

Centers for Medicare & Medicaid Services
Special Open Door Forum
The Impact Act and Improving Care Coordination
Moderator: Jill Darling
June 20, 2017
2:00 p.m. ET

Operator: Good afternoon, my name is (Kim) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Special Open Door Forum: The Impact Act and Improving Care Coordination.

All lines have been placed on mute to prevent any background noise. After the speaker's 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 "1" on your telephone keypad.

If you would like to withdraw your question press the "pound" key. Thank you. Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Kim). Good morning and good afternoon everyone. My name is Jill Darling in the CMS Office of Communication. Thank you. Welcome to today's Special Open Door Forum. As always, we do appreciate your patience.

A lot of these large calls, we get a large amount of participants and collect a decent amount of information from you also.

As always, we appreciate your patience and holding on the call. So, one brief announcement from me, this Special Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any enquires please contact CMS at

press@cms.hhs.gov. So, now I'll hand the call off to Maria Edelen who is from the RAND Corporation. She's the director of this contract. Maria?

Maria Edelen: Thanks, yes, I'm Maria Edelen. I'm at the RAND Corporation and I've been working on this contract to CMS for almost two years now, and thanks everybody for getting on the line.

I'm going to be joined by Terry Moore, my colleague at Abt Associates who's been also working on the project. We originally thought Barbara Gage would be on but she won't be speaking today. So, I'm going to start us off on slide three.

The focus of this Special Open Door Forum is to give you an update on the RAND contract that is working on the Impact Act. So, we'll just give you a reminder of the goals of Impact Act and then talk a little bit of our scope of work at RAND and then a description of the activities that are associated with that scope of work.

Next slide, so just as a reminder the Impact Act, it stands for Improving Medicare Post-Acute Care Transformation. It was bipartisan bill passed on September 18th, 2014. It requires standardized patient assessment data across all post-acute care settings.

And this is among other things to enable improvements and quality of care outcomes to enable comparisons of quality across settings, information exchange across PAC settings, enhanced care transitions and coordinated care and, finally, to promote personal standard and goals driven care planning and discharge planning.

Next slide, so the four post-acute care providers that are covered by the Impact Act are home health agencies, which we refer to throughout the rest of this presentation as HHAs, Inpatient Rehabilitation Facilities or IRFs, Long-Term Care Hospitals or LTCHs and Skilled Nursing Facilities or SNFs.

Next slide, slide six, so in the Impact Act they specifically call out categories that would require the standardize data across post-acute care settings and these categories include functions, self-care and mobility and then cognitive

function including expression of and understanding of ideas, mental status and also mood and then special services, treatments, and interventions, medical conditions and co-morbidities and impairments.

So, the RAND scope of work is, sort of, within these – within these bullet points. So, we've been focusing on some aspects of cognitive function. Another contract is doing – is working on functions self-care mobility.

RAND has been working on cognitive function, some work with special services, treatments and interventions, a little bit in medical conditions.

We've been looking at pain and we've also been doing some work in impairments and then we have – there is also a bullet to capture other categories that maybe of interest and we have a few pieces of work in that other category as well.

Next slide please, so the idea is not to create a new instrument, per se, and impose it on all of the post-acute care settings. The idea is to identify a core set of standardize data elements that will go across the current assessment tools.

So, as you know their home health uses the OASIS and IRFs use the IRF-PAI and LTCHs use the LTCH CARE Data Set and SNFs use the MDF.

So, the idea is that we're going to – we're trying to identify a small core set of standardized elements that could be integrated into each of these four instruments and also the HCBS.

Next slide; so the idea here is just to remind you that with one question there's a lot – we get a lot of information from one question and we use the responses in a lot of different ways.

So, this is – this item on slide nine is the new section GG about functional mobility and you can see that the data element and response code can be used for care planning and decision support can be used for quality improvement, it can be used for payment, use for quality reporting and also use for care transition.

