

CENTERS FOR MEDICARE & MEDICAID SERVICES
Special Open Door Forum:
Coming Soon: Star Ratings on Dialysis Facility Compare
Monday, October 6, 2014
2:00 p.m. – 3:30 p.m. Eastern Time
Moderator: Jill Darling
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2:00 p.m. ET

Operator: Good afternoon. My name is (Leanne) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Coming Soon Star Ratings on Dialysis Facility Compare and Overview for Consumer Special Open Door Forum.

All lines will be placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Leanne). Hello, everyone. Good morning and good afternoon. My name is Jill Darling. I'm in the CMS Office of Communication. Welcome everyone to today's Special Open Door Forum Call.

This call is scheduled until 3.30 and there will be a Q&A session at the end. For those who did get the announcement, I'm not sure if everyone did, take a look in the middle of the announcements there is a link for the PowerPoint slides for today.

The link is www.dialysisdata.org and so that will help you along with today's call. So, I will hand the call off to Elena Balovlenkov to begin the call.

Elena Balovlenkov: Thank you, Jill. I'd like to welcome everyone to the call today. I do want to make a general announcement prior to beginning the call.

One, I wanted to thank everyone for reaching out to CMS and submitting your questions and news articles and to let you know that we went through all of the questions and comments we received either by e-mail or through which we affectionately call snail mail and also concerns that were raised in the various articles and answered them all so that everyone would have access to the same information and that information has been posted to the dialysisdata.org Web site.

So, please feel free after the call today to look at the answers to the questions. We wanted to be sure that everyone got the same level of information, and if you have any additional questions you know how to reach us. So, I look forward to hearing from you not only if you have questions about that document, but also if you have any additional comments or concerns that we are unable to get to during the question-and-answer period.

We did receive several questions as a precursor to this call. Some of them actually were very detailed and would be very difficult to answer on this call. So, for those individuals, we will be, again, add them to the consolidated question document for any questions that we received in relation to this presentation.

So, feel free to reach out but know that we will continue to take questions and respond to those questions, again, in a consolidated question format because our belief is that if one person has a question, someone else may as well.

So, let's get started, we're on slide 2 and I'd like to introduce our presenters today. I'm Elena Balovlenkov. I am the DFC lead for public reporting. We have Christopher Harvey who is the research analyst from the University of Michigan, Kidney Epidemiology and Cost Center and UM-KECC is the ESRD Quality Measures Development and Maintenance contractor for CMS.

We have Dr. Kate Goodrich, director of the Quality Measurement and Health Assessment Group in the Center of Clinical Standards and Quality. Dr. Judy Hibbard, professor of Health Policy at the University of Oregon. Christine Bechtel, president of Bechtel Health Advisory Group. Kathy Day, member of the Consumer Union's Safe Patient Project and William Dant, an ESRD patient of 18 years who is a patient advocate and also a subject matter expert on kidney disease.

So, for our agenda today, we'll be talking about the Star Rating methodology. We will be following up with the questions and talk a little bit about what we've learned from the stakeholders who have taken the time to contact us and from patients and consumer groups who have written in and shared their ideas with us.

We also will be hearing about some of the issues and some of the positives about Star Ratings for consumers from Judy Hibbard, Christine Bechtel, Kathy Day and William Dant and we'll also, again, as I said have a question and answer period where we will answer some of the questions that were submitted in addition to having our usual question-and-answer format.

So, let's get started we are on slide number 4. So, one of the things that people want to know is why are we doing Star Ratings? The CMS' vision as we've all seen and heard in the past is basically focused on optimizing health outcomes by improving clinical quality and transforming the health care system. This mission aligns with the three aims and the three aims are better health for individuals, better health for the population and lower cost through improvement.

And so one of the things the Affordable Care Act called for is an expanded public reporting initiative to ensure ready access for the public so that this national call is to increase transparency and to discuss the wider use of publicly reported data on health care quality that aligns with the vision and mission for CMS and also president Obama's digital government strategy which lays out in pretty clear steps milestone actions that are outlined in the

ACA to enable the American public to access high quality digital government information and services.

What we are looking for is increased transparency so that people can go to various government Web site and get the information that they need to help them drive health care decisions and also to help them in finding access to services.

Next slide, please, slide 6. So, the Compare Web sites are the CMS official source for information on health care provider quality and, again, in alignment with the digital government strategy, they include the issues surrounding data contribution to data.gov and medicare.gov. It also involves mobile optimization of all of the compare Web sites.

The use of the increased analytics to improve the quality of the (site), the use of visitor and consumer surveys to improve the (site) and one of the biggest things is that there's been a national call not just from the government and different regulatory agencies but from the public asking for an easily understood format for new reporting requirements because people want to be able understand what they are searching, Right now we have the Web site for the five different health care settings, Nursing Home Compare, Dialysis Facility Compare, Home Health Compare, Hospital Compare and Physician Compare.

And as you can see on the dates on the slides that these sites have been in existence for a period of time, so again as part of the natural maturing of the sites, we are working on improving the quality of information that is available to the consumer.

Next slide. Star Ratings are currently reported as part of Nursing Home Compare, Medicare Plan Finder and Physician Compare. And on our call today, we're going to talk about the future releases for Dialysis Facility Compare but while we're the first ones out of the gate for this period of time, we're not (the only) one.

Hospital Compare is moving forward next year around April. Home Health Compare will be coming out later this summer in July and the reason behind this is that we believe that it is important for patients to have information they can understand, that we want to leverage the knowledge and the lessons that we've learned from the existing sites, that it is important for CMS to coordinate information across the Compare sites and that we work on improving and reporting quality data that is easily understandable by the consumer.

As you know, we initially provided information on the National Provider Call held in July and also that as a result of feedback from the consumer community, and from the stakeholders, we released a memo stating that the Dialysis Facility Compare implementation would be delayed until January 2015. So, I want to talk about not only what we talked about in July but also what we're talking about in moving forward in terms of the information we've collected from consumers.

The star rating, what do they mean to the public? Facilities can earn between one and five stars. The more stars a facility has, the higher the quality compared to other facility and a rating of three stars reflect the facility providing quality of care that is equal to the national average.

Star ratings are based on quality measures currently reported on DFC and I'll repeat that, again. There are no new measures that are being reported in the Star Ratings. The Star Ratings are based on quality measures currently reported on DFC such as patient health outcomes and processes of care.

Now, the star ratings were started, again, to provide an easy recognizable way to compare facilities by the dialysis community. It offers additional information the consumer can use to make informed choices, but we don't want those choices to occur in a vacuum.

We believe that it is extremely important that individuals visit the facility, that you meet the staff, you talk to your nephrologist, you talk to the patient care managers, the technicians, get a tour and also look at all the information that you can get on the government Web site.

