Dialysis Facility Compare (DFC) National Provider Call
October 11, 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 today's presentation with background information and provide additional background information on DFC. Jesse will provide a measures and methodology update, a Star Ratings update, and an update on new quality measures to be reported on DFC. Scott will then give an update on the Star Ratings of CAHPS survey results, and Jesse will discuss measure updates for the 2019 release. Elena will 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 question throughout the presentation using the question 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 in the Q&A document following today's call. Now I would like to introduce Elena Balovlenkov. Elena, you may begin. Elena, your line may be on mute.

Elena Balovlenkov: I'm sorry. Next slide, please.

So, hi. My name is Elena Balovlenkov. I'm a nurse, and I'm the lead at CMS for Dialysis Facility Compare. And I work with Dr. Jesse Roach, a nephrologist here at CMS and others within CMS to find a way to bring information to patients to increase transparency. So, that was one of the reasons that initially the Dialysis Facility Compare Star Ratings were established. And it was to help patients understand just exactly how CMS measures quality because everybody talks about measures, but the idea is to bring measures down to a level of understanding for the patient so that they can look at this information and use it to make informed decisions. Next slide, please.

So, what are Star Ratings? One of the things that we as a society look at is visual pictures to help us understand information. So, the Star Ratings basically is a mechanism that we use to summarize performance on a 1-to-5 scale because it's one that we have found that consumers are very comfortable with using and that by using the stars, it helps consumers to quickly visually understand quality-of-care information. Star Ratings allow someone to spotlight differences in healthcare quality and identify areas for improvement. Star Ratings are actually useful for consumers because we are very used to things in society being rated. We go to a 5-star restaurant. We stay at a 3-star hotel. So, that this is a way that we can make information that could oftentimes be complex for patients be brought down to a level where it is much easier to understand. You can look at the stars and see where on a 1-to-5 scale you fall. And then, also, there's an opportunity to drill down for more information about the Star Ratings, about DFC measures on the website. Next slide, please.

So, I'm going to turn the next part of the presentation over to Dr. Jesse Roach, a nephrologist here at CMS. Jesse?

Jesse Roach: Thank you, Elena. Next slide.

So, our technical-expert panel on the Star Ratings met in 2017. This technical-expert panel was made up of nephrologists, nurses, pharmacists, other healthcare professionals, representatives from academia, as well as from the large dialysis organizations, and also had significant patient input. The recommendations of this technical-expert panel were to update the SMR, the standardized mortality ratio, the SHR, the standardized hospitalization ratio, and the STrR, the standardized transfusion ratio, as well as hypercalcemia quality measures to reflect updated NQF-endorsed measure specifications. They also recommended replacing the current vascular access measures with the Standardized Fistula Rate and the Long-Term Catheter Rate measures. They recommended including pediatric peritoneal dialysis Kt/V in the Star Ratings. They recommended providing input on potential next steps for resetting of the Star Ratings. And they recommended adding the ICH CAHPS survey as a separate Star Rating from the DFC Clinical Quality Star Ratings. In the slides, you can link to the complete report of the technical-expert panel. Next slide, please.

For the October 2018 Clinical Quality Star Ratings, they will be released in October. The DFC Clinical Quality Star Ratings will be calculated using this updated methodology. Details about this updated DFC Clinical Quality Star Ratings methodology for the October 2018 release can be found at dialysisdata.org and the website listed in this slides. Next slide, please.

Updates for the 2018 Star Ratings included many of the recommendations of the technical-expert panel. They include updated versions of the following measures -- the Standardized Mortality Ratio, the Standardized Hospitalization Ratio, the Standardized Transfusion Ratio, and Hypercalcemia. The current vascular-access measures will be replaced with the Standardized Fistula Rate and the Long-Term Catheter Rate measures. New measures to be added are pediatric peritoneal dialysis Kt/V and standardize readmission ratio, which measures the readmissions to hospitals by patients under the facility's care. The pediatric PD Kt/V model will be added into the total combined Kt/V measure, and the ICH CAHPS Star Rating will be added as a separate Star Rating from the clinical Star Ratings. So, the survey, which is patient experiences of care, will be considered its own separate Star Rating. One thing to note -- the NHSN Standardized Infection Ratio, or the SIR, will remain on the DFC website but will not be included in the Star Ratings. Next slide.

