Centers for Medicare & Medicaid Services

Affordable Care Act, Section 3401, subsection 10322
Inpatient Psychiatric Facility Quality Reporting

Listening Session
June 2, 2011
2:00 p.m. ET

Operator: Good afternoon everyone. My name is (Sara). I'll be the conference operator today.

At this time, I'd like to welcome you all to the Inpatient Psychiatric Quality Management Listening Session. All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a comment session. If you would like to make a comment during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your comment, please press the pound key.

Thank you. Miss Cebuhar, you may begin your conference.

Barbara Cebuhar: Good afternoon everyone. My name is Barbara Cebuhar. I work in the Office of Public Engagement here at CMS. I just want to make sure folks know I am not an expert on inpatient psychiatric facilities or quality measurements but have been asked by my colleagues in the Office of Clinical Standards and Quality to help moderate this session in order to get maximum input from the advocacy community about the best way to implement quality reporting program in inpatient psychiatric facilities.

The law requires CMS to establish a Quality Reporting Program otherwise known as the Paper Reporting Program for inpatient psychiatric hospitals for fiscal year 2014 and each subsequent year. There is a 2 percent payment linked to reporting quality data for inpatient psychiatric facilities. CMS is required to publish the measures no later than October 1, 2012.

Psychiatric hospitals and psychiatric units shall submit data on quality measures in a form and manner and at a time specified by the secretary.

Measure rate data submitted will be made publicly available. In an effort to align this program with other CMS quality reporting and value-based purchasing programs, CMS aims are to include a mix of standards, process, outcomes and patient experience of care alignment across Medicare and Medicaid programs, minimize burden and seek national endorsement.

Through these listening sessions, CMS seeks input from the advocacy community. This listening session is not limited to quality measures alone. In addition, CMS is interested in learning about your experiences with public reporting, data infrastructure and storage, and protection of patient privacy. We would like to know what measures stakeholders in psychiatric community and the advocacy community have use to drive meaningful improvement in patient care.

Areas for consideration include but are not limited to clinical processes, outcomes, standards and patient experiences of care satisfaction. We also seek your feedback on the program's benefits and opportunities to improve quality and reduce cost relative to the impact of collecting data on facilities. Your thoughts and insights about the implementation of this program will be considered as part of our effort to further our public reporting program.

I just want to make sure that folks know that I included an attachment in the invitation to the forum which lists the psychiatric measures under consideration. But, just in case you don't have that in front of you, you can get off your computer at https://www.cms.gov/hospitalqualityinits/05_hospitalhighlights.asp#topofpage and you can find it under the download sessions.

CMS will be unable to answer questions during this listening session. We are requesting that there'll be one representative per organization on the call as there are a limited number of lines available. If more than one representative is interested in joining, please do so in a group and please identify yourselves by your organization when you speak. Our operator will instruct you how to access the queue so that you can get in line to provide some feedback after I read each question.

I just want to make sure that folks know that a transcript and a recording of this call will be available in approximately two weeks at www.cms.hhs.gov/center/quality.asp. You can listen to the various thoughts offered later by dialing 1-800-642-1687 up until June 6, 2011 at midnight. And you need to ask for the call number 66779237.

I'm going to go ahead and start the question. So, if you could — we appreciate your insights about the proposed quality measures. And, if you could pull those up and look at them again and give us your opinions about the measures currently under consideration that would be helpful. (Sara) do you want to tell people how to get into the queue again?

Operator: Again a reminder, if you would like to make a comment, please press star then the number one on your telephone keypads.

There is no one queuing up at this time.

Barbara Cebuhar: Do I need to repeat the location of the proposed measure? It was attached to your invitation but you can also get it at https://www.cms.gov/hospitalqualityinits/05_hospitalhighlights.asp#topofpage and it's under the download section.

So, (Sara) if you could ask people to queue up again, I'd appreciate it.

Operator: Again, if you would like to make a comment, please press star one on your telephone keypad.

The line has queued up. Karin Buscher of San Mateo Medical Center, your line is now open.

Karin Buscher: Hi. Thank you. All these indicators are good. And we're usually measuring all these except for the alcohol screening. I think we just assess for that on admittance.

But I have a comment mostly about number seven medication reconciliation. We're doing that now for everybody that comes into our psych emergency services. However, there have been problems with either inaccurate list or

rewriting the list transcription errors. So, we were just wondering if it's OK to get a printed out list from the facility the patient is coming from if they're coming from a facility and use that attached to the medication reconciliation record rather than rewriting everything again and introducing another chance for error.

Barbara Cebuhar: Karin, I don't have answers for you right now. But I do appreciate the insight into the potential for error. But I think that — and, Karin, you are with again? I'm sorry.