We have a general ESRD site and we also have other attributes on the DFC site beside the Star Rating such as important information for patients looking for shifts after five, for the distance to a facility, information to use whether or not a patient is selecting peritoneal dialysis or hemodialysis. A patient who is traveling can use this site to also access information for all the places they travel to as they continue to need dialysis during vacation.

So, one of the things to remember when comparing dialysis facility star ratings, is to look at the quality information reported on DFC. They are not a rating of patient satisfaction. They are an estimate of the quality of care using specific measures that have been reported by the clinical facilities over the last several years.

Star ratings compare one facility to all the others. One star does not mean that a facility provides poor care. What it means is that the facility rated in the bottom 10 percent on the DFC measures that were used to compare them to all the others. Remember, Star rating should always be used in combination with other information.

I'd like to introduce Christopher Harvey, research analyst at UM-KECC who will talk about the Star Rating methodology. Chris?

Christopher Harvey: Thank you, Elena. So, now, I will describe the Star Rating methodology that was created for DFC and give a little insight into development process. We will finish here in the section by providing some results summarizing the outcomes of this methodology and the differences between Star Rating categories that were observed.

We now move on to slide 12. Before I get into the actual methods, I want to expand a little bit about the goals and meaning of star ratings we want to keep in mind on developing the system.

Currently, there are many measures available to consumers on the DFC Web site but no summary ratings that can be used to directly compare facilities. The Star Rating would score facilities between one and five based on these

measures and the goal for consumers is to use these ratings to compare facilities to one another.

Consequently, the methods were created with interpretations and stars that make comparisons meaningful and simple. Specifically, the categories are interpreted as a range from much below average which is one star to much above average which is five stars -where the average of three stars referred to the national average facility performance.

We now move on to slide 13. In developing the methods, discretion had to be used to determine how the DFC measures will be scored, how these measures will be combined to score facilities and how final scores would be summarized by the Star Rating. Many measures have different ranges of values, shapes when graphed either symmetric or non-symmetric and variation and among facilities so that these factors do not give measures (undue) influence on the rating system.

All measures were scored from 1 to 100 based on national ranks. Additionally, we realized that the potential – that now and in the future, there could be many measures rating similar aspects of care.

By simply averaging all of the measures, we could be giving – this aspect of care more influence simply because it was measured more often. For this reason, we (looked) to group similar or more correlated measures into groups using an analytic technique called factor analysis.

Facilities scores – were scored based on averaging the domains created from these groupings rather than averaging individual measures. Finally, these final scores are used to create the Star Ratings which will be described in a few slides. In summary, measures were ranked from 0 to 100, measures were grouped into domains, scores are created by averaging measures within a group and final scores are created by averaging domain scores.

We move on to slide 14. Here we provide the results of the groupings that were created. The first group was named the standardized outcomes domain and has measures that measure mortality in a facility compared to expected

hospitalization in a facility compared to expected and transfusion rates in a facility compared to expected.

The second grouping, other outcomes domain one, contains percentage of adult patients who received treatment through fistula where higher is better and percentage of patients who had catheter left in vein longer than 90 days; a had ahemodialysis treatment using a catheter where lower is better.

And finally moving on to slide 15, the third group was called other outcomes domain two and had two measures: Percentage of patients who had hypercalcemia and the measure of waste from blood measured by Kt/V levels for different types of patients.

Moving to slide 16. After the domain scores were averaged to create a final score, we observed that the final score were symmetric.t. Based on this and the interpretations of the star rating as a comparison to average based on the star ratings as follows, the top 10 percent final scores were getting five stars, the next 20 percent of final scores are given four stars, the middle 40 percent of final scores are given a rating of three stars and next 20 percent are giving a rating of two stars and finally the bottom 10 percent of facilities were given a rating of one star.

Finally, moving on to slide 17. Here we see a few results that we used to validate the usefulness of the Star Rating System as developed. Average measure of scores, were higher with higher star ratings across the board. Meaning that facilities that tend to perform better on individual measures tend perform better overall.

Finally, final scores were significantly different across rating categories and average round scores were consistent between groups. This indicates that ratings reflect true differences in the quality of care received based on the DFC measures. The average difference between three and four stars is similar to the average difference between four and five stars.

For more information on the methods and analysis conducted, we have a few extra slides in the appendix of the slide deck. And at this point, we're done with the methods; I will pass the presentation back over to Elena.

Elena Balovlenkov: Thank you, Chris. I'd like to introduce our next speaker who will be talking about what we've learned from stakeholders, Dr. Kate Goodrich, director of Quality Measurement and Health Assessment in the Center for Clinical Standards and Quality.

Kate Goodrich: All right. Thank you, Elena. Hello, everybody. Nice to have everyone here today. Thank you for joining. So, I'm going to talk a little bit about what we've heard from the various stakeholders over the last few months. So, to start, we had a national provider call back in early July where we presented to the public, the Star Rating methodology that we had developed and we (sought) input from the public not only on that call but in an ongoing fashion ever since then.

We had a lot of questions and answers, and as Elena indicated earlier, a number of those are posted for everybody to see. They are on our Web site with a list of responses to all the comments that we've received since the National Provider Calls. So, we encourage you to go there and take a look and see if maybe it answers some of your questions. We also sought some feedback from colleagues at the Consumer Purchaser Alliance as well as from ESRD patients focus group calls and we sought feedback from a variety of other stakeholders as well.

Moving on to slide 20. So, I'd like to take the chance to answer three frequently asked questions about DFC rating. Some of which may be top on your mind. So, moving on to slide 21, the first question that we frequently get is; does a Star Rating System use a forced bell curve methodology that will distort facility performance?

It is true that the measures as they naturally fall out do fall into a bell curve distribution. It is not a forced distribution which is the way that the data in aggregate performed. So, this is a valid method that combines measures with different scales and distribution. It is a relative ranking system which

objectively characterizes a facility in comparison with all of the facilities nationwide.

Moving on to question number 2. So, this is probably one that we've gotten the most which is, are the star ratings inconsistent with the ESRD Quality Incentive Program or QIP? And so this is an understandable confusion that we would like to be sure that we try to make as clear as possible for you all and for other stakeholders who are interested in DFC star rating.

Star Ratings and QIP are similar in that they both strive to improve the quality of care for dialysis patients and the QIP measures are a subset of the measures that are currently on Dialysis Facility Compare. So, all but one of the clinical quality measures that are in the QIP are used for the DFC Star Rating. So, again – and this is an approach that CMS has used in the past where we take a subset of all the measures that we publicly report to use for payment purposes.

The one thing to take note of is that the standardized transfusion ratio has been proposed for the QIP for payment year 2018 and is not currently part of the QIP. So, again, they both strive to improve quality but they do it through different (levers). The QIP does it through tying a payment to reporting of measures, as well as performance on measures whereas the star ratings to provide transparency around facility performance on particular measures and to allow consumers and patients and others to be able to compare facilities to one another.