So, this is just a list with NQF numbers of the new quality measures to be reported into DFC. I won't go into these in detail, but, as you can see, they're the ones that we've posted before, the SMR, SHR, STrR, the Standardized Fistula Rate, SFR, the Long-Term Catheter Rate, Hypercalcemia, and then normalized Protein Catabolic Rate, which is a measure for pediatric hemodialysis patients. Next slide.

So, here again is a list of the measures that will be used in DFC Quality Star Rating calculation. So, the new measures that we have listed above that we have listed on the previous slide. This has a breakdown of the total Kt/V measure, which includes adult and pediatric hemodialysis, as well as peritoneal dialysis. Next slide.

So, updates to the 2018 Star Ratings. So, in order to allow DFC users to follow annual trends in the Star Ratings, after the changes to the measures have been implemented, facility scores are recalculated using the updated measure set and applied to the April 2018 DFC facility Star Rating data. The score distribution resulting from these calculations is used to define Star Ratings cutoffs that result in the same proportion of facilities in each star category, as was achieved in the prior measure set using the April 2018 facility data. So, these same cutoffs will be used to define the October 2018 star categories. This will allow DFC users to compare results from the prior to current year based on facility performance, accounting for changes in the measure set. So, this basically means we will be keeping the proportions of the facilities the same that were in each Star Rating category to allow easier comparison, given the changes in the measure set. Next slide.

When will the DFC Clinical Quality Star Rating distribution be reset? So, the Star Rating distribution will be evaluated once three years have passed since the last reset. After three years have passed, the distribution will be evaluated for a reset when 15% or less of facilities are receiving 1 or 2 stars. This aligns with the TEP, or the technical-expert panel, recommendations for CMS to evaluate a potential resetting at predictable time intervals. A resetting of the Star Rating distribution will also include the establishment of a new baseline year. Next slide, please.

Now we'll turn it over to Scott Scheffler, who is the ICH CAHPS survey sampling task leader in the division for statistical and data sciences at RTI International.

Scott Scheffler: Thank you very much. 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 beginning data collection for the Fall 2018 survey. The survey questionnaire contains 62 items. Of those 43 are considered core CAHPS. There are several processes that help ensure that the quality of data meets a high standard. Independent survey vendors are used. All survey vendors maintain ongoing training. There are in-person oversight meetings with the vendors. There is an ICH CAHPS website that provides announcements and updates. And there is a constant, ongoing QC review of the data that is collected. Next slide, please.

CMS began publicly reporting results from the ICH survey on the Dialysis Facility Compare, DFC, in October of 2016. The results are updated twice a year as new data becomes available. The data that we use are from the two most recent survey periods. For an ICH facility to be displayed, they need to have 30 or more completes for the two survey periods. This is 30 total. It's not 30 from each period. So, 20 and 10, 15 and 15. The DFC displays top-box scores, which

are the most positive ratings for an item. If the item goes from 0 to 10, it will be reporting how many answered a 9 or 10. If it has four responses, it would report how many answered the top or best response. In other words, you're either in the top-box tier, or you're not at all. There is no middle ground. Next slide, please.

Now, the DFC reports on six measures for ICH CAHPS. Three of those measures are based on a single item -- rating of the kidney doctor, the rating for the staff, and the rating for the center. These items are on a 0-to-10 scale, 0 being the worst score you could get and 10 being the best. And three of those measures are composites. The kidney doctors' communication and caring has six survey items that go into it. Staff, care, and operations has 17 items, and providing information to patients has 9. Most of these items have four responses, which you could rank from 1 to 4. The responses might be like "never," "sometimes," "usually," or "always." And some of these questions have two response items. They're either "yes" or "no." Next slide, please.

And so, now we come to Star Ratings. And Elena did a pretty good job of explaining these. These are on a 1-to-5 scale that's immediately familiar to everyone. They're quick and they're easy to use. They allow you to spotlight differences in healthcare quality relative to the peers. And they allow consumers, advocates, and providers to see areas of improvement. Next slide, please.