So, it's really because there are so many uses and then these uses really transcend the different settings that if we have the same data elements that are going into these uses then we can generalize across settings much easier and thus achieve the vision of the Impact Act.

Next slide, so given all of that background we just wanted to then talk more specifically about RAND scope of work in our approach. So on slide 10, just as an overview, our project goal is to develop, implement and maintain standardize post-acute care patient assessment data.

And our project is organized around three phases of work. In the first phase, we've done in the first year of the project it was really just gathering information.

We gathered information from focus groups and from the literature and from clinicians and from stakeholders and just did a lot of, sort of, iterating around finding out what's out there and where are the gaps and where should the standardize data elements focus given these categories that have been selected.

And then, also some item development around that information gathering phase and then we did some pilot testing and we're actually in our second alpha test. And alpha just means that it's small scale – it's more of a feasibility not for really hardcore reliability and validity data.

The purpose is to get some preliminary reliability but mostly just say how, do these data elements work; are they feasible to collect across the four settings. I'll tell you a little bit more about the pilot testing in later slides.

But as I said, we're in the middle of our second alpha test right now and we're also gearing up for a national data test which is going to begin in a fall – this coming fall. So, as I mentioned earlier, our focus is on the clinical domains that are outlined in the Impact Act.

So, we have data elements covering aspects of cognitive status, mental status, medical condition, impairments and these other clinical topics including care preferences and medication reconciliation.

So, slide 11 just shows you a really, really high-level timeline for the project – for the contract. So, the green bar is the period that was focused largely on information gathering and then our Alpha 1 test occurred last – started, it was about a year ago.

And then, we analyzed those data and we also had a public comment, which is not in here and we also, and now, are running Alpha 2 data collection and as I said gearing up for the national training and data collection and the contract ends September 2018.

The other thing – throughout this whole time, this is really just the testing activities but we've obviously had these quarterly special open door forums as you are aware.

We've also had several technical expert panels and other stakeholder activities as well as public comments throughout the project period to keep the stakeholders involved and to find out make sure that stakeholders have input into the item development and testing.

So next slide, slide 12 just shows that when we were – when we started out and we're trying to identify some candidate data elements that we might want to consider to fill some gaps and promote as possible candidates for standardize data.

We looked at the literature. We created organizing framework with in consultation with clinical advisors. We also consulted heavily with our partners at CMS as well as other contractors who are working on other aspects of the Impact Act with our other CMS contractors.

We conducted several focus groups as I mentioned earlier and we also engaged with a technical expert panel at a few different times throughout the process.

And in all of these cases if you go to the next slide, we kept in mind these four aspects of performance in terms of evaluating whether the data element should continue to be considered for standardization.

So, the first thing we wanted to look at is whether the candidate data element has the potential for improving quality. Is it going to improve care transition, person-centered care and care planning?

Does it have the potential to improve care practices and patient safety? Can it be used for quality comparisons including value based payment models and does the data element have the chance to support clinical decision making a care coordination?

And remember this one is at the top of the list for a reason. It's very, very critical that we keep the patient in mind and the Impact Act – the implementation of the Impact Act is somewhat of a heavy list but the motivation is really to improve patient care.

And so, the potential for improving quality is really critical – are critical component of the data elements that we want to continue to consider as we move forward with the standardization process.

However, we also want to make sure that the data element is valid and reliable. We want to make sure that it has strong intra-rater reliability and also want to know that it captures the construct that we wanted to capture so that involves looking at its relationship with other variables, and that's mostly going to come in our scheme from the Beta testing.

We also want to look to make sure that the data element is feasible for use (intact) across all the settings. Can it be made interruptible? Is it reasonable and relevant to all the patients across the four settings? Is it relevant to workflow? Is it clinically appropriate?

Now, some of this were determining really based on conversations with advisors and the CMS and with (TAP) but some of it we're learning by doing

the alpha testing. And a final quality that we're looking for the standardize data element set is its utility for describing case mix.

