing. We are refreshing the data using more up to date data. So if you consider the 2016 Star Ratings we use data essentially from calendar year 2015. For the 2017 Star Ratings we'll be using performance data from calendar year 2016. The SMRs is different because it uses multiple years of data, but yes, the data that are used to calculate the Star Ratings won't be updated, but the scoring methodology and the measures set will not change.

MODERATOR: Thank you. The next question is how do we request patient lists for the preview period?

JOEL ANDRESS: Thank you. I'm going to hand that question off to the University of Michigan who handles the request process through the help desk.

UM-KECC: Hi, this is a UM-KECC. So during the preview period when you are logged into dialysisdata.org to get your report, there is a tab on the website called Comments and Inquiry and there's a spot there to request patient lists. And if you don't have the proper permission to do that or if you don't – if you have questions, you can email dialysisdata@umich.edu and we can walk you through it.

MODERATOR: Thank you. Next question is – do you know if there'll be any changes to the DFC public file structure like columns, etc. In October, will there be a data dictionary published?

JOEL ANDRESS: Yeah, this is Joel. So as far as I am aware, we are not changing the structure of the data that are being reported for 2017 because there are no changes going into it. There are no new measures, there are no new data elements that are being incorporated within it. So that should not be changed. As you can see, we'll be publishing the same documentation that we do for every year.

I believe we provide detailed description of the data file and the elements done within it as part of the downloadable database that's incorporated within the CMS data site which, again, you can link through DFC and is updated with each refresh – each quarterly refresh, excuse me.

MODERATOR: Thank you. The next question is – you mentioned during your discussion on new measures adjustment in catheter rates bases, on life expectancy and other comorbidities, where will I find this information?

JOEL ANDRESS: I'm sorry, can you repeat that question please?

MODERATOR: Sure. You mentioned during your discussion on new measures adjustment in catheter rates bases on life expectancy and other comorbidity. Where will I find this information? If that's hard to understand, we can ask Caroline, the person who asked the question to clarify.

JOEL ANDRESS: No, I think I can address this. Thank you. So the answer is that it's not catheter rates that are risk adjusted, we provide adjustment for the fistula rate only and this is part of the discussion – part of the recommendations that came out of the vascular access technical expert panel that we convened to develop these measures. The information on the risk adjustment for the measure is available through the National Quality Forum website where the measure is located.

We also have measure documentation available on dialysisdata.org, and then, finally, when we update the CMS ESRD measures manual, we will be providing an update to the vascular access measures to reflect what will be reported in 2018, and so the manual will also reflect the

measures specifications for all of the new measures in the new and modified table including the vascular access type measures.

MODERATOR: Great. Thank you. The next question is – is there is a disadvantage to transfusing in an outpatient unit? Are the transfusions counted and administered elsewhere?

JOEL ANDRESS: Hold on a second, I'm going to confer and we'll get right back to you.

Okay, thank you for your patience. So to clarify – I want to clarify first of all that we're only speaking to disadvantage as it regards to the scoring on DFC for the measure so this shouldn't be taking as applying to payment or any other portion of CMS policy. There is no difference in terms of how those are captured for inpatient or outpatient settings. We capture the – we capture the transfusion the same so there's no scoring disadvantage with regard to whether the transfusion occurs inpatient or outpatient.

MODERATOR: Okay. Next question is – will patient satisfaction surveys ever affect a clinic's Star Ratings?

JOEL ANDRESS: Thank you. So the recommendation from the TEP was that we should incorporate the ICH-CAHPS into a separate Star Rating. So essentially you would have a Star Rating based off of patient experience and a Star Rating based off of the rest of the quality measures set. As I said before, we are still considering the recommendations that were made by

the TEP so I don't want to speak to exactly what will be provided and displayed as part of the Star Ratings.

However, our expectation is that if we follow the recommendations of the TEP, certainly it would have an impact, but it would be distinct from the stars that you see – the Star Rating that is currently calculated. I would have said the – a companion Star Rating. So that's based on the recommendations that the TEP made. I think we'll go into more detail in terms of how its impact will be – what its impact may be on the Star Ratings at a future call.

ELENA BALOVLENKOV: The other thing – this is Elena. I wanted to add that remember that what is presented currently on the DFC website in, say ICH-CAHPS, which is the patient experience of care, it is not a specific patient satisfaction survey, and while that may be measured indirectly, we do not currently display a patient satisfaction survey on the DFC website.

MODERATOR: Ok great. Thanks Elena and Joel. The next question is – now that AKI patients can be dialyzed in outpatient settings, will their data be captured in some manner moving forward?

JOEL ANDRESS: Thank you. I figured AKI was going to come up as a question during this call. So to clarify, the way our measures are currently constructed, AKI patients are broadly excluded from them because we exclude patients during the first 90 days of dialysis. And the measures are specifically developed for ESRD dialysis patients – that is for chronic dialysis patients. At present, we don't expect to have these patients in place.

I know there's been some guidance going around a BSI and I will simply say that our data for the bloodstream infection measure is identical to the data that are provided for the QIP so it will be aligned with the QIPs policy in that regard.

However, for the future, I think we're currently considering our options for accounting for AKI patients within dialysis facilities. It certainly – we think it's within our mandate in the Balance Budget Act of 1997 to incorporate AKI patients potentially, but there are a number of methodological issues that have to be addressed. The relative low density of AKI patients in any given facility, as well as the appropriateness, the clinical appropriateness, of AKI patients in specific measures.