Star Ratings are not new. They are currently being used on other CAHPS surveys, including Hospital CAHPS, Home Health CAHPS and CMS Parts C and D. We will begin using Star Ratings on ICH CAHPS this month, using data from the 2017 spring and fall surveys. The Star Ratings will be used on the same six measures that we talked about earlier. There will also be an overall Star Rating that is a simple average of the six individual stars. In fact, for this DFC refresh, only the overall Star Rating will be shown on the DFC website. However, you can get the individual Star Ratings and the linear means on the downloadable file from the DFC. If you haven't downloaded the data before, there is a tab at the top of the DFC in the middle, called "about the data," and it will take you to the link where you can download it. However, I should say that for the next refresh, in April, the website will be showing both, the individual Stars and the overall. One other comment is the Star Ratings, are they superior in any way to top-box or are they replacing them in any way? And the answer to that is no. It's kind of a misleading question to think one is better than the other. Star Ratings are simply another tool or another way of summarizing the data. They both have a purpose, and depending on what question you're asking, you may want to use one over the other. But overall you probably want to use both. Next slide, please.

So, these next three to four slides give an overview of how the Star Ratings are created. There are two main steps in this process. One is creating the linear mean. And the second one is using a cluster analysis on those means to create the Star Rating. So, basically, we're taking an average for a provider, and then we see how that provider's average compares to other providers to determine the Star. In the first step, creating the linear mean, we scale the ratings and composite items. We put every one of these items on a scale of 0 to 100. The easiest

example to think of is the three ratings questions that are on a scale of 0 to 10. So, if a person rated a plan a 0, then you'd rescale it, and it'd still be a 0. And if the person rated the plan a 10, when you rescale it, then it'd be 100. A 5 would be a 50. So, it's pretty easy. Then you average the scores, and it will be somewhere between 0 and 100. So, what's the purpose of this exercise, and why are we rescaling? Well, we have some questions that are on different scales, as you may remember. Sometimes you have a question that has four responses that might be "never," "sometimes," "usually," or "always." And for that question, a "never" would be a 0, and the "always" would be 100. So, rescaling puts all questions on the same scale, which ranges from 0 to 100. And for the composites, we average all the items that go into that composite at the provider level. And so, at this point, we have all six measures on a scale of 0 to 100, and we have taken averages of all six measures for every provider. And we are almost ready to run the cluster analysis and assign the Stars. Next slide, please.

But before we do that, we want to patient-mix-adjust these means. This is a step that we also perform with top-box scores. Patient-mix adjustments evens the playing field among providers that are known to have different mixes of patient characteristics. It is a model-based adjustment. Patient-adjustment factors include age, gender, self-reported overall health status, education, years on dialysis, and selected diseases and conditions. 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, and they have been patient-mix-adjusted, we can create the Star Ratings. We do this using a cluster analysis. Once again, we only do this for facilities where we have 30 responses across the two survey periods. The clustering forms five groups which correspond to our five stars. And it's a fairly complex algorithm. You won't be able to take the average, do a back-of-the-envelope calculation and come up with the Star Rating. It is also not percentile-based, meaning that a 5 Star Rating does not represent the top 10% of facilities or something along those lines. Rather, we are taking these provider averages, and we are seeing which group of providers are the most similar. Which group is the most different from another group? Differences within a group are minimized, and differences between competing groups are maximized. And so, the group with the highest scores are our 5 stars, and the group with the lowest scores are our 1 stars. And there is no quota to fill in these groups. It doesn't have to be equal. The groups can be small, or they can be large. Next slide, please.

Now, these star groups, their scores don't overlap. You can define a star group by its cut points or its range of scores. For example, the cluster analysis may determine that the 5-star rating of a kidney doctor should be for those providers with an average from 90 to 100. And the 4-star range for that same rating is for providers who have an average between 83 and 89. The 3-star range might be from 75 to 82, and so on and so on. So, there's no overlap at all. And if you have a different measure, say ratings for the center staff, it can have an entirely different set of cut points. A 5-star rating for that measure may not be 90 to 100, like we were talking about previously. It could be 93 to 100. Each measure has its own cluster analysis run, so the results are likely going to be different from measure to measure. Another important point is that these cluster analyses are going to be re-run each reporting period. So, the cut points are likely to be