So, we want to consider is this potentially useful for payment models? Is it going to give us some information about severity levels that might help us understand resource needs and how they differ across setting, et cetera?

So, the next slide, slide 14 just outlines the feasibility testing that we've conducted and are conducting. So, our first alpha test was in August of 2016 and we had eight agencies and facilities, two of each type, two home health agencies, two IRFs, two SNFs and two LTCHs and they were all in the Greater Hartford, Connecticut area.

And I think in some other Special Open Door Forums we've reviewed some of the information that we learned from that Alpha test.

We're now in Alpha 2 which includes 15 agencies and facilities that are in three different markets Houston, Texas, Chicago, Illinois and Denver, Colorado and that data collection will wrap up in the end of July and will inform both of these Alpha test that are informing what data elements we'll go through into the national test.

In slide 15, we do have some – as I said we noted in an – in an earlier Special Open Door Forum some of the results that we learned from Alpha 1. For the Alpha 2 test we're testing some new – some different data elements.

We're getting really strong engagement among the facility and provider participants and they're interested in participating is, what we're hearing is, "Well, I want to make a difference.

I want to have a seat at the table. I want to be a part of the solution," and they've also found that the staff training and a practice assessments have been really useful for early identification of issues and questions.

So, they've been appreciative of our process of the sort of, slow work up to pull on a data collection. We give them extensive training and then give them some practice assessment time before we start collecting data and it makes it –

it means that it takes a little -- that you're in the field or you're actively collaborating with us for a little bit longer but it really, really helps because we can get rid of -- work out some of the kink that every provider is a little bit different. And so, it's nice to have a little bit of time to work those things out and they're finding that that that's been really helpful.

Another piece of improvement that we worked on between Alpha 1 and Alpha 2 was to get -- to use electronic data collection with a tablet base data collection.

So, an Alpha 1 was a paper and pencil and we're finding that the acclimation to the tablet use is going really smoothly and the staff that have been selected to conduct the assessments are really appreciating, using the tablet.

They're finding it just a lot easier than doing paper on pencil. So now I'm going to hand it over to Terry Moore who has been leading the recruitment for the national beta test. Terry, you want to take it?

Terry Moore: Sure, thanks Maria. Hi, everyone. I'm going to walk you through our plans for the national beta test and I'm going to talk to you a little about the sample of post-acute care providers that we've selected for the national test, talk a little bit about why anyone would want to participate in such a national study.

I'll talk a little bit about the data collection process, the training that our team is providing to participants of the national beta test and then I'm going to give you some resources if you're interested in hearing more.

So, on slide -- if you're following along on slide 16, this is an overview of the national beta test. As Maria mentioned right now or in the field with Alpha 2 but this fall starting in November, we will begin the national beta test and that will look over six months period and this is the final phase of data collection for this project.

We have 14 different geographic markets that I identified and I'll tell you what those are in a moment. And we've selected randomly a group of eligible post-acute care providers within those 14 areas.

We're in the process right now of contacting those providers who are eligible to participate and we're inviting them to participate and hopefully some of you on the phone – we have a lot of people on the phone today and hopefully some of you are in our 14 geographic areas and are interested. It is a voluntary project. So, it's up to you if whether you participate when we call you but we hope that you do.

On slide 17, we layout the 14 metropolitan areas that were in for the beta test. Those are Boston, Massachusetts, Harrisburg and Philadelphia, Pennsylvania, Fort Lauderdale, Florida, Durham, North Carolina, Chicago, Illinois, Nashville, Tennessee, Kansas City and St. Louis Missouri, Dallas and Houston Texas, Phoenix, Arizona and Los Angeles and San Diego, California.

On slide 18 you can see that the sample that we're ultimately looking for the beta test is 210 post-acute care providers and roughly 28 of those 210 we were looking for roughly 28 inpatient rehabs, 28 Long-Term Care Hospitals, 84 Skilled Nursing Facilities and 70 home health agencies. Within on average we're looking for two IRFs, two LTCHs, six SNFs and five Home Health Agencies per market.

