

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Long Term Care Hospital, Inpatient Rehabilitation Facilities and Hospice
Listening Session
Thursday, December 16, 2010 1:00-3:00 pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on Section 3004 of the Affordable Care Act where the Secretary is directed to establish quality reporting programs for Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals/facilities (IRFs), and Hospice Programs.

LTCHs, IRFs and hospices will be required to submit data on specified quality measures in order to receive their annual payment update. Entities that do not comply will have a reduction in their annual payment update of 2 percentage points. The required measures affecting these payments are to be published no later than October 1, 2012. The Secretary is directed to establish procedures to allow providers to review the data prior to it being publically available.

CMS envisions the implementation of high priority, site-specific and cross-setting quality measures for LTCHs, IRFs and hospices that are valid, meaningful, feasible to collect, and that address symptom management, patient preferences and avoidable adverse events.

Through this listening session, CMS is seeking to understand your experience with quality measures and how that experience can inform the goals for the measures outlined above.

Proposed measures must also meet the implementation requirement that is stipulated by the Affordable Care Act Section 3004, which stipulates that these quality measures be made available by 2012. Reporting on these measures is anticipated to begin in FY 2013. For fiscal year 2014, and each subsequent year, failure to submit required quality data shall result in a 2% reduction in the annual payment update.

You are also encouraged to submit additional ideas following the session to an email address established for this purpose: LTCH-IRF-Hospice-Quality-ReportingComments@cms.hhs.gov.

We are most interested in the work that you have been doing measuring and reporting on quality measures in your respective facilities. CMS would appreciate your feedback to help inform our deliberations. Questions we will be discussing during this Special Open Door Forum:

- Of the quality measures that you currently use in your settings, which would you suggest as meaningful to report? o Are they process, structural, or outcomes measures?

- Which would you suggest be selected for the quality reporting programs to drive quality improvement and why?

- Which processes of caring and programmatic monitoring have been effective in improving the quality of care in your facilities?

- To you and your organization, what are the key elements of a quality reporting program for LTCHs, IRFs, and Hospices?
- Do your measures meet the NQF rating criteria?
- Can you share the lessons have you learned from your quality measurement and improvement efforts?
- Do you have concerns or considerations that you would like to share with CMS regarding the development of a quality reporting program for these settings?

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial 1-800-837-1935 Conference ID 26277390

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and a Relay Communications Assistant will help.

An audio recording and transcript of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around January 14, 2011.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at <http://www.cms.gov/opendoorforums/>.

Thank you for your interest in CMS Open Door Forums.

Audio File - <http://media.cms.hhs.gov/audio/LTCIRFHospice121610.mp3>

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Barbara Cebuhar
December 16, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is (Kyle) and I'll be your conference operator today. At this time, I'd like to welcome everyone to the Long Term Care Hospital, Inpatient Rehab Facilities and Hospice Listening Session Special Open Door Forum Conference Call. All lines have been placed on mute to prevent any background noise. If you should need assistance during the call please press star then the zero and an operator will come back on the line to assist you. Thank you. Ms. Cebuhar, you may begin your conference.

Barbara Cebuhar: Good afternoon, everyone. My name is Barbara Cebuhar and I work in the Office of External Affairs and Beneficiary Services here at the Centers for Medicare and Medicaid Services. We are pleased that you could join us today for our Section 3004 of the Affordable Care Act, Long Term Care Hospital, Inpatient Rehab Facility and Hospice Special Open Door Forum. Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting programs for long-term care hospitals, inpatient rehab hospitals or facilities and hospice programs.

CMS is conducting a listening session today to get your insights about what is currently working in the field and to learn from your experience about quality measurement in the industry. CMS is in a listening-only mode today. We can't answer questions as we are in the process of rulemaking. But we still are encouraging your comments and ideas about the best way to structure this measurement process. We are most interested in hearing your thoughts to guide the conversation today. If you at your computer go to: www.cms.gov/QualityInitiativesGenInfo/03_NewQualityReportingProgramsSection3004.asp. Let me repeat that for you. It's http://www.cms.gov/QualityInitiativesGen/03_NewQualityReportingProgramsSection3004.asp to find them and follow along. Otherwise the questions we are asking were included in the agenda that was sent out earlier as part of our announcement about this meeting. We also want to remind you that this call is being recorded today and a transcript as well as the recording will be available on our special open door forum Web site on or around January 13, 2011.

We are most interested in the work that you've been doing, measuring the reporting and quality measures in your respective industries. CMS would appreciate your feedback to help inform our deliberations. Now I'd like to turn it over to Stella Mandl who will be asking you some critical questions for your consideration. After Stella gives us some insights about the enabling statute, our operator will tell you how to get in the queue to offer your feedback and insights about what will work best.

We appreciate your help at this process. Stella, do you want to tell them more about Section 3004 of the Affordable Care Act?

Stella Mandl: Yes, thank you Barbara. This is Stella Mandl at CMS and I want to thank everybody who has taken the time today to join this call. The Affordable Care Act, Section 3004 requires CMS to establish quality reporting programs for Long Term Care Hospitals, Inpatient Rehab Hospitals and Hospice programs. It requires providers to submit data on selected quality measures to receive annual payment update for fiscal year 2014 and subsequent fiscal years. Noncompliance will result in a two percent reduction in annual payment update. Selected measures affecting the annual payment update are to be published by CMS no later than October 1, 2012. And this was why we are glad you could join us today as part of this call so we can find out from you the measures and processes that are important to you.

CMS is directed to establish procedures no date specified to make data available to the public and allow providers to review data prior to publication. And meeting the deadline for publishing the selected measures, we are seeking your inputs regarding your experience in monitoring quality data. Considerations for quality measures. Is the quality measure an important indicator of: better care for individuals that is patient-centered and well-coordinated? Does it result in better health for populations? And does it result in lower costs through improvement?

Our criteria for measure selections of quality measures includes the following areas of focus. They should be high priority, site-specific and/or cross-setting quality measures. It should be valid, meaningful and feasible to collect. Address symptom management, patient preferences, and avoidable adverse events. And can the measures be generated from a standard-based item set such as the CARE data set.

We are seeking stakeholder involvement in the quality measures development process. Stakeholder participation is key. CMS' goal is to build on existing measures that are reliable measures of structure, process or outcomes or built-upon evidence-based measurement science, and meet reasonable criteria for inclusion. We're now ready to hear comments from you regarding the following questions. And I am ready to ask the first question. Regarding

goals, CMS seeks to understand, what you think is important for measuring quality.