changing. What does that mean from a practical standpoint? It means that the performance on a given measure is going to be based on how a provider compares to other providers solely within that reporting period. In this cycle, the 5-star range may be 90 to 100 on a measure, but in the next reporting period, if all providers are equally working hard to increase their performance on that measure, it could be that the new 5-star range in the next cycle might tighten and be between 91 and 100. Or, alternatively, it could widen and be between 89 and 100. Now, the overall Star Rating is different from these other six. They don't have cut points, nor does it have a cluster analysis run. It is just simply the average of the six individual Star Ratings rounded up. Now, that's kind of the last point of the slide, and this was a lot of information that got thrown at you. So, I just wanted to quickly summarize some of the key points from this, the first being that Star Ratings are not new. They've been around for a while and used on other CAHPS projects. Star Ratings are not a replacement for top-box scores. It is simply another tool for summarizing the data, and their strength is in making comparisons between providers. The analysis and calculations that go on behind the scenes are pretty high level, but ultimately it boils down to a 1-to-5-star system that is easy and quick for consumers, advocates, and providers to understand. And, lastly, for this October refresh, we will only be showing the overall Star Rating on the DFC website. The individual stars will be available through a download. But starting in April next year, we will be showing the overall, as well as all of the individual stars on the website. And with that, I'm now going to pass the presentation back to Dr. Jesse Roach. Thank you.

Moderator: Jesse, your line may be on mute.

Jesse Roach: Next slide, please.

So, for the 2019 October Release, these are the measure candidates -- the percentage of prevalent patients waitlisted, or the PPPW. This refers to patients waitlisted for transplants that are in a dialysis facility. And the standardized first kidney transplant waitlist ratio for incident dialysis patients, or the SWR. This refers to the number of patients in the first year of dialysis that are waitlisted.

Next slide, please. The measure updates for the DFC October '19 Star Ratings -- we do not plan on having any updates to existing measures that are planned for the next Star Rating release. Next slide.

Commenting on the DFC October 2019 measure candidates. Next slide, please.

Submitting comments for measures for consideration. CMS is accepting comments beginning on October 11th through December 31, 2018, on DFC measure candidates or additional measure candidates for DFC or Star Ratings. So, if you have comments on the two transplant measures that I've just talked about, the PPPW or the SWR, this would be the venue with which to make comments on these. If you have comments on the Star Ratings, the ICH CAHPS, or the Star Rating changes that we mentioned, this would be a place to register those comments. And if you have any suggestions for measures that we should include in the DFC program, this is

where we would also take those suggestions. We welcome any comments that you have and would love to hear suggestions for other measures that could be added to the program. Next slide.

Measure submission requirements. If you would like to submit a measure for consideration as a candidate measure, you must provide: one, the complete measure specifications, two, clinical evidence supporting the use of the measure, three, measure-testing data consistent with the requirements of the National Quality Forum. We would recommend using the National Quality Forum Measure Submission Form as a basis for any submitted measure. And we will consider them based only on the information that's provided. Next slide.

I will now turn it over to Elena to discuss including the patient voice measure development.

Elena Balovlenkov: Thank you, Jesse. Next slide, please.

So, why do we do all this? The biggest thing that we are concerned about here at CMS is that patients and providers understand that we want to assist the patient in making the best decisions possible regarding their care, that the patient is a member of the health care team, and, as a result of that, they are the best subject-matter experts and the best patient advocates for their own care. So, CMS continually goes back to the patient community to make sure that we have an idea if things have changed, if there are things that we need to change, whether or not patients are understanding the information that is ongoing that we're putting out so that we really started focusing on this, probably most seriously starting in 2017. While we had a lot of informal meetings previously, we started formalizing the process more and have worked with different contractors to assist us in reaching out to patients. So that in 2017 we met with the AAKP, the American Association of Kidney Patients, and used a contractor from NORC to help us meet with all of the national advocacy organizations -- NKF, Dialysis Patient Citizens, AAKP are some of the examples -- to see if we could get representatives that were not what we call the patient ambassadors. We wanted patients that were between the patient ambassadors, who are very used to talking to government officials, maybe lobby on the Hill and stuff. We wanted individuals that would understand the concept of measures and what we were trying to explain and to get some information from them to find out whether or not we were taking information that measured quality at CMS and putting it out in a way that provided information that patients wanted, but also that we were depicting dialysis patients as individuals who were not just someone who was tied to the machine. So, what we did is, we had a 5-hour session with patients, caregivers. As I said, they represented all of the advocacy groups. And this was the first time that basically we've had an opportunity to get everybody in the room from all of the advocacy sites at the same time and also to really get some what I call down and dirty insight onto the website and also give us an opportunity to engage patients who said they were willing to engage with us moving forward, as well. Next slide.