So within each of those 14 markets and you might ask, "Well, why do we have more SNFs and more home health agencies, well that's just because nationwide there are more home health agencies and more SNFs providers in general and so we have a higher number of those that we're looking for in our sample.

You might ask if you're in one of those markets, well why do I participate and what's in it for me. So on slide 19, we have a list of reasons that we think it would be a good idea for you if you're post-acute care provider and one of these markets to participate.

You'll receive staff training and experience with the data elements that may eventually become Impact Act requirements. Maria mentioned about Alpha 2, we're already getting good feedback about the training that folks have received and they're finding this helpful.

If you participate you have the ability to provide some on the ground input to CMS. You'll be telling us as a project team how feasible is it to collect these data elements, how long does it take it to collect them, what the experience was like and all of this information goes to CMS and as final decisions are made about what elements will go live.

There's a small honorarium for participation which is a \$1,000. We also provide some help with a media kit, so that you can do some internal and external publicity to emphasize what you and your market area might be good for business and good for your reputation to emphasize your commitment quality or to demonstrate that you're participating in a national standard testing effort.

You might also get some national visibility and ability to network with peer organizations that who are also participating in the national test. And if you're interested in more – in seeing why some of our Alpha 2 providers decided to participate in that phase of the study, we have a link on slide 19 that you can follow to click into that and you can watch a video of several people that we interviewed about why they participated and what they hope to get out of it.

So, I would encourage folks who are interested in participating or just want to know more from one of your peers, I would take a look at that video. On slide 20, we talk about the assessments that we're going to be gathering in the national test.

Maria already mentioned the domains that we are trying to collect data for and that we've been developing assessment data elements for, in the beta test the assessment will focus on care preferences, impairments, medication reconciliation, cognitive function, medical conditions and mental status.

Depending on what type of setting you're in the number of assessments will range from up to three a week for a total of up to 60 assessments and I'm going to show you on the next slide how that breaks down by post-acute care setting. The beneficiaries who are selected in the data collection sample are Medicare only or duly eligible beneficiaries.

And we got a lot of questions from folks who are interested in participating that worry a little bit about privacy protected data and we want to encourage those who might be considered participating to understand that when we're asking you and your facility or your agency to collect data or when our research nurses are collecting data at your setting we're not removing any privacy protected data.

We're not taking resident names, social security numbers, any of those kinds of IDs out of the setting with us. We'll assign a unique study identifier for patients who end up being in our sample so that they cannot be identified.

On slide 21, you can see the number of target assessments per provider type and this ranges across the four types of providers and you can see the total.

So for Long-Term Care Hospitals, we're looking for about 61 total assessments, for Inpatient Rehab, 68, in Skilled Nursing Facilities a total of 48 assessments and Home Health Agencies a total of 46.

Of those totals, a subset will be gathered for that intra-rater reliability that Maria mentioned earlier. We want to see if we can have your agency or facility nurse measure those resident characteristics and medical condition the same way that our research nurse can and we compare those data afterwards to assess intra-rater reliability. So, a subset of those totals will be coded by your staff member as well as our research nurse so that we can get intra-rater reliability.

On slide 22, you can see that the data collection, Maria mentioned this already for Alpha 2, we're continuing this into the beta. Data collection is going to be completed electronically on hand health tablets that our project team supplies to you as a participating provider.

The staff will – your staff will be trained in how to use those, how to navigate around the tablet and it's not a requirement that your staff have prior experience but with a tablet it's helpful, not at all required, because we do

provide training and it's very straight-forward. And the data collection includes not only patient interviews but also medical record review items.

We get a lot of questions about well what's the time commitment, how much what do you – what if I do want to participate and I'm interested but what does that mean for my setting.