Operator: Ladies and gentlemen, in order to respond to our presenters, please press star then the number one on your telephone keypad. We will pause for a moment to compile the responses. Your first response comes from Sean Muldoon from Kindred Healthcare. Your line is open.

Sean Muldoon: Sean Muldoon commenting. I think the important thing here is to try not to retread too much ground. I think we ought to just make a decision on whether these are going to be processes or outcomes of care and then take into account that outcomes would need to have some recognition of the variability across long-term acute care hospitals ranging from the government owned hospitals that are low acuity and chronic and the more contemporary ones that are ICU level care.

Barbara Cebuhar: Thank you. Our next question, (Kyle).

Operator: There are no further responses.

Stella Mandl: OK. And I think what I am going to do is then phrase these three concepts with specific questions. The first concept which I just brought up is what do you think is important for measuring quality? How are you collecting quality data now and how you use the quality data collected? And let me go to some specific questions. Of the quality measures that you currently use in your settings, which would you suggest as meaningful to report?

I'm ready (Kyle).

Operator: Again, to respond please press star then the number one on your telephone keypad. Your first response comes from (Sheryl Smith) from Transitions Hospice. Your line is open.

(Sheryl Smith): Right now I think particularly infection control and because we work in hospice, pain management based on the patient's perception of the pain. What else do we do?

(Sheryl Smith): I know that we also deal with lot of falls, that sometimes with the elderly, the disease process you can only do so much. But I think hospital-wise how often is the patient readmitted and hospice wise are we controlling secondary infections, pressure ulcers, secondary things that come into play that are not related to the disease process. And we track those mostly through our software and then look at any similarities or differences that we need to address. And that's all I have to say.

Barbara Cebuhar: Thank you Ms. (Smith). If we could go to our next participant please, (Kyle)?

Operator: Your next response comes from Lou Little from Wellstar Windy Hill Hospital. Your line is open.

Lou Little: Thank you for taking my call. One of things that I think is important to focus on would be healthcare acquired infections, echoing the earlier caller. I think there is the ability to utilize (CDC) definitions and we represent a long-term acute care hospital and that has been a very strong focus of ours for the last few years and have seen some positive results. And I think that's a significant issue in our industry. Thank you.

Barbara Cebuhar: Thank you. Lou, we appreciate your help. Thank you. And our next question (Kyle).

Operator: Your next response comes from Kim Demerchant from MaineGeneral Medical Center. Your line is open.

Kim Demerchant: Thank you. We measure functional independent outcome so we're thinking some quality measures along the same lines would be really helpful.

Barbara Cebuhar: Thank you. (Kyle), our next comment please.

Operator: Our next comment comes from Deborah Cousino from Haven Hospice. Your line is open.

Deborah Cousino: Thank you. In regards to hospice and collecting measures, we participated in the rural demonstration project a few years ago and recorded pain on admission. And while that was fairly easy to collect, it was a manual process and the software vendors had still not quite caught up with a good recording system through the electronic record.

The other thing I wanted to mention is that the State of Florida has their own requirements for hospices here to report pain measures. And it would be helpful if the state or CMS could look at what the state reporting requirements are in order to avoid us having to report one thing to CMS and something else to the different states.

And in regards to infection control with hospices, I am concerned that hospices currently may not be collecting and reporting the same definitions and the same measures. We use the Association for Professionals in Infection Controls, APIC. We use their definition for hospice and homecare. But I am not sure that all hospices utilize those. So if you're looking at infection for hospices, we would have to ask them clear-cut definitions on those.

Barbara Cebuhar: Thank you for your comments. (Kyle), our next comment please.

Operator: Our next comment comes from Bradley Beukema from Capital Hospice. Your line is open.

Bradley Beukema: Good afternoon. The measures that have made, particular difference. I'm with Capital Hospice in Northern Virginia in the Washington D.C. area. A couple of years back we implemented a form in our medical record to mandate our clinicians must report pain at every clinical visit. So we've have been tracking pain particularly in the first 48 hours. And using a sort of variation of the NHPCO comfort measure, we asked the patient what their desired comfort level is. And our quality outcome internally that we report to ourselves was the percentage at which we meet the patient's pain goals. And as a quick aside looking at the (AIM) toolkit that was just published by CMS for Hospice and Palliative Care, there's a real significant shift or switch in sort of mandating fixed number as quality measures, let's say reporting the patients who are at three or less on a zero to 10 scale in the 48 hours.

That assumes that that number is the same across the board. And for the end-of-life measure that they're looking at in the last seven days, it assumes that a behavioral pain relating is identical to reported rate. And I think there are some measurement issues there that they need to be addressed. We also get the last pain measure at the end of life, that's our quality, internal quality. And we're also using the National Cancer (inaudible) Network, the distress thermometer, where we are assessing both patients and caregivers on a regular basis for distress. And then referring them to the appropriate pain (member), given the source of distress. As a quick aside, there's a very high incidence of caregiver distress reported higher than patients. And we think that's under recognized and under treated.

One more quality measure that we use is we are working to reduce the number of calls to 911 in the emergency rooms through education. And sort of preventing things like calls which are key trigger to 911, where symptoms are short and suppressed. So we're working on treating symptoms with education as a way to reduce call to 911. That's what I'll report for now. Thank you.

Barbara Cebuhar: Thank you for your help. Our next commenter please (Kyle).

Operator: Your next comment comes from Janice Bauer from Cardinal Hill Healthcare. Your line open.

Janice Bauer: Thank you. Yes we're a long-term acute care hospital in Northern Kentucky. We're presently again as a long-term care, monitoring closely the high risk, high volume with the (B infection). These are medically complex individuals that have had a long ICU stay and then coming into our particular environment. So we have already touched on – some of the facilities have touched on the infections, the blood stream infections, surgical infections that are later associated.

We also focus because we do so much of the traumatic brain injured patient, all falls and how that impacts the quality outcomes for the patient. Our collection, I think you had asked, how do we do the collection. That is of course by our infectious control nurse, that's a daily audit. So we're always collecting that information as well as related falls. And then that particular

information, we report through our system to (ORYX) to the Joint Commission, to be benchmarked with many different long-term acute care hospitals within the United States. That information is then of course shared every other month with our particular board, so they can stay in contact and have the information related to our quality indicators and outcomes. Thank you.

Barbara Cebuhar: Thank you Ms. Bauer. Our next commenter please.

Operator: Your next comment comes from (Dina Gustafo) from Princeton Homecare. Your line is open.