Moving to slide 23. Just to expand a little bit more on the Star Ratings and the ESRD QIP. So, for the QIP, I think the other thing to point out about the QIP that's important is that is a value-based purchasing program. It incentivizes both a achievement, as well as improvement by linking quality score to payment and, again, star ratings provide information for patients and consumers to compare facilities based upon current national data.

Moving to slide 24. Question number 3 that we get is, could patients get confused by the two different CMS programs and leading them to change dialysis facilities? One of the things that we did earlier on is that we solicited patient feedback from dialysis patients on both the readability, as well as the

ease of interpretation of the star rating. And so far, the feedback has been that the star ratings have been easier to interpret although we certainly welcome feedback from you all on that as well.

We will provide guidance to patients on using the star rating in conjunction with discussions with their physicians and during. Their site visits as Elena indicated earlier.

The star ratings are not intended to be used to assess dialysis facilities in isolation. It is very important for patients to talk their nephrologist about their facility, to visit facilities and to start conversation with their providers – nephrologist and dialysis nurses about the quality of care provided, and we very much welcome any suggestions that you all have for education and training of consumers and patients on the use of star rating.

Other learnings from stakeholder input. So, we have collected and avidly researched all questions and all suggestions that were sent into us and we did hear from many of you and other providers which has been really helpful for us. We have met and we'll continue to meet with stakeholders as we welcome ideas and input and I would say this is not just for the now. This is ongoing for the future.

We see the evolution of our Compare Web sites as something that we always have to be very attentive to and to constantly get input for the life of the site from stakeholders, patients, providers and everybody else.

So, next steps--, we are still in the process of listening and reviewing all comments. We hope we get more from you today. We are cataloguing and logging all of the comments and sometimes even performing additional analysis to help understand how the star ratings can be improved over time. We anticipate that over time based upon this feedback that we will update our methodology for future releases.

We certainly anticipate over the next over several years adding more measures and potentially even other components of quality like you see on some of our

other sites like Nursing Home Compare. So, again, this is an ongoing iterative process that requires ongoing feedback.

So, moving to slide 26. I'm going to introduce Judy Hibbard from the University of Oregon. On slide 27, a little bit about Judy. She's a professor of Health Policy at the University of Oregon and the lead author of the "Patient Activation Measure Survey" and a recognized international expert on consumerism and health care.

For the past 25 years, she's focused her research on consumer choices and behavior in health care. And her research interests examine topics like how consumers understand and use health care information, how health literacy affects choices, enrollee behavior within consumer-driven health plans and assessments of patient and consumer activation.

So, I am very pleased to turn it over to Judy.

Judy Hibbard: Thank you, Kate and good afternoon and good morning to everyone. One of the most important valuable lessons that we've learned in public reporting thus far is that how we present information really has a profound impact on how much it's actually understood and used.

So, what I'm going to do today is at a very high level, share with you some of the lessons that we've learned from empirical studies over the last decade. These studies examined how people process and use information and apply it to choices. And much of the research actually comes from (decisions) and sciences and human judgment studies.

So, not only is there a science about measurement but there's also a science about how best to present the information that's more likely used and understood. So, let's go to slide number 28 and just start with what does the choice process require of consumers? First of all, they have to understand what the options and the attributes are and that means really understanding also the language and the terms that are used in a public report.

They need to understand the implications of those different attributes for their own personal situation, and this means that they have to be able to apply it to

their personal life. In addition to this, two things they also need to consider are other factors that may not be in a public report such as what network they are in distance, hours of operation and many other factors that aren't based on performance that have to go into their decisions.

And then they have to be able to bring all of that information together and differentially weight different things that are more and less important to them.

And let's go to slide number 29. All of that represents a pretty serious information processing challenge for people not just consumers who don't necessarily understand this arena but for human beings. We're just not wired to do these kinds of cognitive (tasks) very well.

So, processing information and multiple options and differentially weighting them and bringing them together into a choice are very difficult and what happens when people are faced with this level of cognitive burden and we've seen this over and over again in studies, is that people just take shortcuts.

They may not even be aware of the shortcuts they're taking but they take a shortcut to reduce the burden of this process and they might (allow) one or two factors to dominate their decision and this shortcut process often results in people undermining their own intentions and their own self-interest.

So the bottom-line is that more information often does not translate into more informed choices. So, what's the solution? Studies show that there are very specific ways that we can help people overcome these challenges and the specific ways in which we present the information.

So, let's go to slide number 30. This slide sort of lays out what it is we're trying to achieve with information presentation strategies and in the first box, it talks broadly about the kinds of strategies that are going to help people and so they include strategies that reduce the information processes burden such as summarizing the information or helping people by narrowing choices.

The second point is about experience and bringing people closer to the experience of the actual choice, and things like narratives or stories can help

people understand what it is that they should be focusing on and what it might feel like to live with the results of their choice.

And then the third point in that top box is highlighting meaning. So, there's things that we can do in the way we present information that helps interpret data for people so that they can see how it might apply to them and actually in the case of public reporting, it interprets what is good performance and what is not so good performance.

So, these strategies if we use them, should result within the second box which is increased comprehension, actually increased motivation when you make the task easier by reducing the cognitive burden, helping people understand the information more specifically. Their motivation to use the information actually increases.

And then third it will also help them – they will see the information as more valuable if presented in ways that supports what's in the top box. And finally, if those things happen that people's motivation increases, their valuing and their comprehension increases and then it is a much more likely that people will actually use the information and choice.

So, these star ratings actually do two of these things. They reduce the cognitive burden by summarizing a lot of information and they also interpret information for consumers. It tells them what is really good performance and what, is not so good performance. So, this is what we're aiming for.

Let's look at slide number 31. Here is a very simplified version of a report that is using numbers, and we know that this actually gives a lot of precision but we know that about half of Americans are innumerate that means they have difficulty deriving meaning from numbers, and this report is simplified. It only has two categories of performance, but still consumers are faced with the question of what is most important here to consider and what is a meaningful difference? So, what can we do to help?

Let's look at slide number 32. In this one, we'll see a display that is star ratings of the same reports that we saw on the previous slide and it does something that I think it's a good thing to do in evaluating the effectiveness of

a public report and that is that a good public report, says viewers should be able to identify top performance within five seconds. It shouldn't have to be a lot of work and that's we can do with this data display because if it takes more effort and time, we're losing lots of people.

So, this highlights the meaning. It summarizes the data, and it increases the likelihood that that consumer is actually going to use the information and choice. So, there is a science to public reporting. We know it helps people and public reports, if we follow the science, just like we do with a measurement. If we follow the science with public reporting, more people are going to benefit from the public report.

Thank you.

Elena Balovlenkov: Judy, thank you very much. Well now, I'll introduce Christine Bechtel who'll be talking about helping consumers choose dialysis facilities.

Christine is the president of the Bechtel Health Advisory Groups an organization that was founded out of desire to implement advanced, patient-centered health policies and practice and Bechtel Health brings national credibility and health policy expertise to an arena with multiple issues including patients and family-centered care, patient-centered medical home, health IT, patient engagement and quality measurement.