So I think that's something that we're going to be addressing through the measure maintenance process in the future and in a fashion that addresses their appropriateness for either new measures that are under development or for maintenance that we're conducting for existing measures. Beyond that, I think it will be difficult to say exactly where they may or may not be included in the future until we've undertaken that work.

MODERATOR: Thanks Joel. Before I move onto the next question, I just wanted to remind everyone on the line that the slides used in today's presentation will be posted on the ESRD general information page and we'll send the announcement to all of the participants once the slides are available.

Moving onto the next question. Do you provide any information about transplantation and the patient toolkits or other patient-centered information?

ELENA BALOVLENKOV: Hi, it's Elena. Right now we do not have a current focus within the toolkit on transplantation other than when we're discussing modalities, but that is something and I'm glad that you suggested it because we are currently in the process of relooking at the toolkit and that's one of the things that we will focus on as we move forward. So thank you for bringing that up because like I said other than talking about it as a modality choice, we do not have extensive information in the toolkit, but thank you.

MODERATOR: Okay, thank you. Moving on to the next question. I'm referring to a new measures table that will be available this October. During the webinar, it was stated that it will be available to the facility, but you did not state the format or whether or not the information will also be available to the LDO or only the facility.

JOEL ANDRESS: Alright, thank you for asking for the clarification. So first of all, to clarify, the table will be available in July as part of the preview – as part of the preview reports that you receive in July and August in advance of the October release. So it will be available in the same format. So essentially when you get access to the preview reports for a facility, then you will have access to the new and modified table – new and modified measures table, which is simply an additional table within that report. So you will have access to both at the same time and through the same method.

MODERATOR: Thank you. Moving on to the next question. Is there is a DFC beginner class that I could attend to help me understand this material better?

ELENA BALOVLENKOV: Hi. Actually, one of the things we talked about because we have had and as part of our release we did January of 2015, we had a short video about how to best utilize the DFC websites, and we are currently talking about setting up a separate webinar for the facilities and for others that may be interested in helping navigate. So now you have confirmed that I'm heading down the right direction and not a rabbit hole that people will actually like a WebEx on that, so be on the lookout for an announcement about that. Thank you.

MODERATOR: Thank you Elena. Before we move on to the next question, we just wanted to let everyone know that we have about four minutes left today so please get your questions into the Chat and any questions that we are unable to answer during today's presentation we will share the email address with you to share your questions to in the Chat Box.

Moving on to the next question. Wish to remain anonymous. How do we ensure we are not hurting the members of the ESRD community with this? Example: noncompliant patients or very ill patients, doctors are aware this hits our outcomes, as well as the reimbursement. Doctors are not wanting to admit patients because of mistreatment of medical issues like chronic bleeding, etc.

ELENA BALOVLENKOV: Hi, this is Elena. I'd like to take this question not only as a nurse, but also as someone who has worked for multiple years in the dialysis community. That we see

our patients more than any other provider, we have an opportunity 13 times a month to interact with our patients and to partner with them in understanding and accepting a plan of care that we believe we can work on together to get good outcomes for our patients and to keep them healthy in whatever disease state they're in.

I personally never used the term noncompliant because I do believe that this is a partnership and that a lot of it is based on understanding. So that the intent behind this site is to help patients understand how quality is measured by CMS and that it is – causes a discussion to occur between the healthcare team and the patient to say, okay, this is my monthly report card, what have we done well together, what is it that we have to talk about, whether we're looking at lab values, whether we're looking at estimated dry weight, understanding renal diet, understanding medications, transportation issues that may come up, social issues that may interfere with patients, being able to attend an entire dialysis session, that we have an obligation to patients to look at all aspects of insulin care.

So this tool basically is intended to create a dialog between the patients and the healthcare team. We don't look at it as guidance to say this is a good facility or a bad facility, we look at it basically to talk about what is going on here and how can we improve what's going on for all of our patients?

MODERATOR: Great, thank you Elena. In the interest of time, we'll take one more question. Can you please expound upon the patient list? Is this a list of facility patients which need to be verified?

JOEL ANDRESS: Thank you. So the purpose of the patient list is to provide facilities with detailed information at the patient level for who fell within a particular quality measure – a particular quality measures. So, as an example, if you would like to know who in your facility was readmitted and fell within that measure and certain characteristics about those patients, then you can request that patient level information and it can be provided to you.

I think the main purpose here is that it provides you extra detail and insight into how, first of all, how the measures are calculated, who was included within it and to help you identify within your own facility processes that it will help you to avoid, in this instance, readmissions in the future. It's intended to provide you with additional information, it's not intended as a validation source.

Of course, if you find information on a patient list that you think is potentially problematic, then we, of course, encourage you to contact us and let us know and we'll work with you through the help desk to try to resolve any issues that you may have identified.

MODERATOR: Great. Thank you Joel and that was the last question. So we will now turn it back over to Elena to close out the call.

ELENA BALOVLENKOV: Again, I want to thank you all for being forthright in asking us really good questions, but also giving us some things to think about like some suggestions for the toolkit and some future steps moving forward. Change doesn't occur quickly, but we take your comments seriously, and we look forward to being able to continue this dialog, and we will be

looking at setting up the webinar, we'll be looking to keep you all informed of when we have our next National Provider Call in the fall and to keep you abreast of any decisions that CMS makes relative to recommendations that we get from the community, and again, I want to thank you all for your time and for your commitment to improving patient outcomes. Thank you again.

(END)