Dina Gustafo: Yes, we're currently measuring pain and other symptoms are managed within 48 hours to the patient's level of comfort and satisfaction. We're looking at bereavement services and the care plan that was setup was followed at the patient or the family which contacted and bereavement services provided throughout the 13 month as we had planned to do. For infection control, we're monitoring for UTIs and central line infections.

One of our indicators are selected to ensure that they are absolute that we can – in the process of doing that data collection. And then the last thing and I think I heard another caller speak to this is to make sure that there is an acuity adjustment placed into the indicator within (inaudible) say there can be everything from almost SNF levels up to ICU-level patients. And we've got to be able to compare outcomes appropriately to the acuity of the patients.

Barbara Cebuhar: Thank you Ms.Gustafo. Do we have any other comments?

Operator: Your next comment comes from (Andrea Pfaffl) from Aurora Healthcare. Your line is open.

(Andrea Loduha Pfaffl): Hi, I'm calling from an inpatient rehab facility in Wisconsin. And I guess from our perspective for inpatient rehab, I think our biggest request probably is to really make sure that you're working closely with CARF or (UDS) or E-rehab data because there are already so many things that we are measuring that we don't want it to be something new in addition. And really I

think those three entities CARF, (UDS) and E-rehab have a really good grasp on what we measure.

From our perspective we think two of the greatest measures for inpatient rehab would be stem change because we're so much based on function and then also a community discharge because ideally in inpatient rehab our goal is to get someone in, functionally get them ready to get back into the community. But then the other piece here is to take into account the acuity or the case mix because no two inpatient rehab facilities are the same. And that's it.

Barbara Cebuhar: Thank you Ms. (Pfaffl). Stella, we're ready for the next question.

Stella Mandl: Of the quality measures that you currently are using, can you describe for us, if they are process, structural, outcome or composite measures?

Operator: Again, in order to respond, press star then the number one on your telephone keypad. Your first response comes from Sean Muldoon from Kindred Healthcare. Your line is open.

Sean Muldoon: Yes, we have two tiers. Most of them are outcome measures, many of which have been already reported. And then we secondarily have process measures which generally are in the phase of kind of not ready for prime time because we haven't made collection methods, reporting methods and in some cases interpretation methods known well enough. But the goal is to have these as outcomes of care. Thank you.

Barbara Cebuhar: Thank you, Mr. Muldoon. Our next comment please.

Operator: Our next comment comes from Susan Greco from Methodist Rehabilitation Center. Your line is open. Ms. Susan Greco, your line is open. Your next response comes from (Lorain Michael) from Peterson Regional Medical Center. Your line is open.

(Lorain Michael): Yes, that's correct. We're from an inpatient rehab facility. And we do outcome-based measurements and I would just like to emphasize what the previous inpatient rehab facility person stated that we also – our outcomes that

we track all the time are in (UDS), which is a very helpful way to do that. We do the discharge disposition (inaudible) patient satisfaction (inaudible), those kinds of things and I also noted that on the (inaudible) by itself there is a quality section where just you can report on (quality) and pressure we have not utilized that but I think since the (inaudible) form is a form that we all have to send to Medicare that that would also be another good tool to use for reporting.

Barbara Cebuhar: Thank you Ms. (Michael). Our next comment.

Operator: Your next comment comes from the line of Lou Little from Wellstar Windy Hill Hospital. Your line is open.

Lou Little: Use of both outcome and process oriented, the vast majority are focused on our long-term acute care patients. We do have part of an integrated health system and so we do share some of the same quality measures as our short-term acute care hospitals do. So its most heavily weighted towards our unique patient population, but we do have some shared system wide goals. The other thing I was going to ask if I could is the slide deck that you've provided to us for this call. If that would be a good template to use to provide you with written responses because there is certainly more than we can tell than you have time for on the call.

Barbara Cebuhar: Yes, if you wouldn't mind sending that to our e-mail address, that would be great. Thank you very much.

Lou Little: Thank you.

Barbara Cebuhar: Our next comment.

Operator: Your next comment comes (Rebecca Miller) from the University of Kansas Medical Center. Your line is open. Our next response comes from Patricia Blaisdell from California Hospital Associates. Your line is open.

Patricia Blaisdell: Yes, thank you. Actually I'm going to be reiterating a couple of things that the previous callers had said that in the inpatient rehabilitation facilities and in some of the (SNFs) that do at the transitional care using something like FIM

data to look at functional outcome would be a major outcome measure that I think would be, its already being collected and would be very appropriate. Again, they would have to do somehow risk adjusted or interpreted in the context of the diagnosis and the amount of – the starting point of the individual patients.

I think this tells (inaudible) the community and also this (goes) back to acute care and avoidable re-hospitalization from various settings. It's something that is regularly tracked in many of these facilities and would be an outcome measure of interest to this process.

Barbara Cebuhar: Thank you for your comments. Our next commenter please.

Operator: There are no further responses.

Barbara Cebuhar: Great. All right, Stella we're ready for the next question.

Stella Mandl Thank you. Which measures and some of you have already gone over this but that's OK, which measures would you suggest be reported to meet the requirements of Section 3004 and if you could tell us why?

Operator: Again to respond, press star then the number one on your telephone keypad. There are no responses at this time.

Stella Mandl: OK. Next question will be what are you measuring or monitoring that has been effective in improving the quality of care in your settings?

Operator: Your first response comes from Sean Muldoon from Kindred Healthcare. Your line is open.

Sean Muldoon: Yes, this is Sean. I think the editorial comment here is the sophistication of the measuring that's been going on for decades, is to the level where things that don't improve the quality are discarded and those that do are followed, incentivized and tracked. So anything that we are measuring, I think you can assume is tied to the improvement of care when those results are driven to our process improvement processes. Thank you.

Barbara Cebuhar: Thank you, Mr. Muldoon. Our next commenter, please.

Operator: Your next comment comes from the line of Connie Parker from the North Carolina School Health Alliance. Your line is open. Ms. Parker, your line is open. Your next response comes from Bradley Beukema from Capital Hospice. Your line is open.

Bradley Beukema: Yes, thank you. Just to say and maybe I'm getting redundant but we've seen a significant improvement in patient comfort, particularly in the first 48 hours identifies by systemically measuring that along with education of staff and actually daily reporting out to the teams for the patients who are measuring at pain of five or greater. And that's all I'll report for now. Thanks.

Barbara Cebuhar: Thank you. Our next comment please.