So the time commitment would be two staff members from your group would need to participate in about two days of training and we're looking – we don't tell you who those staff need to be but they should be staff that are experienced, of course, in completing patient and resident assessments.

We'll also ask for time from your staff for checking calls with us meaning with our research nurse in the very beginning when they're on site and periodic – we might do some periodic data collection by asking your staff to submit some information about how the process is going over the course of the six months data collection period.

As I mentioned earlier, you're going to see on slide 24, we will provide staff training. And these are scheduled to be held in mid-October through November 2017 to get everyone up and ready with their tablet data collection and understanding the items that they're going to collect by November and the training will be a combination of in person as well as some virtual.

So, there's going to be some modules that you can do virtually that would be on your own time and then the two-day training that we described earlier. The staff who do the training, of course, that they're doing eModules will need to have access to a computer.

So, that's another resource we would need from you and we do plan to offer nursing continuing education units for portion of the training. So, we're hoping that that's a desirable feature.

So, finally on slide 25, you can see that we have if you're interested in more information we have several resources. I will let you know that remember I said 210 providers were being recruited right now for the beta test.

We've got about 45 providers who've already signed up to join. So if you're in one of our 14 markets and you haven't yet joined there's still – we have plenty of room for you and we would urge you to participate.

We would like you to take our phone calls if you hear from us, look at our – look at the recruitment package that we sent to your facility if you're in our sample or if you're agency.

I'd would encourage you to call the 800 number which is on the slide I will read it just in case you're not looking at the slide 1-855-233-5690 or you can e-mail our e-mail address with any questions and also to express your interest and that's impactbetahighfintest@rand.org. Again, it's on slide 25. So, I would encourage you to go to that to get the right e-mail address.

What we've done with some of our providers that we've been recruiting is we scheduled special information of webinars for your – if you have a group of agencies or facilities that you might be interested in participating but what you want to know more we can schedule a conference call for your team and we can also just answer questions one on one via the 800 number. So with that, I will turn it back over to CMS.

Jill Darling: Thank you Terry and Maria. (Kim), we'll go into our Q&A please.

Operator: As reminder ladies and gentlemen if you would like to ask a question please press "star" then the number "1" on your telephone keypad. If you would like to withdraw your question press the "pound" key.

Please limit your question for one question and one follow-up to allow participants time for questions. If you require any further follow-up you may press "star 1" again to rejoin the queue. And your first question comes from the line of (Nancy Richer with Baldwin Hospital). Your line is open.

(Samantha Colby): Yes, this is (Samantha Colby). I'm a colleague of (Nancy's). I was wondering if you could comment, I know that there was some testing in the Alpha 1 beta round and in particular I know that the medication reconciliation metrics were particularly burdensome.

I was wondering if you could comment on how you have taken feedback from these previous beta runs and modify the matrix that you're asking us to complete. Thank you.

Maria Edelen: Yes, hi thanks for that question. This is Maria. So where the med – the medication reconciliation protocol was indeed very burdensome and awful long and that's the concern. We have no intention of rolling out something nationally that's taking that long.

So we – and we're iterating on this. The whole protocol is completely new and so it wasn't expected that we would get it right the first time and maybe not even the second time but in the Alpha 2 what we did was between Alpha 1 and Alpha 2 even early on, we saw that there were issues.

And so, we started, sort of, revisiting about what's being asked and how it's being asked and the protocol that we've come up with for Alpha 2 is taking less time. So, one of the things they did was break it down and focus specifically on certain high risk medication classes rather than the whole range of medications.

I'm not an expert. I'm not the person who did the work. So, I can't tell you the nitty-gritty details but it's certainly a concern and there's been some modification to try to address it. In the early returns from the Alpha 2, it looks like it's probably going to need to be a little bit more work done on that but that we've made some significant improvement.

(Samantha Colby): Thank you.

Operator: And again to ask a question please press "star" then the number "1" on your telephone keypad. Your next question comes from the line of (Yasa Angur) with Isabella Geriatrics. Your line is open.