Christine advises the dialysis community on integrated patient- and family-centered care and is working with numerous dialysis facilities on methods for including patients and families on their quality improvement teams, for example, monitoring access rates for AV fistulas.

Christine

Christine Bechtel: Great! Thank you, Elena. It's great to be with you guys this afternoon. So, I wanted to start out with a little bit of context just from a consumer perspective and that's on slide 35. I think we all know that consumers in general are a diverse group but even consumers with kidney disease and consumers who are facing the need for dialysis also are a very diverse group, of course, and are more likely to have chronic conditions like diabetes and hypertension.

But with respect to demographics, they remain very diverse in terms of their age, their gender, race, ethnicity, their disability status, their literacy level and that means that they're going to have different resources available to them and that they will deploy different resources to support them in their decision-making around the best care to pursue and the best dialysis facilities.

This diversity is important to recognize because you can't ever have a single strategy that's going to really work perfectly for every single consumer or family member out there but certainly we need to think about how the vast majority of patients are going to come into the system and it turns out, as I think many of you know that many patients really start dialysis in a hospital on an emergent basis. So, it's not something that is particularly planned at that point in time.

So, they are really experiencing a lot of stress, with a lot of new information coming at them and really the question is how can we make it easier for them and for those who are supporting them in their decision making process. I would also add that there are lot of quality measures out there -- we've spent a lot of time in this call talking about the QIP program and patient experience information, things like that which are available to consumers to make decisions but often the data are very technical, very clinical.

They were often designed by providers for very good reasons, to monitor the state of care with respect to the best science and evidence available, but frankly, the information that is out there can be very difficult to understand. So, we have complex information and a very stressful time for a lot of patients and so really the question is how do we make it easy for consumers to make a good decision but also for the system as well as to improve as a result. The ratings I think are something that can help.

There are four criteria that I want to focus on in terms of public reporting and rating systems that we know are very helpful to consumers and that starts on slide number 36. So, the first is that the ratings can be helpful if they are useful and relevant to the consumer.

So, the number one job of rating systems, how do we provide consumers with an easy to understand picture of overall quality and Judy just did a wonderful job of explaining how it is essential. So, we don't have consumers taking shortcuts and undermining their own best decision-making processes.

Second is giving consumers an easy way to understand information about how that picture was actually painted. So, what are the measures that were used? What are the methods and how did that generate the rating system or the particular composite measure et cetera, making it sure that it's built on measures that patients care about which usually are things like health outcomes, patient experience.

And I think we're not to this point yet but hopefully someday, how we can look at those measures of outcomes and experience stratified by disparity variables, so the patients can see how people like me are faring the system, and then, of course, most importantly that the rating systems are really tested and developed in partnership with patients and families.

, Rating systems also need to be comparable. They need to facilitate an actual decision where I can look at facilities and see the similarities and the differences and, therefore, make a decision and a choice. So, I've called that here avoiding the Lake Wobegon Syndrome where everybody is above average. That's not particularly helpful when you're trying to sort through a lot of complex health information.

On the next slide, I talk about how the rating system needs to also be flexible. Consumers are pretty resourceful, right? How do we enable them to drill down and see what measures were used to create the rating which would also help them focus on measures that matter to them, and so they can see how much weight those measures are given into the rating system and then, again, have an easy to understand explanation of how the methods that were used and how the measures were used and, of course, how it was tested with patients and families.

And then finally, a criterion I call connected and contextual, and this has a couple of different applications. One is that ideally, we would find the rating

systems not just on government Web sites. That's a huge step forward but we would also find that same information really integrated into the places that consumers already go online. So, you can think about YELP and CastLight and other services that are really coming in to the health care arena where we look for reviews today so that, again, that cognitive burden is really reduced because we can find things all presented in an integrated forum.

Second that we make sure that in any rating system, we're connecting consumers to other resources that are going to support their decision-making. (Yes), again, rating systems are going to be one thing that people look at. They are also going to look for other sources of information like their doctors and friends and family members et cetera. So, how do we connect consumers to other resources that encourage and support high quality decision-making?

And finally what do we do to arm consumers with the information they need in the event that there are only one or two facilities that are the closest to them but may not be the highest of quality. So, what does that mean? Does it mean, you see two stars and you think – I'm not going to dialysis. I don't think so.

Consumers would want to know, OK, well, how – if I'm online looking, how do I really dig deeper and find out what's driving the issues at these facilities, how do I take a set of questions to the facility and interview the facility administrator and talk to other patients there about what I need to know and what do I need to look out for to really make a good decision here?

So, finally just a couple of closing thoughts on slide 38, as I said, patients are very resourceful. They will research. They will enlist their friends and family members. They go to community resources. They will look at Web sites.

There are many wonderful kidney advocacy groups out there that will help and support them in their decision-making, and so we just have to remember that a rating system is one piece of information and that it is a terrific way to make that burden of decision-making a lot less on consumers particularly when many but not all of them will be going through a very stressful time and

that takes me to my last point which is making sure that we understand the audiences and the context in which decisions were made.

So, there's the example that I've used already which is a first time dialysis patient needing to make a decision about which facility to start at but there also will be patients and family members who will use this site to look at changing facilities if they're not happy with their current facility. Another audience will be family members and friends who are doing research on behalf of the patient.

And then of course, another audience is the facilities themselves, right? They will go and see how they're doing compared to their competitors. So, again, one site and one rating system can't be all things to all people but the key question is does it take really complex information and boil it down in a way that is usable and methodologically sound and then give consumers the ability to dig into that information.

So, Elena, back to you.

Elena Balovlenkov: Christine, thank you very much. I'd like to introduce our next speaker who's going to be talking about patient advocacy and the perspective of public reporting. Kathy Day is a retired nurse, and I would find that funny because I don't believe nurses ever retire and I think she's living proof of that because she spends her days giving back to the community. She was a patient safety and health care consumer advocate and is a member of the Consumer's Union Safe Patient Project. Kathy.

Kathy Day: Hi. Thank you, Elena and thank you for asking me to be part of this forum. I became a patient safety advocate after my father died of a preventable hospital acquired infection almost six years ago. So, I learned the importance of making fully informed decisions. My father and family were not informed about the infection outbreak at this hospital or his risk of getting an infection, but if we had known, we could have made different choices or decisions regarding his care.

So, later, just like two years after this happened, I became a surgical cancer patient myself and I made it my business to learn about the surgeons and

facilities that I was considering. So, I used several hospital and physician rating Web sites to help make my decisions to care and I chose well and I had a stellar outcome, thank goodness, although each of these rating sites uses different types of data, they're all a good tool to help make very serious medical decisions about where to get the highest quality of care.