Operator: Our next comment comes from Wendy Grove from Brooks Rehabilitation. You line is open.

Wendy Grove: Thank you, good afternoon. We'd like to comment that we encourage you to measures that are already defined. We collect quality measures and submit indicators through the NDNQI system as I think other inpatient rehab facilities do. And I think that, it's important to use well defined measures that are already in existence and already being collected and that have shown to be effective in improving care. Thank you.

Barbara Cebuhar: Thank you. Our next comment please.

Operator: Our next comment comes from Patricia Blaisdell from California Hospital Associates. Your line is open.

Patricia Blaisdell: Again, I think my colleagues have be intuitive in terms of saying what I was planning to say, but I think one of the most significant outcome measures that is probably applicable to most of the post-acute settings is just discharge disposition and I know it's something that many facilities monitor on a regular basis and look at their strategies to improve return to community and avoiding moving on to institutional levels of care whenever possible. And that's something that I think has been well documented and is internally used in a very regular basis to look at processes of care.

Barbara Cebuhar: Thank you very much. Our next comment, please.

Operator: Your next comment comes from Marci Ruediger from Rehab Hospital. Your line is open.

Marci Ruediger: Hi, this is Marci from (McGee). A couple of things that we've measured includes (inaudible) patient satisfaction and one that hasn't been really measured yet, or I mentioned yet which is blood sugar control and the complex rehab patients.

Marci Ruediger: Yes. All of which we think have – measuring those has improved the quality of care for our patients.

Barbara Cebuhar: Thank you very much Ms. (Ruediger). Our next comment please.

Operator: Your next comment comes from (Rob Greens) from Rehabilitation Hospital. Your line is open.

(Rob Greens): I was just going to echo what some of the other folks from the inpatient rehab facilities had said about looking at measures that have already been implemented and utilized, standardized for a number of years. And I agree with the previous comment that you know discharge disposition I think is key for inpatient rehab, I mean that's our goal is getting people back into the community as (high) functioning as possible. So and I don't know, I mean the question and outcome measure, I don't think an outcome measure really improves quality, I mean it's an indicator, I think it goes back to your first question. But the outcome measures in and of itself is not going to improve quality, you know it's more to question of is it important, is it meaningful and I think we've kind of answered that question already. That's all I had to say.

Barbara Cebuhar: Thank you very much. Do we have any other comments?

Operator: There are no further comments or responses.

Barbara Cebuhar: Great. Stella, we're ready for the next question then please.

Stella Mandl: OK. To you and your organization, what are the key elements of a quality reporting program for long-term care hospitals, inpatient rehab hospitals, or hospice programs? Key elements of the quality reporting programs.

Operator: Your first response comes from Bradley Beukema from Capital Hospice. Your line is open.

Bradley Beukema:(Thank you again). More philosophical point but I mean in this interesting grouping I guess the three who were not providing systematic measures at this point to CMS. A key point about hospice care it's really built around within medical practice so that the patients and his families wishes. So I'd say a quality program that includes hospice really needs to take into account how the care is built around assessing and working with the patient and family. So what's desired outcomes are as opposed to some global idea that we impose on them, what their quality is. Thank you.

Barbara Cebuhar: Thank you. Our next comments.

Operator: Your next response comes from Sean Muldoon from Kindred Healthcare. Your line is open.

Sean Muldoon: Yes, we have couple of principles; one is that they are incident rates rather than prevalence rates, and that the incidence rate is constructed such that the risk factor is captured in the denominator. And we assure that everyone from the numerator in fact came from the denominator. Second, we try to make them within the control of a hospital. Yes we do understand that the hospital has a high risk population coming in than they don't get release from that, it's just that they need to build their plans for provisional to patient care targeted at that population.

Second of all on the precision versus accuracy. We tend to prefer precision over accuracy so that they can be auditable and highly reproducible and we've sort of suffered through some complaints that they aren't actually measuring what we wish they would. And the third and the last one is that we give a small number relief to those who have very small incidence, a very small denominators. Thank you.

Barbara Cebuhar: Thank you. Next comment please.

Operator: The next response comes from (Andrea Pfaffl) from Aurora Healthcare. Your line is open.

(Andrea Loduha Pfaffl): I echo the thoughts of the two previous callers but then again in addition just that we are not adding on another layer of different reporting. So whether it would be along the lines or joint commission, CARF you know and especially with inpatient rehab that would (ever reporting easy), right. I think a really important piece would be that that reporting would be done on the (inaudible) form because in these ever pressing days of not having enough staff if we add more and more, we can't add additional hour, they are additional people that just continues to take away from the patients.

So whatever is being done please take that into consideration that it's not adding another layer. It's not extra work and that it can be done in the streamline process and because for inpatient rehab we already have that (inaudible) form, it would seem most fitting that whatever data reporting we do would be the (out) form. Thank you.

Barbara Cebuhar: Thank you. The next caller.

Rob Grange: Against our kind of internal goals but also keeping in mind what's going on in the region because as anyone who knows the data knows that things do change as regulations change and acuity changes and (case mix) changes and then also it is then going to impact your some of your other high level outcomes statistics like discharge disposition. So just accounting for those things as I think (to the element).

Barbara Cebuhar: Thank you Mr. (Grange). The next commenter please.

Operator: Your next comment comes from Connie Parker from North Carolina School Health Alliance. Your line is open. Ms. Parker, your line is open. Your next comment comes from Patricia Blaisdell from California Hospital Association. Your line is open.

Patricia Blaisdell: Yes, I have two sort of general principles that I think would apply to any setting, that is that any quality measures should be something that is directly derived from the care provided in that setting, meaning there is a logical consequence sort of the data and processes that are provided in that setting as the example we talked frequently today is in the rehab setting, the FIM score is viewed as a measure of functional gain and that's a logical part of the training process and also supports quality reporting.

A second principle I'd encourage you to keep in mind is the need to ensure that not only is there an acuity adjustment but that somehow the measures are differentiated in the context of the patient and the patient's goal. A good example of this would be in the (inaudible) setting where there are many patients that are there for a short-term transitional stay for which you might have one kind of measure and then the other patients are there for a long-term (critical) care, and other measures might be more appropriate. And we certainly saw some of the problems with that was the, I assume the five step program that tended to make a one side (withdraw) process for those kinds of patients. So two principles, a logical extension of the care provided in that setting to those patients in some way that it is modified based on the individual patient acuity and circumstance.

Barbara Cebuhar: (Our next comment) Thanks.

Operator: Your next response comes from Jeremy Curtis from Carelink of Jackson. Your line is open.