Karin Buscher: San Mateo Medical Center.

Barbara Cebuhar: All right. So, this is not Liz Evans. Right?

Karin Buscher: No. No. She couldn't be here today.

Barbara Cebuhar: Karin, your last name?

Karin Buscher: Buscher. I'm the nurse manager for (GES) and our acute unit.

Barbara Cebuhar: Great. Thank you very much. We really do appreciate your help.

Are there any other questions, (Sara), or comments, (Sara)?

Operator: There are no other lines queued up at this time.

Barbara Cebuhar: OK. I don't know if it would be helpful for me to read the psychiatric measures under considerations. But we have, number one, metabolic screening for patients on antipsychotics. Number two is discharged with continuing care plan and discharged with a continuing care plan communicated to the next level. Number three is alcohol screening. Number four is screening within three days of inpatient admission. Number five is hours of seclusion and hours of restraint. Number six are patients discharged with two or more antipsychotics and patients discharged with two or more antipsychotics with justification. And seven is medication reconciliation.

Any other insight? (Sara)?

Operator: No other line queued up at this time.

Barbara Cebuhar: All right. I think we have our next question which is which quality measures have been effective in driving quality improvement? Which quality measures have been effective in driving quality improvement?

(Sara), if you could ask people to queue up, I'd appreciate it.

Operator: Again, if you would like to make a comment, press star one on your telephone keypad.

There are no lines queuing up at this time.

Barbara Cebuhar: I would really appreciate insight. We are — CMS is very dependent on your insight in the advocacy community to learn more about what measures seem to make best sense. If anybody could help us here with which quality measure have been effective in driving quality improvement that would be most helpful.

(Sara), if you could ask them to queue up again please.

Operator: To queue up your lines so you can make a comment, please press star then the number one on your telephone keypad.

The line queued up from Karin Buscher of San Mateo Medical Center. Your line is now open.

Karin Buscher: OK. Thanks again. You asked about quality measures driving. Obviously, hours of seclusion and hours of restraint are always good to try to measure and lower. But one of the problems, it doesn't always get to the root of things which is how do you measure your rate of assault in comparison to other like hospitals. So, it's hard to know how well you're doing when there is no standard measure to measure yourself against.

Barbara Cebuhar: No. Rate of assault?

Karin Buscher: Yes. The rate of assault; patients to patients and patients to staff. There is no standard of care there. And it's, you know, like fall rate. There is a way to

compare per patients base. How many falls the facility should have? But we don't have any way of judging how we're doing in our assault rates and presenting assault — so — because there is no standard; National standard or statewide standard.

And, obviously, you know, different variables would have to come into play like, you know, your type of population, the people you serve and etc, etc. But still there's just no way to kind of judge where you are in the continuum there if you are at an extremely high amount or extremely low amount considering your patient base. We know within our own facility because we measure from month to month and year to year. But we don't have any way to compare that in the community or in the larger States.

Barbara Cebuhar: That's very helpful Karin. Thank you very much. Do we have any other calls queued up?

Operator: There are no other lines queued up at this time.

Barbara Cebuhar: OK. We'll move on to the next question. Which measures do you feel are meaningful to public reporting? Which measure do you feel are meaningful to public reporting?

(Sara), if you could help people queue up again please?

Operator: OK. If you would like to make a comment, press star one on your telephone keypad.

The line queued up of Alfred Chiplin from the Center for Medicare Advocacy. Your line is now open.

Alfred Chiplin: I was thinking perhaps number six and the number four. This is patients discharged with two or more antipsychotic and patients discharged with two or more antipsychotic with justification. And four is screening within three days of inpatient admission.

Barbara Cebuhar: That would be useful to public reporting?

Alfred Chiplin: I think so.

Barbara Cebuhar: Thank you. Alfred, do you have any other insights about the measures themselves?

Alfred Chiplin: No. Not at this time. Maybe I could send you something off.

Barbara Cebuhar: All right. That would be very helpful. Thank you very much.

Is there anybody else that would like to offer comment about which measures do you feel are meaningful to public reporting?

Operator: The first line queued up from Ray Bridge of Mental Health America. Your line is now open.

Ray Bridge: (Inaudible). Thank you. I'm looking at this from a patient perspective and I think that number five is certainly very important as an indicator; hours of seclusion and hours of restraint.

Barbara Cebuhar: That's very helpful. And I'm sorry. This is who again please?

Ray Bridge: This is Ray Bridge with Mental Health America. I'm sitting in for Dr. Shern.

Barbara Cebuhar: Ray Bridge.

Ray Bridge: Yes.

Barbara Cebuhar: All right. Great. Thank you very much.