One thing that's lacking on almost all of these tools or ratings Web site is cost information and that should be addressed because not everyone is well insured. I'm lucky enough that I was but cost can be a patient's priority and they'll choose according to the cost to them. After I volunteered to be part of this forum, I did a dialysis facility compare search of the clinics closest to Bangor, Maine where I lived.

There was no quality information at all on the clinic closest to me. The largest of the three that I compared in Maine you know we're talking about patients having choices and being able to choose between or amongst two or three different clinics and that's not necessarily the case (this area is pretty rural).

So, anyhow, without that information, I guess I'd be perplexed about how we could assign a star rating to that particular clinic. So, my opinion is when the information is consistent and complete and includes data on what is most important to patients, then; the star rating tool will be excellent for patients who are faced with making perhaps the most important decision they'll ever have to make.

So, currently there is some very good information on the DFC Web site and the star ratings are a good next step in providing additional information to help patients understand the quality of care based on what currently exist.

So, we'll go to the next slide, this number 41. So, I talked to a lot of dialysis patients over the past few years and many of them have been harmed by their care, not all of them but many of them and they share their stories with me and taught me what is most important to them. And I believe that these measures are important to patients. There may be more in involving patients in this rating sites and the five rating will bring a lot of value.

So, those that don't have the slides in front of them, it would be good to expand the DFC ratings to include items such as rates of infection, HAI, complications and hospital admission, involuntary discharges, survey deficiencies from both state and local Departments of Health, and some patient reported outcomes.

I think that's absolutely essential to get, nurse to patient ratios, staffing mix and staff turnover, and also does the clinic have a reuse program. A colleague sent me an additional shortlist this morning to include falls which she said, (her mother is a nephrologist) is one of the problems in their clinic and blood pressure stabilization, dry weight stabilization, phosphorus management and potassium management.

So, in order to get an idea about star ratings other than health care star ratings, I looked at regular consumer star ratings online. I did a little research of my own and my conclusions is that patients should be given the opportunity to report some of their own outcomes and experiences of care, and apparently, they are given that opportunity on the experiences of care. And then after validation, that data could be used in star rating.

Also on other star rating sites, consumers are given the opportunity to comment. In most star ratings, the entire rating comes from consumer customer comments and evaluations. I appreciate the consumers are able to find more public information about health care providers and facilities. This dialysis compare and five star rating sites must be constantly reviewed and upgraded because they will affect patient's decisions about high quality professional dialysis care that will sustain their lives and improve their quality of care.

And then this last slide are basically ideas about including the patient's voice in aspects of care and I think another measure may be does your –dialysis facilities have Patient and Family Advisory Council and then have the patients' voice included in all levels of care. Also the education part of it, at the end, more information for staff and patient, about patient providers and about the many forms that patient signed, those are the things that could be addressed by Patient and Family Advisory Council.

Patient reporting, I have already mentioned and it may be a good idea to do the patient surveys for patient's input should go to CMS directly and not through clinic staff and, of course, the information about cost would be an important factor for a lot of patients.

So, I think that's about it. Elena, thank you.

Elena Balovlenkov: Kathy, thank you and before I introduce Bill, one of the things that is incredibly important to CMS is the type of information that you're giving us in terms of reaching out to the patient community and finding out what is important to patients and we realized that the DFC star ratings as they currently are proposed are just a one-step measure and that's one of the reasons that we've also invited Bill Dant, a dialysis patient and actually does a lot of work as a patient educator, speaker and activist.

He has been on hemodialysis patient for 18 years. He's incredibly active in the ESRD network. He's been a member of the ESRD Network Board of Directors, the Medical Review Board, the Patient Educator and Speaker, he's on the Patient Advocacy Group, and he's an activist and very good about reaching out to CMS to help us become aware of concerns and matters that are important to the community.

Bill, I'll turn the talk over to you.

William Dant: Thank you very much, Elena. If I could just clarify for a moment, although I spent a couple of decades on an ESRD Network Board of Directors and Medical Review Board, I no longer do that. I'm involved in other kinds of patient advocacy. I appreciate following Kathy as you (went) through the few slides I have. I'm actually in the wilderness of Wyoming and I don't have access to the slide deck so you all have to – as I change topics follow along to my new slides.

I really appreciate following you Kathy because you cover a lot of the nitty-gritty details that are so vitally important both to the interest and concerns of patient and from long patient experience, things that help patients do well in

their facility in terms of their personal relationships and do well in their facility in terms of patient outcomes.

I'd like to begin by talking a little bit about patient empowerment and I'd like to thank CMS. When they talked to me about volunteering I asked some extremely pointed questions to CMS staff about concerns I'd read about in the community and I was pleased with the answers I received. I think patient empowerment is so limited in this day and age by lack of information and a lack of provider transparency.

As an example and again a follow-up with Kathy, I have a close associate who was a registered nurse, who's been a charge nurse who has been an ER nurse, an OR nurse and recently needed a knee replacement.

When she talked to her surgeon, he referred her to the infectious disease specialist at the hospital which caused her to prick up her ears, and when she talked to an associate, she learned there had been two patients who had knee replacements who had expired due to MRSA, and so she chose a different facility. But I think the lack of transparency today is so great that the average patient is unaware of those kinds of situations.

And given this lack of transparency and given that the ACA is calling for increased transparency, I think that having a reporting initiative that provides more information about dialysis facilities and in a way that's easy to understand for patients no matter what their demographics are, is very much a step forward. Now, I say a step forward because this is new and I think and perhaps each of us needs to think to ourselves of when the real smartphone revolution started in 1997.

If you look at the smartphone that came out at that point and compare it with the 2014 smartphone, there is an incredible improvement and most of the faults that were found in those early smartphones have been addressed so that nowadays we have a super computer in our pockets that will accomplish astonishing things.

And I see the star system much the same way. It's a new system. It has time to mature and I think some of the concerns in the dialysis community can be

addressed as time goes by. But I think there are three key things about the star system that I think are very good. The first is the issue of having valid data. The second, the issue of having reliable data and the third issue which has been extensively addressed is making that data accessible in a way that almost all patients or their caregivers can form decisions about what's going on.

So, I'd like to move to my next topic the star system itself and I think that there are some key positives to the star system, mature data, data that's been reported for a long time, and data elements that I think are very important.

They're not exhaustive, and Kathy has talked about many other data elements that could be considered, but I think there's a sufficient number of data elements and measures, it would be extremely difficult to game the system as it might be there were only one or two measures. And so I think that is a key advantage to the system and important as time goes on in making this system extremely useful to patients.

I think we have to ask what does the star system offer to patients? And again, I appreciate CMS accepting my input even though I'm pretty independent and asked some extremely pointed questions before they offered me the opportunity to be here. I think in terms of clinical measures, the star system is extremely useful in its present form to patients and I think in the future as it is refined, it will become even more important.

I do think there's an area that it could be improved and I think each one of us on the summit call across the country can identify with when one is seeking a facility or a health care provider, what questions do we ask typically I think we'll ask a friend and say, "What are they like? How did they treat you? How do the other patients seem to do?" And I think in terms of measures both process and outcomes measures; the star system does a good job.