So, we also have done other patient focus groups. We've conducted six focus groups in three different cities across the United States where we talked to patients of all ages to hear about their experience with dialysis. And one of the things that we wanted to find out is how do

patients get information? Do you talk to the person sitting in the chair next to you? Do they have an educator at your dialysis facility? Do you go online? Do you talk to someone else who has been on dialysis within your family? And we wanted to know just exactly what they understood about the care they received within their facility and also what types of questions they had, and if they had questions, where were they finding the answers? Next slide, please.

So, what are some of the things that we learned? One of the things that we learned is that patients wanted us to change our graphics on all of our websites and all of our printed material that had to do with ESRD, CKD, AKI because they felt that basically what we were doing is showing either frail or disengaged patients that just looked at somebody being tied to a machine and that we were not representative of individuals who were doctors, lawyers, truck drivers, grandparents and that we need to show a more robust community. And it's something that we've been working very closely on and have taken very seriously and have changed a good deal of our graphics and will continue to do so over time. That we also needed to identify patients who did not know that they needed information, or, as somebody nicely said, people who get in their own way because they don't know what they don't know or they don't know who to ask or they don't believe that there's information that they should be asking. They also wanted us to work and make sure that instead of just talking about ESRD, that we are looking at ways to educate patients about how do you measure quality at all levels of the disease process? What happens when you have CKD, and how can you help yourself put off the progression to end stage renal disease to CKD 5? What are the types of questions that you should be asking? What information should you be looking for? Also, that if you have a patient who is in ESRD and receiving treatment, what are the things that you need to find out about transplant? What questions do you need to ask? What about the concept of a preemptive transplant before you even start dialysis? So, this is one of the things that we were looking at as to how do we get information that is helpful, that is not just "specifically" ESRD? And it was good to hear from patients that they actually felt that Medicare is a trusted source of information and that our information is something that is reliable that they could, as one patient said, take to the bank and know that people would understand the language that they were using, the vocabulary they were using, the information that they were asking about. Next slide, please.

So, one of the things that we looked at with DFC -- initially DFC was much more so a stakeholder tool, as opposed to a patient tool. And while patients were getting on, we found the traffic to the site was extremely low. We do monitor that monthly. And we look at the data that we get, the Google metrics that tell us who's getting on? Are people getting on from their desktop, from their telephone? How long are they spending on the site? What part of the site they're looking at. And so, we're using that information and the plain language on the site to see how accessible information is to patients, because frankly, when you use the word "hemodialysis," you're already up at a higher grade level. And so, trying to find words that are simple but explain concepts is one of the things that we're working on. Working on usability -- testing of the site -- and also making sure that one of the things we learned is that a majority of patients with end-stage renal disease or even CKD do not have computers in the home. They go with their children to the library to use the computer. And most of them, if they are going to get information, access it from their cellphone, which can be limited because getting on a

website uses a lot of data. So, looking at how we can help patients move around on the site and make it easier to get the information they need. And so, we're adding the capability for patients to be able to filter results by CAHPS-rating this, as well, because there are patients who told us, "Look. I'm not so much worried about the clinical. I want to know how people treat patients that are in the chair. So, that's one of the tools that we added as a result of feedback from the community. Next slide, please.

So, in closing, here's what we want you to understand, that we're always looking to build a better mousetrap. We will continue to go back to the community and look for suggestions. We'll continue to work with AAKP, DPC, all of the other advocacy groups, to get feedback and information. Patients have allowed us to save their information and say that they want to come back and help us get us right. So, we think that's important. We're currently working with the community to build a measure tool kit to help patients understand what measures are and how to use them at the community level. And so, this is important for us. We are also creating a DFC handbook to help patients navigate the site, and we also have a DFC tool kit, which is in English and in Spanish, and it's available to the networks to use, or to the facilities, actually to help patients understand. Next slide, please.

So, we also are looking to do more with social media. CMS does have a Facebook page, and we're looking to see about how do we incorporate some of that information and the feedback that we get and making sure that not only are we sensitive to the pictures that we're using in our educational information but also the terminology that we use. As patients have told us, "I don't live to dialyze. I dialyze to live my life the way I want to live it." And we're also looking at the bigger picture as we progress in all of the compare sites, not just DFC, because we realize that it's an integrated patient and that it's not just about kidney disease. Next slide, please.