Jeremy Curtis: Hi, this is Jeremy Curtis, Carelink of Jackson here in Michigan. I just want to echo the previous comments that it should be acuity adjusted based on where an LTCHs. So as this was mentioned previously we have patients from (inaudible) all the way to ICU level care and we have to adjust our staffing. And we examine the quality indicators based on those. So I think adjusting that for acuity and then also apples-to-apples comparison, so LTCH should compare to LTCHs, IRF should compared to IRFs hospice compared to hospice, et cetera. Thank you.

Barbara Cebuhar: Thank you. Our next comment please.

Operator: Your next comment comes from (Michael Klimblad) from Columbus Healthcare. Your line is open.

(Michael Klimblad): Thank you. I wanted to add on to what the latest commenter said regarding the three programs that are talking to you today. It's clear that the focus of each of them in terms of their quality measures have used different databases and actually have a different special interest. So while CMS might be also be interested in the cost setting quality of various measures that are being considered, I think it's also clear that there were some unique characteristics and unique quality measures to each one of these kinds of programs that shouldn't be lost in the shuffle.

Barbara Cebuhar: Thank you for your comment. Our next respondent please.

Operator: Our next response comes from Sharon Cheng from Strategic Health Care. Your line is open.

Sharon Bee Cheng: Thank you very much. We represent a number of providers in each one of these three settings and I'd say a comment read among all of them are fairly tight fiscal times ahead as you know the LTCHs s have not seen an increase any kind of substantial increase in base pay. Hospice looks also to be not expecting a substantial update and so they are in a different starting place from some of the other settings that have begun reporting quality measures to CMS. I hope that you'll consider the current circumstances of each of these provider types and start a quality reporting system with a period of confidential feedback, so that the providers get a chance to get a hang of the new system and develop valid reliable quality reporting with confidential feedback.

And then moving forward let it be voluntary, there won't be a four percent update to put a risk here for any of these providers. At the same time, they're going to need to invest in systems to collect quality data and report it as those activities are not without some resource requirements. And so any contemplation of help essentially to the settings whether isn't any stimulus funding for EHR or (HIT) to get up the speed and develop quality reporting

systems would be tremendously appreciated given the payment environment for each one of these settings. Thanks, for the open door forum.

Barbara Cebuhar: Thank you. We have time for one more response please. Thanks.

Operator: Your next response comes from Allison Silvers from Village Care. Your line is open. Ms. Silvers your line is open. Your next response comes from (Olivia Michelle) from the Specialty Hospital. Your line is open.

(Olivia Michelle): Thank you very much. This is appropriate because I've been punching the star one for the last 30 minutes and then I am hold with the company for the last 15. So it's appropriate that I am the last one. I had many things to say probably forgotten most of them by now but I do want to mention some things that I feel they are very, very important. We are an LTCH. We're a small LTCH in rural Mississippi. One of the biggest things that I wanted to make sure that everyone understood not only the acuity being different from LTCH to LTCH which is most definitely the truth.

We have an LTCH across the street that doesn't do any of the high acuity that we do over here. So I certainly would not want to see anything that would put all LTCHs as apples-to-apples because we're certainly not. I do like to hear the fact that we need to be LTCHs toLTCHs, rehabs to rehabs, hospice to hospice not try to put us all into one bucket. Another thing as far as (rural staff) is concerned. We needed to look also at the geographic areas of where our facilities are. Down here in the south, you know we (inaudible) would have to increase our productivity which would be increasing and that is what we are a long-term acute care hospital. The swing beds or anything like that, we had very, very sick patients that require very skilled labor.

And we certainly don't need any type of care to burden that down in taking care of the patients. One other thing that I did want to mention is that some of these things that I've been seeing on and off has been things like measuring mortality and such as that. When you look at mortality you're also looking at what an LTCH does. What type of patients do they take? LTCHs take the sickest of the sick and sometimes we're the last hope for these patients and these family members. And it could be high in a facility because of the

patient is OK, there is not a patient in our facility at present that a single nursing homes, anything in the south would take.

Our patients are way too sick. So I guess that's the biggest thing I wanted to let you think about was the fact that we do need to look at also the geographical areas. Thank you.

Barbara Cebuhar: Thank you Ms. (Michelle). I think Stella we're ready for the next question.

Stella Mandl: Do your measures meet the NQF rating criteria? And can you include if they are in the criteria important, scientifically acceptable, usable and feasible, particularly for e-reporting in 2014?

Barbara Cebuhar: (Kyle) do you want to instruct folks on how to get in the queue?

Operator: To respond to the question, press star then the number one on your telephone keypad. Your first response comes from Cheryl Burzynski from Bay Special Care Hospital. Your line is open.

Cheryl Burzynski: Thanks. I am an LTCH also. I am in the State of Michigan. We use (NHS) database that was created by the (CARF) industry organization. And we do measures – we also have the people that belongs to Joint Commission accreditation also do the (RS indicators). At this point (NHS) database is not within (inaudible) has not been accepting any new people to join. So we've been trying to do that and find a way to get our stuff NQF certified or whatever the right term would be for that. But again not only do the quality and outcome measures. We also do operational measures and we have a very complex database that people individually choose to join and participate in to the (CARF) organization but you don't have to be a (CARF) member to be in it.

Barbara Cebuhar: Thank you Ms. Burzynski. Our next commenter please.

Operator: Your next comment comes from (Linda Bayer) from New England Rehabilitation Center. Your line is open.

(Linda Bayer): Hi, I just wanted to mention that in terms of NQF we do in the State of Massachusetts report a couple of NQF design measures. We report them on falls with injury and hospital acquired pressure ulcers also, stage two or greater that are identified during at the times prevalence study. So those are three measures – possibilities they're really opening outcome measures but that are NQF designs that we've been reporting for a couple of years now.

Barbara Cebuhar: Thank you. Our next comment please.

Operator: Your next comment comes from Sean Muldoon from Kindred Healthcare. Your line is open.

Sean Muldoon: Yes, we probably would share passing (inaudible) importance and acceptable and useful with the exception of although the metric may be scientifically acceptable, we'd have to ask the hard question on the methods of collections. For example survey data, many hospitals collect a valid survey but with methods that are quite varied and NQF may have trouble with that. The e-reporting it's easy to e-report, it's very difficult to e-collect. And almost all of our outcomes are abstracted from the chart because we have found as others that administrative datasets don't capture the things that we describe to you previously as important. Thank you.