But on the other hand, each of us when we look for a provider, we not only look at clinical outcomes, we want to find out how we're treated and I think that's a key issue for dialysis patients because they spend so much of their time in a dialysis facility and that time can either be time well spent with providers who are doing their best to care for the patient with an atmosphere

in the facility of healthfulness or hopefulness and of a desire to improve patient health or it can be the opposite.

It can be opposite. It can be a facility. I'm thinking of patients who've spoken to me over the telephone who would say, "My provider doesn't care whether I live or die?" Or patients who have asked the facility to please put an ice machine in but they say-are told "There's absolutely no money to that."

So, I would hope in the future and have expressed to CMS that as time goes by, we can incorporate patient experience of care along with clinical outcomes I think which would greatly strengthen the star system and I think this is one of the most desirable improvement we might see.

But then to summarize my view after examining the methodology carefully, and after speaking to CMS, I think the star system is a wonderful first step that offers real value to patients and offers patients an opportunity evidence to choose a facility.

One thing I might mention is there has been considerable criticism of the use of the bell curve and I believe the criticism is focused around CMS forcing the data to fit that curve in ways that really don't reflect realities on the ground. And as I asked questions about that, I have largely been satisfied that facilities do fall out into a bell curve and there are some facilities who are not doing very well on many different measures.

And I think the star system offers a wake-up call to those facilities to improve, so that they can reach up and acquire a higher star rating. Now the claim could be made, yes, but there's always going to be 10 percent of facilities that are 1 star facilities. And I would respond to that in two ways.

The first way is there is always going to be 10 percent of the facilities and more who provide a quality of care that is noticeably lesser than other facilities. And I think that's simply a reality and I think though that there is a second way of approaching the bell curve question and that is, well, why not instead of using a bell curve, why not develop criteria of excellence, so that all

facilities have an opportunity to improve their quality of care and if all facilities can improve their quality of care to 5-star status, if it so be.

But I don't think that's particularly practical because I think developing new standards that people would agree on would be very much like trying to create and identify a person as a saint. The procedure is very long, it can be very controversial and it would be a very long time if ever when all stakeholders could agree on such standards.

So in the end, I feel that the bell curve methodology offers advantages to patient and offers advantages to caregivers in terms of improving in the future. So, I think I would like to end my presentation at that point.

Elena Balovlenkov: Bill, thank you very much. I would like to take this opportunity to talk about some of the next steps going forward and then we will go into our question and answer session. So one of the future directions is I think that has been pointed out to us, not just by Bill and Kathy but also with the consumer research that was presented by Christine and Judy that you know we need to look at adding more patient-centered measures to DFC and to the star rating.

And one of the things is the patient experience of care that while now some facilities do administer the experience of care survey, what we're looking for is for it to be used consistently and to provide us with higher quality information and the biggest thing that I think that all of our speakers have pointed out today is that while we've done focus groups and while we've reached out to the community, that we need to actually see about getting the patients and their care providers involved more in our development of future measures because as we said the measures that we presented currently are based on the 11 measures that exist on the DFC Web site but we know that they're not all encompassing and we know that there other issues related to patient safety and access to care. They're incredibly important to patients.

And that's one of the reasons why we're not doing it at this time,. We'll be having discussions about including data about beneficiary grievances, the results of state inspections that are used currently on some of the other Web sites. They t want involuntary discharges and Kathy mentioned about staffing

and infection control. There are a lot of other measures that we need to consider as we move forward.

So, one of the things, and we're on slide 50 now, that can be explored for future updates is exploring using thresholds as Chris talked about. We've included in the appendix data on the research that has been done based on consumer questions and stakeholder concerns. So, please feel free to look at those slides as well. We'll also be looking and examining measure performance to make sure that we identify measures that are topped out.

Also we will investigate the possibility of adding statistical uncertainty to the star ratings but the biggest thing for us moving forward is that we're looking in 2015 of developing a technical expert panel with the public call for nominations and that we're looking to make that TEP 30 to 40 percent of patients which is a real positive step for CMS, while we've always included patients. One of the things that we've learned is the importance of including patients and advocacy groups.

We are including patients more and more, that as we said in the beginning of the call, the DFC Web site is intended for patient and their families. That is our primary audience and while we are aware that currently the Web site and the metrics is used more by the stakeholders and the patient advocacy groups, we are looking to make sure that our campaign comes up with a way to include patients in our work for improvement.

And we want to also include those consumer groups that advocate on behalf of patients and also individuals. For example like (CAHPS), who is involved in different consumer groups and advocates for patients. We will also be soliciting TEP input on measures that we believe should be included in the star rating, so it can be validated.

And those are some of the ones that we talked about, the patient reported measures, patient-centered outcome measures, survey results and also making sure that we stay true to our vision that the measures that we used, the data that we used are easily interpreted by the consumer because Judy and Christine pointed out that all of this information needs to be put in a way that

it reduces cognitive burden, that it helps patients in their decision making process and that we don't create a system that it's even more complex.

So, we will continue to consider other items that are used on the other Compare Web sites. We'll continue to engage with the community stakeholders, so we're really excited about our future work and the fact that patients have also let us know that while the DFC is a good start, that what we need to do is see about making it more robust as we move forward. So, what I would like to do now is go into the question and answer session.

I have two questions that we received ahead of time. We actually got several, questions that were – as I stated earlier were very detailed and were not appropriate for answering but we are including them in the consolidated question document. So, I have two questions that I would like KECC to answer and then I will also answer one of the questions before we open up the line.

So, I can turn over to KECC, the first question is how are pediatric facilities rated when most of the measures do not apply to pediatric facilities?

Joseph Messana: Elena, this is Joe Messana. I'll answer this question and for those on the call who don't know me, I'm a clinical nephrologist on the faculty at University of Michigan and an investigator at the Kidney Epidemiology and. And they gave me the easy one to answer, so facilities that only treat pediatric patients are currently not rated by the star system.

These facilities have limited quality measure information available and so therefore it's difficult to establish a star rating in the absence of quality information. And the absence is largely because pediatric patients are systematically excluded from certain quality measures on DFC based on their original development and endorsement with (national) quality form.

This is an issue of particular concern because of the vulnerable nature of the pediatric population in the ESRD and we continue to investigate ways in which quality measures and other sources of information may be used to provide some rating for these facilities in the future that reflects the quality of good – of care provided for pediatric ESRD patients.

Elena Balovlenkov: Thank you Joe. Question number two, why are you using the bell curve to grade facilities performance. This is not how YELP works. Can you use another grading system? Most patients do not understand the bell curve; have you've seen this type of rating systems be effective in other areas of care?