Ray Bridge: You're welcome.

Barbara Cebuhar: I really appreciate your comment. Any other insights in terms of the measures themselves that are proposed?

Ray Bridge: (Inaudible) and what I'm not seeing in this group of measures are measures of patient experience and patient satisfaction.

Barbara Cebuhar: OK.

Ray Bridge: Which I think are very important.

Barbara Cebuhar: Thank you very much.

Ray Bridge: You're welcome.

Barbara Cebuhar: Any other comments.

Operator: There are no other lines queued up at this time.

Barbara Cebuhar: OK. What measures do you feel are meaningful for inclusion in the inpatient psychiatric facility quality reporting program? What measures do you feel are meaningful for inclusion in the inpatient psychiatric facility quality reporting program? And, if there are others that you have identified in the past that would be very helpful to know about, we are grateful for your insight.

(Sara), if you could tell people how to queue up again, I'd be grateful.

Operator: If you would like to queue up for comment, please press star one on your telephone keypad.

Barbara Cebuhar: And, just so people know, the public reporting is public reporting at the facility level. So, any insights about that would be very helpful.

Operator: First line queued up comes from (Katie Bess) from NACBHDD. Your line is now open.

(Katie Bess): Hi. I'm Katie Bess and I'm sitting in for Ron Manderscheid today with the National Association of County Behavioral Health and Developmental Disabilities.

And, so, I just wanted to comment on a few things that we've talked about together. And one of them is that an act that supports all these performance measures through the psychiatric hospitals. And they think that they match with the appropriate measures for the population of concern. There were two different areas that we just threw out there. And one of them was involvement in the health-related quality of life (HRQOL) measures as developed through the CDC. And then the other one was the consumer assessment of health care providers and systems (CAHPS) which is used in primary care settings to

bring a consumer point of view in quality care. So, those were just some ideas that we brought forward.

Barbara Cebuhar: (Katie), thank you very much. Any other insights into the measures that we have proposed and using them a reporting for a facility at the facility level?

(Katie Beth): No. I think that is all it, right now.

Barbara Cebuhar: Right. Great.

(Katie Beth): Thank you.

Barbara Cebuhar: Thank you very much. Any other comments.

Operator: There are no other lines queued up at this time.

Barbara Cebuhar: OK. We will move on to the next question which is how can CMS efficiently collect data from all psychiatric facilities including freestanding facilities. How can CMS efficiently collect data from all psychiatric facilities including freestanding facilities?

(Sara), if you could help people queue up again, I'd appreciate it.

Operator: Thank you. For comments, press star one on your telephone keypad.

There are no lines queuing up.

Barbara Cebuhar: This is a very quiet group today. We were hoping to get a whole lot more feedback from you all about your experience with quality measures in the psychiatric community. And I am hopeful that people might queue up to help us understand how to more effectively collect data so that it's not burdensome or problematic. If people could queue, again, it's star one. And it would be very helpful to get your insights today.

CMS is very interested in your thoughts. And we are really trying to tap into your expertise about the sessions that make sense. So, if, (Sara), you could tell people how to queue up again, I'd appreciate it.

Operator: I've got a few lines who have queued up. The first one is (Sally Wise) of Riverside County. Your line is now open.

Kim Baumgarten: Not (Sally Wise). Kim Baumgarten from Riverside County Regional Medical Center. And we were talking amongst our group here. And we feel that similar to what the Joint Commission does with their (Inaudible) common access to electronic depository of information being able to be streamlined into your — you know, to CMS I think would probably be the best in this day and age. It's really hard otherwise if you have any other way of trying to get information quickly and streamlining it.

Barbara Cebuhar: Could you please elaborate for me.

Kim Baumgarten: Well, for instance, if we're gathering, we select our quality indicators and the specific data that we're going to collect. We would have somebody in the facility, usually in our quality department, that would then be the data collectors that would then have access and, you know, submit the information to you directly. And that all other facilities would do the same.

Barbara Cebuhar: All right. So, streamline the system.

Kim Baumgarten: Yes. I mean you would have — we have — you'd give an access. You would develop — you know, you would have this developed and then give us access. And then you would be then able to identify us, you know, so you would be able to identify where the information was coming from — the data was coming from. And each other facility would be given the same access and the same data indicators. And, so, we would have like — you know, common data, like data being deposited into one program.

Barbara Cebuhar: Common database.

Kim Baumgarten: Correct.

Barbara Cebuhar: All right. And I'm sorry. Your name again pleas?

Kim Baumgarten: Kim Baumgarten. B-A-U-M-G-A-R-T-E-N.

Barbara Cebuhar: Thank you very much.

Kim Baumgarten: Sure.