Barbara Cebuhar: Thank you Mr. Muldoon. Our next commenter please.

Operator: Your next comment comes from (Ed Callahan) from NALTH. Your line is open.

(Ed Callahan): I think that's (Ed Callahan), correct? Hello.

Operator: Yes.

(Ed Callahan): OK, thank you. Thank you, like Ms. (Michelle) I've been doing star one and knocking in on for a while. I have one overall comment, I'd like to make, I think in establishing quality indicators we have to be aware that they could operate discourage the admission of some patients for example because of the risk adjustment factor. For example there are some ventilator patients who

have a more difficult prognosis to wean if they are in hemodialysis or if they have spinal cord injuries which I'm sure you understand.

So a simple outcome measure of weaning would have an incentive, could have an incentive some providers not to admit those patients. So we think that including through this issue, that (RTI) and CMS should be keen to recognize that problem and perhaps move towards the process measures. Also, the national health information system that's been referred to on this call has 26 measures, that's currently being used to collect and report data throughout the nation for the long-term care hospitals. Thank you.

Barbara Cebuhar: Thank you. Our next commenter please.

Operator: There are no further comments at this time.

Barbara Cebuhar: (Kyle) I know that we've had a few problems trying to get into star one. I know that (Dexana Coleman) is trying to reach us. Is there a chance that if you could open her line please.

Operator: OK. (Dexana Coleman) your line is open.

(Dexana Coleman): Yes, this is (Dexana Coleman) thanks a lot and I feel really big burden to say something important because I imagine there are other caller who have been having same technical difficulty I have. First we appreciate you holding this listening session. I think the answers to a lot of these different questions kind of flow together in an effort to pick measures that are important, that are valid, that are useful. And that are practical and not too burdensome to collect.

My opinion would be that particularly in the IRF sector, we think with measures that we have success and experience collecting accurately and certainly there is FIM measures are outcomes measures, we're proud I think in rehab that we do have true outcome measures as opposed to process measures. And I'd like to keep our things going with that. At least 60 percent I'd say the rehab industry is familiar with reporting. There is a composite measure of FIM change, discharge destination. And (inaudible) you can see five different factors that everyone who reports to (EDS) is familiar with having those rolled

into one measure. And there is a lot to be said for familiarly, lot to be said for FIM and I think consistent with other comments there probably is a limited attention span of what people can keep in mind and can focus on.

And so while there is a enthusiasm and desire to create new measures and tackle new problems in the world of quality, I think my opinion would be we should keep tackling some challenges we've been tackling but we know we're not perfect at yet FIM change being a good example of that. We think even more improvement could be achieved peoples functional success. So I guess I'd caution us against being lured to some attractive new measure that we don't have experienced with just and or to say true to trying to squeeze the last answer for real achievable quality out of measures (where we all are familiar). Thanks.

Barbara Cebuhar: Thank you Dr. (Coleman). Do we have other people in the queue please?

Operator: We do. And your next response comes from Lisa Tudor from Cardinal Hill Healthcare. Your line is open.

Lisa Tudor: Yes, thank you very much for holding this listening session. I have been trying to get in. I think that it is everything I'm echoing was said but the standardized format for the metrics that are risk adjusted or based on acuity really looking at some transitional metrics as well as access to care. And these are also important element especially as we go through to look at all the measures having an adverse impact on the clients that are served in these three settings. So and that's what I have to say. Thank you very much.

Barbara Cebuhar: Thank you. Our next commenter please.

Operator: Your next response comes from the line of Kristen Smith from Vibra Healthcare. Your line is open.

Kristen Smith: Great, thank you very much and I appreciate you holding this open door forum. I too had been trying to get on from a question way back. So I think you know what everyone is saying is, I'd echo that. At Vibra we have long-term acute care and inpatient rehab facilities. And really try and focus more on the outcomes I think in general post-acute care settings. There has been

limited evidence on the process indicators, but as one gentlemen mentioned, the question that the LTCH setting is where you deal with the outcome indicators you very easily could limit yourself to the patients that you're expecting and/or when you're looking at discharge disposition from the LTCH setting if you look at acute transfers back to the hospital trends, and if you don't want to incentivize people to keep patients if they're not appropriate meant for that setting.

So my biggest recommendation would be to make sure that you standardize the measures and to find them accordingly to this setting and those definitions take into consideration like everyone else is saying risk adjustment and appropriateness of the setting. And what the goals of the setting are? Each setting LTCH has, there is different goals that teams are working on in those settings. And distinct differences and it's important that you consider what the actual goal is of that post-acute care settings and are we able to reach that goal.

Barbara Cebuhar: Thank you Ms. Smith. Do we have other comments?

Operator: Your next comment comes from the line of (Allen) from Cornerstone Healthcare Group. Your line is open.

(Alice Latere): Hi, this is (Alice) here. I am with Cornerstone Healthcare Group and I too have been continuously trying to get in with star one. I think several questions that I wanted to respond to but primarily one of the last ones you spoke of our own measures that we are measuring our outcomes with. What's important feeds along useful and meaningful outcome measures. And I'd say at this point that we need to consider using the already established outcome measures that had meaningful input from the stakeholders, for instance the (Alpha) benchmark study that had been in progress for 2010.

Our 18 group hospital actually has submitted data quarterly to that. And I as well as many others in the half of nationwide had participated in creating those outcome measures. Also, understand that (CARF) has some type of similar database that they are submitting to. So if you ask what's important feasible and useful to our LTCH industry, I'd say that you need to seek out the

information and the primary stakeholders in the (Alpha) benchmarking study as well as the (CARF) study. Thank you.

Barbara Cebuhar: Thank you. Our next comment please.

Operator: Your next comment comes from Jean Davis from (Center Hill). Your line is open.

Jean Davis: Thank you very much. I appreciate the opportunity (inaudible) very much for holding this open forum. I too would just like to reemphasize some of the important comments that have been made across. And many questions, first one is the standardization of any instrument in which whatever data would be captured and that it would be a reliable measure that is monitored. Second, we fully support that has that data being captured electronically which would create ease of moving the information through organizations to CMS or the designated database.

As you know an inpatient rehabilitation which is sort of (inaudible) line that we service has been capturing an electronic IRF quite for many years and it holds a lot of demographics about the patient as well as measures of outcome. And third, that the only quality initiative we wanted to support what other CMS initiatives are. And therefore I'd only add more focus on the readmission (inaudible) adjusted of course and motion and efficiency measures. The rehab industry has always captured a limit of efficiencies which measures, how much functional main overtime. But we do believe that in efficiency measure is an important area of us. Thank you very much.