Joseph Messana: So, I think we're going to ask Chris to answer this question and I think the bell curve issue has been probably overstated at least in my mind but – and I think adequately addressed by Mr. Dant and others, but we can talk at least about patient understanding of what they need to be equipped with – to interpret the star rating system. So, Chris go ahead please.

Christopher Harvey: So, hi this is Chris from UM-KECC and I would like to thank Bill for a great answer on this question already and I'll just expand a little bit. So, the primary goal of the star rating was not to make a rating based off the bell curve. It was to develop a rating that provides maximal discrimination capability for consumers using all of the available DFC quality metrics, and so as above, the system achieves these goals.

At a minimum, a consumer must only understand that 1 star represents much below average and 5 star represents much above average and that the other star rankings reflect intermediate (accreditation) in this rating system were average first to the national average facility performance.

For those wishing for more detailed information about the technical specifications of the calculations, they can be found in the Frequently Asked Questions and methodology document available on the dialysisdata.org Web site.

Elena Balovlenkov: Thank you and the last question that I wanted to answer before we open the lines is the question I received from the American Kidney Fund and while there's a lot of information, the question, the key points were how does CMS intend for patient to use the star system and what is CMS guidance to patient organization on how to explain the system to patients.

One of the things that – as we've been talking about is – and as Bill and Kathy pointed out is that this is but one step in the processing the information that

patients will use in asking questions of their nephrologist, of the facility administrator, the staff at the dialysis facility on what does this star rating mean for me, how do I interpret the star ratings, what are we doing with the star ratings because even if you're an average or above average facility, we always have quality improvement projects going on within the dialysis facility, the patients get involved in, the staff get involved in.

And also, that we've taken the feedback that we've gotten from individuals into the draft documents and we've been sharing as we're developing them on the three technical guides we have that currently exist.

And we are actually now developing a fourth and we'll be incorporating some of the comments that Kathy and Bill brought up about the fact of coming off with the Frequently Asked Questions to help create questions that patients can use to guide their decision making process and their interactions with the staff. So, we believe that was a really good question and we welcome the opportunity to respond to it. And at this time, I would like to open the line for questions.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your question to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one again to rejoin the queue. Your first question comes from the line of (Glenda Payne), your line is open.

(Glenda Payne): Good afternoon again and thank you for this information. I have a comment and a question. The comment is that I think one of the concerns as a community is that the systems used include complete and accurate data and the slides that are presented today seem to have an inaccuracy on them on slide 31 and 32, the data that was presented by Judy Hibbard.

I think may be this was just as an example but if you translate slide 31 to slide 32, the same number which is 0.00 (right) 2 stars in one place and 5 stars in another, so I'd like some clarity on that. The question I have really, is there

consideration for updating the rating more frequently than annually?
Currently the DFC has a quarterly report, could the rating be updated quarterly?

Judy Hibbard: Hi, this is Judy Hibbard. Thank you for pointing at the error. It was – the slides are put together quickly and it was that just an oversight but the point of the slide was to show how much easier it is for consumers to derive meaning if it's translated and interpreted for them, that was the point.

(Glenda Payne): I appreciate that, thank you.

Elena Balovlenkov: Thank you Judy and (Glenda) to answer the second part of your call, I have Joel Andres, who is working with me on DFC. He is in charge of measure development, he is the lead for that, so I'll have Joel answer that call – question.

(Joel Andres): Thank you Elena. So, our intention at this time is for Dialysis Facility Compare to continue to have the data on it updated on a quarterly basis. We expect that the star ratings will be updated on an annual basis in part because the substantial number of the measures included and are themselves updated annually and we believe that is the most appropriate schedule to take.

I will say that– this is certainly one thing that we'd be interested in hearing feedback on. It's the – if you think that quarterly updates would be more appropriate or useful and why, we would certainly welcome comment from you in that regard.

(Glenda Payne): Thank you.

Operator: Your next question comes from the line of (Jackson Williams), your line is open.

(Herran Goche): Actually, this is (Herran Goche) with the Dialysis Patient Citizens. I would like to start by thank you for hosting the call and saying that you know we support a 5-star program and principle but it's just absolutely critical from the patient perspective that we get it right.

And one of the troubling things from this call was I kept hearing over and over this is one step, give it time to mature, it's just the beginning, moving forward.

You know I hope a patient in a 2-star facility won't stop going to dialysis. It wouldn't be helpful if everyone was 4 or 5 stars and it really kind of reinforce the sense or the feeling that the priority is launching the program versus getting it right. And as a patient advocate, you know seeing what's happened with the you know MA plans, the (PPS), plans, the nursing homes for star rating programs.

There's been confusion for consumers, concerns about discrimination among low income populations and credibility problems for the administrators and providers as a result, are troubled to see the rush to get it out there. In fact you know if you can help answer my question, I know hospitals have one measure.

It's just patient satisfaction and so if this is just a start, why not use one or two meaningful measures where there's consensus in the community because right now it feels like you know CMS is almost saying, it's OK, don't worry about it, we can fix it later but I'm just wondering when is it ever OK for CMS to potentially mislead or provide misleading information for patients and why not you know use the hospital star type, just choose one or two measures, if you can answer that question. Thank you.

Kate Goodrich: Hi there, this is Kate Goodrich and thank you for that question. So, I apologize that it appears that we are doing this for the purpose of just getting something out there, that's not our intent. We believe that having – and we heard from patients and consumers and others that having understandable information out there for people to help people make decisions and understand about the quality of their care is better than having either no information or having poorly understandable information.

And what we heard about our Compare sites, across the board (not just dialysis facilities) for years is that the way it's displayed now is very difficult for people to understand and there's not an overall view of quality. You have to look at a measure by measure basis. So, we do believe that getting

understandable information out is a priority. It's a priority not just for us here at CMS.

As was indicated earlier in the presentation, it's a priority of the Affordable Care Act, the presidential data strategy, so you know our goal is to do this really across the board. We actually do feel that the methodology and the data are very solid. We do think that overtime as we learned through implementation, as we have more measures to include that it will improve by virtue of just what we learned through implementation but we do not feel like we are coming out with essentially a bad product that has poor underlying data.

We feel quite confident in the underlying data and the methodology that's being used. Can it improve? Absolutely. I think we have found through other star rating experiences, they can also improve over time and have improved over time. For the question about Hospital Compare and the use of HCAHPS to start off with, that was a deliberate decision in part because first of all it's not just one measure. HCAHPS actually – is I think 11 measures total.

So, it has more sort of statistical reliability and validity because it has a number of measures and that was also the case with DFC, we could actually increase the reliability and validity of the star rating by combining of all the measures together. Hospital Compare is by far our more .complex public reporting site. It has the most diversity of measures. It's by far has the most measures. It has, I believe, over a hundred measures that are reported on it.

So, we felt like because it has so many measures of so many diverse types, that it made more sense to go out with a more incremental approach. With DFC, we have a much smaller number of measures that we were able to aggregate up.