(Yasa Angur): Hi, this is (Yasa Angur) from Isabella. I have a related question about the QRP and this is about the CMSs on the call about the SNF review and correct report, which was corrected and posted today in the key system.

And I'm wondering if providers of SNFs will get the detail on the numerator on the SNFs (placed) in the numerator so that we can really go back and crosscheck especially since it's period is now open for correction but to come through all of our especially large facilities all of our qualifying MDS books and stage is very difficult to CMS plan to give the patient detail behind these reports and also to release which we never saw yet the quarter four of 2016, which I think was the first quarter in the QRP.

Charlayne Van: Hi, this is Charlayne Van from CMS. Thank you for your question. Question on today's call is limited to the topic of the beta testing that we are not in a position to answer the question about the review on correct report.

However, please feel free to submit your question directly to our post-acute care quality initiative mailbox and that e-mail address is impactqualityinitiative@cms.hhs.gov. Thank you.

(Yasa Angur): OK, thanks.

Operator: And you're next question comes from the line of (Laura Gwab) with Innovation and Rehabilitation. Your line is open.

(Laura Gwab): Hi. Yes, thank you. This is (Laura Gwab) from Inova Rehabilitation Center in Virginia. I have a question regarding how your 14 geographic metropolitan areas for beta testing were determined.

We're an inpatient rehab facility and I noticed that your sample size is 28 rehab facilities and I'm just questioning how that would be to statistically significant given that there were many states and the union that were not included?

Maria Edelen: Yes, hi. Thanks for that question. This is Maria Edelen again from RAND. So what we did was to first draw out the markets, identify markets across the whole country and then scan them for eligibility.

The markets were identified by HHR census data. So -- and then within each market was evaluate for eligibility and part of that eligibility was that there had to be a certain number or sufficient number of facilities close enough to

the metropolitan region but still having some rural representation so that they could contribute up to 15 facilities for the testing and that left us with a sample of – I don't remember the exact number frankly but I think it was about 50 markets across the country and then from that group of 50 or so markets we randomly selected 14. So, that was a process...

(Laura Gwab): OK.

Maria Edelen: ...and yes, and then the...

(Laura Gwab): So, they were done by admissions per year or rather or not they were unit based versus standalone facilities?

Maria Edelen: Yes, so some of that is also coming into place in terms of the act but that's more sort of at the both facility level of selection not selecting the market.

(Laura Gwab): OK.

Maria Edelen: So then with the 28 eligible we decided that the minimum number of facilities that we could – that we would need to support strong validity and reliability testing was 28 and so then within – so that's why two rehab facilities per market and then...

(Laura Gwab): Right, two from Pennsylvania, two from Texas, two from California, two from Missouri, OK.

Maria Edelen: Right.

(Laura Gwab): OK, thank you.

Maria Edelen: Sure.

Operator: And your next question comes from the line of Suzanne Clark with NVNA & Hospice. Your line is open.

Suzanne Clark: Hi, this is Suzanne Clark with NVNA & Hospice. We're a home care agency in Massachusetts. And so, I'm just asking about the number of data items.

So, as a home health agency, it looks like my total number of assessments would be 46 but then I was just wondering about the number of data item for assessment in the time (inaudible).

Terry Moore: Well as Maria said, this is Terry, as Maria said we are still in Alpha 2 right where we're testing a number of data elements. So, we don't have a final, final number of data elements for you today for the beta because we're going to take all those findings and try to – try to figure out what next.

So, that was one of your questions and then you're right that for home health agency like yourself it would be a total of 46 assessments and I can tell you how those might break down over, sort of, admission and discharges if that would be helpful.

Suzanne Clark: Yes, I guess I can see that. On the slide you have like 25 and...

Terry Moore: OK.

Suzanne Clark: ...(inaudible) but I guess I'm just wondering the burden I guess of putting how much time onto ...

Terry Moore: Oh, OK.