Barbara Cebuhar: And next comment please.

Operator: Our next comment comes from the line of (Marge Barbagallo) from PinnacleHealth Hospice. Your line is open. (Marge Barbagallo) your line is open. Your next comment comes from the line of James Prister from RML Specialty Hospital. Your line is open.

Maura Hopkins: Hello this is RML Specialty Hospital. It's Maura Hopkins speaking. We too had been into for very long time with waiting for prior questions. I think at this moment the only thing that I might say in terms of previous questions

about important indicators would include the fact that I don't believe that (pressure also) development was specifically named and so that's one of those measures that we think is very important to indicate the level of quality of care. Otherwise we really have found that many of the comments are right on target. The key concerns about understanding the patient population that's being studied and mentioning that to similar populations is very important.

Risk adjusting, we think is also an extremely important strategy although there would be difficult to say what is the best way to wind of doing that. And if we know that there is great variability in the patients in these different populations and yet there isn't one easy way to be able to describe what those patients look like. So we thank you for the opportunity to provide comment and we'll continue to join the rest of the listening.

Barbara Cebuhar: Thank you Ms. Hopkins. We can take a couple of more questions. So couple of more comments. Thank you.

Operator: Your next response comes from (Davie Hill) from Madonna Rehabilitation. Your line is open. (Davie Hill) your line is now open.

(Davie Hill): Thank you. I want to address just two things that I don't know had been mentioned in response to a variety of questions. In talking about principles of a quality improvement program, I think that it's important to consider the audience. We collect lots of indicators and we use them in a lot of different ways to try and improve our processes, our outcomes, our efficiencies, our relationships. But I think that it's important to have your indicators specifically to meet the needs of the audience that you would be serving with them.

We certainly report different indicators publicly in our annual report than we might report to our Board of Directors than we might report to our physical therapy team. So I think that's one point. The second point I wanted to make is that really the most important part in my mind of any quality improvement program is the analysis part. And I believe that acuity and certainly a risk adjustment is extremely important, but I also believe that it's not possible to do all of the analysis in the indicator itself. So I think as organizations we

need to be prepared to describe the specifics of our populations that might account for differences. Thank you.

Barbara Cebuhar: Thank you Ms. Hill. Do we have other comments in the queue (Kyle)?

Operator: Yes, there are several remaining.

Barbara Cebuhar: All right, go ahead. Your next comment comes from Jayne Chambers from Federation of American Hospitals. Your line is open.

Jayne Hart Chambers: Hi, thank you very much. This is Jayne Chambers at the Federation of American Hospitals. I appreciate very, very much the open door forum and the discussions that we've had today. So I think we recognize that in the beginning there probably will need to be a few measures until the structures could be setup and we know exactly how the data is going to be collected and reported, and can see if there are any unintended consequences from establishing sort of these three new quality reporting programs much like we did with the inpatient reporting programs, a number of years ago.

One thing that will be important to see how the validation comes about and to work towards NQF endorsed measures recognizing that in the beginning there may not be NQF endorsed measures that are readily available, but if we can work towards that so that there is general consistency the federation thinks that would be a good thing to do. And I agree with the comments that have been mentioned about risk adjustment. The other thing I'd mention is that to the extent that these facilities are reporting infection measures to the (NHSN) and since the (NHSN) is now being used on the inpatient side there may be some opportunities to use similar systems so that release some of the burden on CMS in terms of the data collection and reporting mechanisms that they have to (scatter) as well. Thank you.

Barbara Cebuhar: Thank you. The next commenter please.

Operator: Your next comment comes from Dorothy Porter from Asheville Specialty Hospital. Your line is open.

Dorothy Porter: Thank you. Yes, I agree with so many mistakes already, I just went to reiterate as well the need for the risk adjustment and for keeping these three provider settings separate. And so I appreciate with the earlier callers said about why the LTCH populations can really vary just within our own provider settings. And just finally the idea of not trying to recreate the wheel when you've got some really good organizations out there already benchmarking, just haven't heard the one that we use, to manage with healthcare data incorporated through Thomson Reuters. So we just really hope that you would look at what's already being done. Thank you.

Barbara Cebuhar: Thank you. We have time for two more questions – two more comments.

Operator: Your next comment comes from Eugenia Smithers from Hospice of the Bluegrass. Your line is open.

Eugenia Smithers: Yes, thank you. I just wanted to be sure that everyone has an awareness at least in the hospice industry that the majority of the care that we give is in the patient home. And so we can encourage, we can educate, we can instruct, we can bring in tools but the patient and families goals are really going to drive whatever outcome structure that we can put in place. I do reiterate a lot of what's been said about using some established measures being the healthcare provider on the farthest end of the food chain. For instance some caller mentioned to keep it as (altered) that might not be a good measure or indicator for us because sometimes they develop during the actively dying process in spite of all of the best evidence based practice thing that we can put in place.

So while I support a lot of the comments about functional status and some of those other things. They just might not apply practically to our patients and families. And I believe another caller had mentioned about the goals of care and the symptoms, control, that's going to be where the majority of the good work that hospice can do and report is going to be around. So thank you for giving me the opportunity.

Barbara Cebuhar: Thank you Ms. Smithers. One more comment please.

Operator: Your last response comes from Martha Harrington from the LHC Group. Your line is open. Martha Harrington, your line is open. Your next response

comes from Mary Jane Kohan from Holy Family Medical Center. Your line is open.

Mary Jane Kohan: I too put in my request earlier to speak. I am in an LTCH and my concerns were seemed to approve to reiterate what I first wanted to say about our data has to be collected in a way that it assures consistency across the CMS population involved in the study and that its risks adjusted. Thank you.

Barbara Cebuhar: Thank you. Stella, I think we've got time for our last two questions.

Stella Mandl: OK. The first one I think actually I think that a lot of this has been answered but I am going to go ahead and rephrase the question. Number one, can you share the lessons you have learned from your quality measurement and improvement efforts? And then number two, do you have concerns or considerations that you would like to share with CMS regarding the development of a quality reporting program for your settings?

Operator: To respond to the question press star then the number one on your telephone keypad. Your first response comes from (Ed Callahan) from NALTH.