Certainly you know we appreciate the comment about having individual measures or domains that could be ranked by stars. That is certainly something we thought about at the beginning but we also recognized that we

were able to achieve again better reliability but better validity by aggregating to a single star score.

Elena Balovlenkov: Thank you.

Operator: And your next question comes from the line of LaVerne Burton, your line is open.

LaVerne Burton: Good afternoon, this is LaVerne Burton with the American Kidney Fund. I want to join in thanking you for providing an opportunity for this open door forum and we certainly agree that's all the information that we can provide to patients to help them make better decisions about here is the thing that we strongly endorsed.

I have a couple of questions. First I want to thank Mr. Dant for speaking on behalf of patients. About a month ago in a meeting with CMS, we raised the question about who were the patients in the focus group, who were the patients with whom you consulted and how were they selected.

As you said at the beginning of the call, this is a very diverse patient groups and we'd like to know – how the lines of the communications were established and who is included. We were promised a list of the patients and their affiliations. We've not seen that.

Second comment that I wanted to make is, again, I'm very grateful for the call but in the call that lasted an hour and a half, we've only got about 15 or 20 minutes for questions and I'm still hearing that we are very satisfied with the data, we're very satisfied with the structure that were going forward.

And so, I'm not quite sure as we had been told that this is an opportunity both to talk to us about how this is structured, how to talk with patients about it but also to listen to concerns that are being raised.

I agree with (Herran) that I get the sense that this is going through full steam ahead by the January deadline and that there's more focus on the timing than it is on getting it right. That will not help patients.

Elena Balovlenkov: Hi Ms. Burton, thank you for your question. One of the things, this is Elena, and one of the things that I wanted to clarify is that I apologize for any misunderstanding but one of the things that was incredibly important about the patient focus group is that CMS did not run that focus group.

We had an independent contractor do that and patients were offered confidentiality, so that they could speak openly and talk about anything that they felt was important in terms of contributing, to improving to the sites, things that they questioned about the site, suggestions that they had for CMS, so, that those individuals were not selected by CMS.

The questions were not developed by CMS. We did provide the old DFC Web site template and also the new template attributes for the star rating but I – I'm sorry if you thought that we would you know give you those names but what was selected was a selection of patients nationwide and again while I was able to listen in, I was not part of that call and again I apologize.

I'm not going to be able to offer you names of patients because again I think that it was important to the process that patients could speak openly.

A lot of patients are very concerned about sharing information or comments either about their site, their care, the dialysis site because patients, and we know it's in the literature, patients are oftentimes afraid that the information that they provide could impact what's going on at the facility level and one of the things that's important for CMS is that we encourage patients to be as honest with us as possible, even if sometimes we don't like the answers that we get but (that ability) to be transparent on our part and their part is important for us to get good information.

And in terms of just trying to rush this out of the gate, if you look at the consolidated questions that are posted on the dialysisdata.org, we listened carefully to every comment, question that was submitted to CMS, questions that came up with meetings. We had multiple meetings not only with the chief medical officers but with the different advocacy group. I'm actually sending out an invitation today that we finalize the schedule for meeting with the Dialysis Patient Citizens.

We still are listening, we're still taking that information and we will be responding to questions that we got today again in a consolidated question document. So, that people are aware that we have done significant research, on the methodology, on the issue with the bell curve, on concerns about QIP, the QIP certificate. We really have listened and it really is driving our work. So, we have time for one more question.

Operator: Your next question comes from the line of Lori Hartwell, your line is open.

Lori Hartwell: Hi, this is Lori Hartwell from Renal Support Network and I have two questions. One is, I'm concerned about patients if they see like a 2 to 3, (which is) 3 would be average for dialysis facility that they would compare to YELP and one of the things that's really important is that patients trust their staff.

So if they don't think that the patient, if the facility is a 5-star,, they don't understand the bell curve, so that's my first question. Do you think that there could be any problems in undermining this – the trust with staff.

And then secondly, we talked about patient experience of care measure and I want to know if CMS is going to help with the resources, in that I've been a big proponent of the patient experience of care after treatment and I'd been to CMS like in the last five years, did they foresee that there will actually be resources to develop the measure because I've learned that it's extremely expensive to develop a measure and it would be wonderful if CMS would put monies in for us to do that.

Elena Balovlenkov: Hi Lori, thank you for your questions. I'll answer some part of it and I'll have (Joel) answer the other.

One of the – you talked about the YELP ratings, one of the things that we mentioned throughout the presentation and you heard me announced that we are also going to be doing a TEP in the beginning of 2015 and that the educational campaign for patients to understand this is extremely important.

In addition to the tools that we created for use with the Web site to understand the star ratings, we'll also be reaching out to the various patient groups that exist and talking with patients and also talking with support network such as you know (AKFA), AAKP and the other organization, even Renal Support Network to get feedback on how you believe this campaign can be best constructed to make sure that we get as much information as possible out to the public. And I would like (Joel) to answer the second half of your question.

(Joel Andres): Right, – there are really two parts of the question. One is about resources, I'm probably not person to be responding about the resources that CMS is making directly available but I will say that in terms of incorporating the measure in DFC, it was one of the things that we looked into early on. However, at this point we don't have access to the data that would allow us to incorporate patient experience of care as represent by the CAHPS measures on DFC.

As soon as we have access to those data, that that will be something that we will take into consideration on the CAHPS that we'll be taking as – we will be convening on an ongoing basis for future implementation development in the star ratings.

In terms of changing the kinds of questions and issues that are addressed by the CAHPS measure; we're holding that at different times to be able to capture different patient experience issues. So, we actually have our colleagues here from the CAHPS team at CMS and I think they can speak a little bit more to how would that work.

Barbara Crawley: So, this is Barbara Crawley, I'm (responsible) for the ICH CAHPS survey. Currently, the CAHPS survey is going to be administered beyond 2014, twice a year, semiannually. We'll have a spring survey and a fall survey and like on Hospital CAHPS we will have (rolling) calculations for the result. So, we'll combine two sets of results and as we do the next survey we'll push out the older results and combined the more recent results.

As far as the developing new questions for the CAHP survey, we are open to suggestions for that. Right now the survey is for hemodialysis patients receiving care in center, not home, not peritoneal. We have exclusion categories and eligibility categories added on the ICH CAHPS Web site. If you have direct questions you like to ask, you can send questions to our mailbox, ichcahps@cms.hhs.gov , my name again is Barbara Crawley.

Elena Balovlenkov: (Barbara), thank you. So, we're now concluding our call. Again, I would welcome you to check the dialysisdata.org Web site for the consolidated question document and also to submit any questions for those of you who did not get the opportunity to ask a question on the call. And I would also like to point out that those questions that we received prior to the call that were extremely specific, will be responded to as well.

I want to thank everyone, especially our panel for participating and also those of you in the audience and thank you very much for the opportunity to share the work moving forward. Thank you.

Operator: And this concludes today's conference call, you may now disconnect.

END