Suzanne Clark: ...and it was two clinicians, two nurses that you would want to do these ...

Terry Moore: Yes, and it is I know I certainly hear you in terms of your agency. We are looking for two and I guess I can tell you in terms of what have we learned from Alpha how long does it take.

In the last alpha test the patient interview took about 30 minutes and the medical record review portion took about 30 or 40 minutes and our experience was that of course, as after training and after doing a few the staff got more and more efficient and experienced with the data collection.

So, it took less and less time as they went but that's at least an estimate I can give you. Again, it's a great question where we're still determining since we don't know the exact number of data elements.

It's hard to give you an exact number of minutes for each assessment but that's what I can tell you for now and I don't know whether Maria would anything to that.

Maria Edelen: Yes, thanks Terry. I can just say that we're – our goal is to keep it down so that it's about – we also don't want to burden the patient. So, the patient...

Suzanne Clark: Yes.

Maria Edelen: ...interview questions, we're trying to keep those on to half an hour and then for the chart review to not – to not be taking too much longer.

I mean it's, as Terry said, I mean we're looking really closely at what's happening in Alpha 2 and revisiting what we did in Alpha 1 and we're very aware of burden and also that just the scope of this project and that if we were – that we need to be very cognizant of what we're asking people to do and to keep it as low burden as possible.

Hopefully, we'll have more detailed information. I mean, we're going to need to have more details information soon. So, stay tuned and we'll be able to give you a little bit of better answer.

Suzanne Clark: Right, so at this point if I was going to be discussing this with my directors and everything that it would be at least an hour for (inaudible) at this point to locate (inaudible)...

Maria Edelen: Well at least a half a half hour of interview and then I'm not -- I don't know if the chart review is going to – would be a full half hour but it might add up to that...

Suzanne Clark: OK...

Maria Edelen: ...but also a reminder that the discharge assessments are among those who were admitted. It's a subset of the admission assessments. So, it's not 46 unique patients, it's actually 30 patients total.

Suzanne Clark: (Thank you) very much.

Operator: And again to ask a question please press star then the number one on your telephone keypad. Your next question comes from the line of (Troy Reece) from (SOM Healthcare). Your line is open.

(Troy Reece): Hi. You indicated that our packet (with) announced facilities, in that packet is there samples of the assessments just so we can get an idea of what it would require and possibly time?

Terry Moore: Hi, this is Terry. We did not include a sample assessment and mostly because as I've answered earlier we're still we're looking to gather the information from Alpha 2 to make final determinations about which data elements will be collected in the beta test.

So in that packet if you – if you're in one of our markets in our sample you would have gotten a factsheet about the project and for anyone who is interested in that factsheet can also be downloaded from the CMS website the Impact Act link on the CMS website.

We also had a letter from CMS in that packet as well as an agreement letter that would signed if you chose to participate. It's an agreement with the RAND Corporation about what it means to participate.

So, that's what the packet contains but it did not contain a copy of the assessments we have. I think Maria might have a better sense of this. We have been asked for that by other providers and Maria I forget whether we've been providing a copy of at least what's used in alpha or whether we're just waiting at this point on beta.

(Troy Reece): Thank you. One quick (thing, will the) packet go out to the facilities?

Terry Moore: It depends on what market you're in. We started with five markets and then sent another five markets packets last Friday. So, for 10 of our 14 the packets would have gone on – gone out at the end of May and then at the – and on the 16th of June.

(Troy Reece): San Diego market -- so San Diego market SNF?

Terry Moore: Those I believe those went out. If you...

(Troy Reece): Thank you.

Terry Moore: ...if you have questions, I would say in our – in one of our markets, it sounds like you are, you can certainly call the 800 number and we'll look you up and see if you're in the sample and if you didn't get (and you are) and you didn't get a packet, we will e-mail it to you. Love to hear from you.

Operator: And your next question comes from the line of Deb Head with Gundersen Health System, your line is open.