(Ed Callahan): Yes, I'd like to make one observation that I don't think has been made yet. I think that in developing these measures you should be concerned about how and whether they intersect with the payment systems. For example, for long-term care hospitals there is an interrupted stay policy, where if the case goes from a long-term care hospital to an acute hospital and returns to the long-term care hospital within three days, there is no, the long-term care hospital pays for it. Its bundled into the long-term care hospital payment. And also a lot of those discharges and admissions are part of the plan of care that is, they are intended readmissions to the acute hospitals. So they are good signs. And so it's important to look and how these quality indicators may intersect the payment systems and how that should be reflected.

It's also important on the other end a lot of long-term care hospitals bundle complete conditioning into the cost of care and you don't want to have any kind of incentive to change that in my opinion. So that's one thing I'd like you to consider is how these quality measures may affect and play out in the paying systems. Thank you.

Barbara Cebuhar: Thank you Mr. (Callahan). Our next comment please.

Operator: Your next comment comes from Suzanne Snyders from Carolinas Rehabilitation. Your line is open.

(Suzanne Snyders): Yes, thank you. I wanted to speak a little bit about concerns that I have regarding the development of quality reporting programs for inpatient rehab and particular to the unintended consequences of what some of the quality measures could have. The key one that comes to mind for me is if you're looking at discharge the community for inpatient rehab population. And the fact is that some patients require inpatient rehab, but might not ever have a community discharge. And that's reflected in the Medicare manuals. But if the focus is on getting patients discharged to the community there is possibility that sights might think that a 100 percent discharge to community is the way to go and that's their expectation and they are being rewarded for that thought financially with quality, eventually the quality reporting for pay for performance.

That might limit access to care to some of the people who need inpatient rehab most. One other concern that I have relative to using any, a type of functional measure is the existing functional measure tool for inpatient rehab, the FIM manual had some (poor and feeling) effects. It does not measure for our very, very debilitated patients like spinal cord injury, very severely brain injured patients. They might come into rehab, have a very successful course. They might, their family members might become completely independent to take care of them and take them home but they might not ever see a change on the FIM measure. And therefore it might look like they didn't really have any functional progress although they went from requiring complete care in an institution to being able to be cared for by their family members.

And it has also (feeling) effect, I mean there are patients who can get the top score on the FIM tool but not necessarily be able to interact in the community because cognitively they – thought of speaking just the motor section, cognitively they are not able to function and to be in society and still require inpatient care. So just a couple of concerns with, and really any functional

measurement tool that's out there being able to recognize that that it's not a complete indicator of a patient's ability to function in the community.

Barbara Cebuhar: Thank you Ms. (Snyders). Our next comment please.

Operator: There are no further comments at this time.

Barbara Cebuhar: I know that there have been some challenges getting through the star one. (Kyle) do you mind if we go ahead and give other people an opportunity if they have got comments or concerns or issues that haven't been reflected. If they could go ahead and please dial star once again and let's see if we can make sure that everybody has an opportunity to speak.

Operator: Absolutely, and if anyone has a response to anything at any point, you can press star then one on your telephone keypad. Your next response comes from Terry Melvin from Madonna Rehabilitation Hospital. Your line is open.

Chris Lee: Hi, this is actually Chris Lee sitting in with Terry Melvin at Madonna. I'd just like to, really I think kind of second some things that (Susan) from Carolinas Rehabilitation had mentioned regarding the FIM. I've also heard it mention earlier besides looking at FIM change that perhaps FIM change per day might be a measure to be used. I'd have similar concerns with FIM change per day because it creates a built-in incentive in some ways to move people very quickly through the system because often times you will see some of the largest changes in FIM scoring near the front of the stay. And towards the end of the stay you tend to see slower changes and that's just a side-effect I think of the way the FIM system is designed.

But it's often times at the end of the stay where we are doing a lot of things like making sure we have a safe discharge, the family and caregivers are well trained. And it's at that point that we are creating a quality outcome, a quality discharge in getting those folks back into their community, back into their homes in a safe way. And I'd hate to see an incentive that cause facilities to want to discharge people quickly in order to improve their FIM gain per day outcomes. Thank you.

Barbara Cebuhar: Thank you Mr. Melvin. Any other comments?

Operator: Your next response comes from Marci Ruediger from Rehab Hospital. Your line is open.

Marci Ruediger: Hi, is this from (inaudible) rehab and just wanted to go along with the comments made by (Susan) at Carolinas and the gentlemen at Madonna that we also have a lot of concerns about some of the FIM measures and whether they truly are good indication of quality rehabs. We have concerns about FIM change per day as well discharge to community when you have very, very acute population as we do. And as I'm sure some of the other institutions do. You have to be very careful about what we're measuring. Things get skewed by discharges back to acute care because of the critical nature of how sick some of these folks are and you end up measuring how sick the patients are rather than whether the rehab is good.

Barbara Cebuhar: Thank you. Next comment.

Operator: Your next comment comes from (Regina Turner) from (Tyler ContinueCARE). Your line is open.

(Regina Turner): Yes, I just want to just like the earlier callers did, the acuity of an LTCH, you have to really to be careful. You have to take in consideration, if the patients try to, I mean we have lots of patients that are critically ill, ICU type patients. So just to take that in consideration, as far as to comparing apples-to-apples as was stated earlier. Also, if you could some other benchmarking that's already in place. We use CMS which is a specialty one of the measurement system. And their definition system, they're really great definitions, so I don't know if you're familiar with that if y'all could please just take those into consideration.

Barbara Cebuhar: Thank you. Next comment.

Operator: There are no further responses.

Barbara Cebuhar: Stacy, have you got further questions for the audience?

Stella Mandl: No actually I don't but I'd like to just request that we are very anxious and would like to have your comment including those that were verbalized on the call today to just submitted into the CMS mailbox on our Web site because we are looking through and reading comments. So even if it was presented on the call, it was still very much like that very same information submitted to us. And if you do that, if you could please reread the questions to see if you're able to answer or clarify anything that you can that are presented in the slide deck.

Barbara Cebuhar: Everyone just to let you know that once again the e-mail address is LTCH-IRF-Hospice-Quality-ReportingComments@cms.hhs.gov and we would appreciate receiving those by the end of the year. So anything you can do to help us with this, we would be most grateful. Thank you again for everybody's time and passion for this topic. We share it and hope that you have a wonderful holiday season. (Kyle) you can go ahead and disconnect if there are no other comments.

Operator: Again if you would like to make a comment, press star then the number one on your telephone keypad. There are no further comments at this time.

Barbara Cebuhar: All right. The speakers will hold on the line. And if we could go ahead and disconnect with the other callers. Thank you again for everybody's time.

Operator: This concludes today's conference call. You may now disconnect.

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