So, we want to be sure that you have the information that's available to you. We have multiple resources, information about the measures specs, and you'll see these slides will be posted, as they are every time we have a call. Next slide, please.

And that we are going to be starting a question-and-answer session, but sometimes questions are very specific, or you may not want to ask your question publicly, so that you can take and reach out and get answers to your questions. You see that we have it for the contractor at University of Michigan. We gave you the information if you have questions about CROWNWeb. Information if you have questions about the CAHPS survey. Next slide, please.

So, what we're going to do now is I want to thank you for listening, and we're going to start our question-and-answer session. I'll turn the session back to you.

Jesse Roach: Can you go back one more slide?

Moderator: Sure.

Jesse Roach: Yeah, this is -- I'm sorry. Go forward again. I apologize. The dialysis data e-mail address is where you can also send candidate-measure ideas, if you have any of those. I just wanted to make that clear. Okay, we can now go to the question session.

Moderator: All right, thank you both. So, as a reminder, please enter your questions through the question 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 via e-mail following today's call. All right, our first question -- "Our facility is 100% nursing-home residents. When will the star rating accurately reflect the disparity between our facility and a regular outpatient unit?

Jesse Roach: Hang on just a second. So, all of these measures are risk-adjusted, according to the standards that were brought before the National Quality Forum. We're constantly working on those risk adjustments. So, your facility, if it has a significant number of nursing-home patients, that is reflected in the measure, and that we continue to evaluate whether a risk adjustment is adequate to account for the differences between facilities.

Moderator: Okay. Our next question -- "Are the new access measures pulling out grafts so grafts don't count against a facility?"

Jesse Roach: Could you repeat that, please?

Moderator: Sure. "Are the new access measures pulling out grafts so grafts don't count against a facility?"

Jesse Roach: So, if a patient has a graft, an AV graft, they would receive credit in the long-term catheter measure because they don't have a catheter currently in place, but they would not receive credit in the fistula measure because they don't have fistulas. This reflects the evidence that fistulas are superior to grafts, so while it would not be as bad as having for the facility as having just a catheter, it's not reflected as well as if the patient had had a fistula.

Moderator: Thank you. Our next question -- "For the ICH CAHPS Star Rating, what would the outcome be if a facility was eligible and did not administer the survey? Do they receive a 1-star or 0-star rating in ICH CAHPS?"

Scott Scheffler: This is Scott. If they didn't have anyone that's eligible, they shouldn't have a Star Rating at all because they wouldn't have the 30 completes across the two time periods.

Moderator: All right, thank you. So, our next question comes from a clinic manager of an FMC clinic, which agrees with their insurance company to do blood transfusion in their clinic instead of sending patients to the hospital or other clinics. But in their DFC rating, they got worse than expected. This attendee notes -- "We feel we are doing this for patients' convenience, and we shouldn't be penalized for that. Those patients are not on any ESA due to their cancer

diagnosis. We were discussing, because of the rating, to start refusing blood transfusions. Please advise."

Jesse Roach: Please stand by. So, for your specific concerns, I'd recommend sending a query to the help desk, but in general all transfusion events are captured by this measure. So, the location wouldn't matter, whether it happens in a dialysis facility or in a hospital. So, in either case, the transfusion would count towards the measure. But if you have specific questions for your facility, please submit those to the help desk.

Moderator: Thank you. Our next question is, "Will pediatric facilities still have exemption for VA and ICH CAHPS? If so, how will this affect the Star Rating? Will it lower it?"

Jesse Roach: I'll let -- please stand by. I'll let Scott answer the CAHPS question, please.

Scott Scheffler: Yeah. So, for the Star Rating, it wouldn't be lowered because they have no -- they don't have the 30 completed responses. So, they'd have no Star Rating reported.

Moderator: Jesse, is there anything that you'd like to add there?

Jesse Roach: For the pediatric, for the vascular access, I believe those are still exempted. The pediatric patients are still exempted from those measures.

Moderator: All right, thank you. Our next question -- someone states that they "frequently get comments from their patients that the survey questions are too long and are too vague. Is it possible, instead of sending the same long questions twice a year, is it possible to make them shorter and divide them into four sections and every quarter send one section?"