Deb Head: Thank you. Yes, this is Deb Head and I'm from a small unit based rehab in Wisconsin. I do appreciate the needs for standardized quality measures and agree with your comments on slide seven that talks about a small set of measures that can be common among of the different settings.

However with every year we have added quite a few number of added measures and while individually each measures may not take a significant amount of time when you add all of that together, it really can detract from individualized patient care.

And along with this as we continue to have a multiple, multiple measures and I know you had spoke about, well within -- we end up meeting to add measures from different settings.

And in some cases those measures may not be appropriate for the setting that you're in and as I said we're in ERF and we can have patients here for a short of five days and the burden just seems to be getting more and more where it seems like data collection is what's driving patient care versus the individualized patient care needs.

And in effort to standardize assessment data element you're saying that this can be used for clinical decision making that in many cases the measures are not necessarily appropriate for the patients to choose them.

And just real quickly, I'll say with the cognition items we're looking to have three additional cognition requirements added or measures that added and in a lot of cases they may not be appropriate for the patient and we end up having to something completely different when you make a measure that is a specific measure for patients but it's and it's used to go across setting.

It ends up being watered down and not actually the specific measure that's needed for that patient. Is CMS committed to take in some of the feedback from facilities with these concerned?

Maria Edelen: Yes, thanks for that question. This is Maria Edelen. I think I'm very aware of these concerns and I know that we that we've been working with these concerns in mind. I should just emphasize that the data element work is not – is not for a quality measures.

We're just working on standardize data elements. So, we're not – the measure work is it's working with different contractors. So, I don't know if you were using that term literally or not but literally we're not involved in the measures work to every end.

So, our work is just about the data elements. I think I don't know if (Shar) if you want to comment further. I don't – I feel like that's not really my – I don't feel like I can comment further except to say that we're aware of the situation.

Terry Moore: Yes, I think that's the most that we can say about it right now but if you would like to submit your question to the impact quality initiative mailbox and we can get you – we can try to get you a more specific answer.

Deb Head: Thank you. I'm just going to ask one follow-up and I appreciate that but two as we look at – looking at data elements if there can be some consideration for flexibility in applying measures across setting so that again it's not an throw the whole laundry basket in for everybody but create some flexibility so that it can be more appropriately developed for specific settings that it might be most appropriate for. So, thank you.

Operator: And your next question comes from the line of (Nancy Richard) with Baldwin Hospital. Your line is open.

(Samantha Colby): This is (Samantha Colby) again. I had a question. The gentleman asked earlier about was a copy of the new metrics included in the welcome packet and we found about a month ago that new proposed assessments had been posted to the CMS website, the new LTCHs Care Data Set and those did seem to have quite a few of the new metrics on them. Now I was wondering is this directly related to this testing project or is that a different projects?

Maria Edelen: This is Maria Edelen. I am not entirely sure what you're referring to. So those aren't -- whatever is in the new LTCHs Care Data Set is not being tested. I don't -- it wouldn't be in the -- in this beta test.

(Samantha Colby): So...

Maria Edelen: But again maybe -- yes, maybe (Shar) could say a little bit more about that.

Jill Darling: (Kim), we'll take one more question please.

Operator: And you're next question comes from the line of (Dana Moore with Wellstand Health). Your line is open.

(Becky Trumbo): Hi, this is Becky Trumbo with (Wellstand Health). We're wondering we document through the tablets, are we also required to document in our health record?

Maria Edelen: No, at this time it's just using the tablets. So, there's no submission to CMS or anything. We're just testing some data elements right now so there's...

(Becky Trumbo): OK, thank you.

Maria Edelen: ...there's no requirements.

(Becky Trumbo): Thank you.

Jill Darling: All right, Maria or Terry do you have any closing remarks?

Terry Moore: Not from me.

Maria Edelen: Yes, just thanks for your interest and if you're in the market I hope you'll consider participating. Thank you.

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

END