Elena Balovlenkov: Scott, can you answer that question, please?

Scott Scheffler: I don't have a -- I'll have to consult with my other RTI team members on that one. I don't have a good response for that one right now.

Elena Balovlenkov: So, Scott, why don’t you ask them to submit it to the CAHPS website, and that way you can discuss it with the project teams and with CM.

Scott Scheffler: Yes.

Debra Dean-Whittaker: This is Debra Dean-Whittaker.

Elena Balovlenkov: Go ahead, Debra.

Debra Dean-Whittaker: I just wanted to say that we are considering making changes to the survey, and we will be glad to listen to that, as well. Scott is correct. We need to talk among ourselves about this. It's a more complex process than it appears at first. But if you would like

to, please make your suggestions to us at our website. It's our e-mail address -- that's the survey contact. That's not the e-mail address. Go to the website, get our e-mail address, and send your suggestion to us. We will think about it. So, thank you.

The e-mail address is ichcahps@rti.org. And it's also on the ICH CAHPS website.

Moderator: Thank you. Our next question -- "Did CMS develop any patient-facing materials that explain the ICH CAHPS Star Ratings so the facility staff can be prepared to address patient and family questions? If so, can you please share with the community?"

Scott Scheffler: We do have information on the Star Ratings a little bit. I know within our -- we have a document on the ICH CAHPS website that goes into technical details on the coefficients, as well as the Star Ratings and how we calculate it. It might be a little bit overly technical, so if there are other questions, feel free to submit them to the website, and we'll help see if we can give a more layman's term explanation or answer to them. But for now the one thing we have is in the coefficients' document.

Moderator: Thank you, Scott.

Elena Balovlenkov: Hi. This is Elena. And this is one of the things that we appreciate--this question. And myself, as a DFC lead, will reach out to CM and see, because this is part of the DFC website, this is a great suggestion to see if maybe there's a way we can come with a one-pager or something that would help patient understanding, just like we're working on for all of the rest of the measures. So, thank you very much for that question.

Moderator: Our next question -- "Which star domain are the transplant measures expected to land?"

Elena Balovlenkov: Give us one second, please.

Jesse Roach: So, we haven't made a determination about those. These are not candidate measures for the Star Ratings yet. We're going to make a determination as to whether those would even be included in the Star Ratings at a later date. They're just being added to DFC, not to the Star Ratings.

Moderator: All right. Our next question -- "How many patients were included in the patient summit feedback session?"

Elena Balovlenkov: It depends upon which one you talk about. We have had anywhere from nine patients in a group. There was a time when we had three groups of eight patients each. So, it varies. Depends upon what the subject matter is. We've just been working on doing one that was evaluating patient-health literacy that was done in three states, and then we additionally did pediatric patients with phone calls and stuff, and those groups varied from four to nine each in each of the states.

Moderator: All right. Our next question -- "CMS requested feedback on the two transplant measures last year. There's a summary report available online. Are you seeking additional comments, or what is the purpose of another comment period?"

Jesse Roach: We always are soliciting comments, and so we always welcome comments.

Moderator: Our next question -- "While it is extremely important to have the patient input, are there any plans to hold the patient accountable for their choices in the ESRD process?"

Elena Balovlenkov: Hi. This is Elena. One of the things that we're talking about when you talk about holding patients accountable is that just as with any disease process, whether we're talking about heart disease, diabetes, end-stage renal disease, the idea is that the treatment team work with the patient to try to get the best results possible. We do understand that there are patients that have very complex needs, and I know that may sound like a canned answer, but one of the things is, is that there is no way to say whether or not somebody's a good patient or a bad patient because you have to look at the patient from a holistic perspective. Are they homeless? Do they have mental illness? What support services are we offering? And I realize that oftentimes it makes you feel like you're a one-stop shop for everything so that while there are adjustments to everything that we do in terms of exclusions from the measures and looking at the best data possible that's reflective of the needs of the patients, we do understand. And I used to be a dialysis nurse, and I also ran a dialysis center. It can become very complicated, and there truly is no simple answer. But no, in terms of holding a patient accountable, that's not something we can do. It's part of the team working with the patient and trying to help a patient understand what exactly they need to do to live a good life. But we do appreciate the question.

Moderator: Our next question -- "When will ICH CAHPS Star Ratings be public?"

Scott Scheffler: The overall Star Ratings will be on the website this go-around, for this refresh, and the individual stars, the six individual ones, they won't be showing on the website, but they are available through a download. There's a button on the DFC where you can download the data. Now, in the April refresh next year, we'll be showing all seven, the six individual ones, as well as the overall one.

Moderator: All right, we will stand by for our next question. Our next question states, "Our patients tell us that the survey's too long, too many questions, and sometimes confusing. They don't want to keep doing this twice a year. Also, in regards to transplant, our population is mostly elderly. We refer every patient who is eligible and/or wants to be referred, but then it's up to the transplant center. Why would be rated on this in the future?"

Scott Scheffler: Go ahead.

Jesse Roach: I was gonna say I'll let Scott answer first. My answer is more complicated.

Scott Scheffler: Well, I was gonna ask for clarification. I understood the general, the first part of the question, but I didn't quite understand the question at the end, what they were asking.

Moderator: Sure. So, their final question is, "Why would they be rated on that in the future?"

Scott Scheffler: I will say that we are looking at questionnaire length. It's an issue that comes up a lot. And so, we look at the lengths of the question, as well as how many questions, and we are currently going through an analysis, looking at seeing whether we can possibly drop questions and make the survey shorter. However, that's still in progress, and I don't think a final decision has been made on that. We also look at survey burden. That is a topic that comes up a lot because one of the issues is, is that with this national survey, we want to get as many responses as possible. And one of the problems is, is that a lot of these dialysis facilities, the median number of patients that are eligible is, I believe it's in the low 50s right now. And so, on one hand, we're battling to try to get as much useful data as possible for it to be accurate and precise. And so, for a lot of the times, it's not even a sample that we're drawing. We're actually drawing a census. We're trying to get as many people as possible just so we can get that threshold of 30 completed responses. And so, the issue of survey burden has come up. And we looked at it in the past. And the results are kind of surprising. You might intuitively think that if somebody responds to the survey that they would be less likely to respond to it again in the future. And what we have found is that those who respond to the survey are the most likely people to respond to it again. It's as if they've got a story to tell, and they want their data to be known. So, generally speaking, we find that people who complete it once are likely to complete it again. And, to be honest, we want these people. So, if there is a change at a facility, say, in the spring of this year, and some condition in the facility happens, then we want to be able to keep track of that. So, it's an ongoing battle. I hear what you're saying. On one hand, we want it to be as concise as possible and not to be much of a burden, but we also want as much information that we can share, as well, also.

Jesse Roach: And just to address the part about the transplant measures. The rationale behind these measures is that the dialysis facilities and the transplant centers have a shared reasonability for ensuring that these patients have optimal access to transplantation. While the transplant facilities do make the final decision on whether to waitlist a patient, transplant centers and transplant surgeons, while we were developing these measures, told us that the dialysis facilities had a large part in maintaining the health status to get a patient ready for transplantation and also providing the education necessary so that patients could make an informed choice about whether or not -- make informed decisions about transplantation. So, we think that while the dialysis facility doesn't have full responsibility, the dialysis facility does have a shared responsibility with transplant centers for letting their patients have access to transplantation, which has been shown to have superior outcomes to being on dialysis.

Moderator: Okay, I believe we have time for one more question. And just so you all know, if we did not get to your question, we will answer the rest of today's questions in the Q&A document that is posted along with the slides and transcript from today's webinar on the ESRD general-

information page in the coming weeks. So, our last question -- "If a patient does not complete some or all of the self-reporting portion on the ICH CAHPS, how is this reflected in the patient mix?"

Scott Scheffler: I may need to consult with my colleague on that and answer that one online or answer that in the written responses. I'm not exactly sure, and I don't want to guess.

Moderator: All right, thank you, Scott. Elena, I will turn it over to you to close the call.

Elena Balovlenkov: Thank you very much. I again want to thank everyone for coming and for having an interest in what we've been doing in terms of the dialysis refresh for October 2018. Your feedback is important to us. And, again, as Jesse said, there is no such thing as a closed-comment period. CMS welcomes all comments relative to the measures, the Star Ratings, the CAHPS measures. We work very closely with CM on making sure that we get the best information to you all. So, I want to thank you again, and please remember that all of this information will be posted,and thank you for your time.