Barbara Cebuhar: I appreciate it. How can CMS effectively collect data from all psychiatric facilities including freestanding facilities? Our next comment please.

Operator: Our next comment comes from Karin Buscher of San Mateo Medical Center. Your line is now open.

Lawrence Cualoping: No. I'm Lawrence Cualoping with Quality Management Department at San Mateo Medical Center.

We — I was just thinking that it's very time consuming to abstract each chart individually to send it in sort of like a core measure format. So, I was wondering if we could just use secondary data; things like — data that's already been collected for other reasons already. So, you would look at — if there was a ICD code for, you know, certain diagnosis, you could slice it by number of patient base.

And, so, you'd have data that is like more statistical and aggravated rather than very individualized. Because — I mean abstracting each chart individually takes a lot of FTEs. And maybe a more creative use of secondary data for data that's already been collected for other reasons might be the way to go forward.

Barbara Cebuhar: Lawrence, it would be really helpful if you could give us an idea of other measures that you're currently reporting so that we can get a sense of what you're already doing.

Lawrence Cualoping: Say like falls for example. It's a data that already been collected through our IT — through our incident reporting system. Like the falls per 1000 patient base might relate to psychiatry in some way. Assault, it might relate to psychiatry in some way. Assault per 1000 patient base is a proxy measure for how safe a psychiatry unit is.

If you have a psych unit that is very acute, you theoretically would have a much larger number of assault per 1000 patient base versus a psychiatric unit

that is, you know, less acute. And I think there is also case mix data. So, you could correlate case mix with number of assaults per 1000 patient base. So, a psych unit that has a high case mix of a acuity but for some reason low assault per 1000 patient base would indicate that this psych unit is actually very safe. (Inaudible) that are able to control their high acuity patients.

Barbara Cebuhar: That's very helpful. Thank you very much. Any other comments please.

Operator: There's a line queued up of Alfred Chiplin fromCenter for Medicare Advocacy. Your line is now open.

Alfred Chiplin: The one comment is just a general one that these issues about assaults and so forth raise a question of whether we need some measures that look at staffing and staff training.

Barbara Cebuhar: And how would that work?

Alfred Chiplin: I'm not sure. But it's just in my mind when I hear issues of assaults. It's in my view — I always want to look at what the staffing is in the unit and the level of training. Staffing relationship to the ratio of people.

Barbara Cebuhar: That's helpful. Thank you very much, Al. Any other comments.

Operator: There are no other lines queued up at this time.

Barbara Cebuhar: OK. Great. Thank you very much, (Sara). Our next question is what do you think are current measures in protecting the privacy and security of patient information. It's just going to be very difficult to balance the need for public reporting and the privacy and security of information on individual patients.

(Sara), could you help people queue up again please?

Operator: To queue up for comments, press star one on your telephone keypad.

The first line who queued up is Alfred Chiplin from Center for Medicare Advoacy. Your line is now open.

Alfred Chiplin: The — I guess my first comment is question. Where do you see the pitfall in patient privacy occurring?

Barbara Cebuhar: I don't know, Alfred. You could just brainstorm with me for a little about where you think the problems rest?

Alfred Chiplin: Well, I think the main thing when this has come up in other kinds of measures discussions is to make sure that you use patient identifiers that are not name specific or, you know, that kind of thing. And I think that provides a level of protection. Also, you have to be clear about what level of information is publicly reported and also providing some of ability for people to drill down if they want more in-depth information about a particular piece. But I think now it's possible to collect the key data pieces to go into your data set without — data sets without having a personally identifying element in the information.

Barbara Cebuhar: Any other obstacles or problems, Al.

Alfred Chiplin: Well, of course, there's always the issue of how you gather the data — you know, in terms of, you know, if it's being collected through a — by the patient or what proxy person is preparing the data. That's also an important piece to look. It also excuse what people report to.

So, I would be attentive — in general, there are a certain kinds of data — for example in other settings, if you're reporting on pain. If you ask a patient about pain, the report tend to mean — tend to indicate that there is more pain. If it's — if the paint measure is being recorded and reported by a staff, it's also less pain. So, you got that at times going on. So, who is the reporter?

Barbara Cebuhar: So, would you suggest that the reporter be someone that is a person on the unit itself or what would you propose?

Alfred Chiplin: Well, I think it probably needs to have maybe two reports; one from someone who's on the unit and maybe some kind of way to get some outside —

Barbara Cebuhar: Validation.

Alfred Chiplin: Validation.

Barbara Cebuhar: All right. Thank you. Do we have another comment?

Operator: The next comment comes from Karin Buscher of San Mateo Medical Center. Your line is now open.

Karin Buscher: I had — we both had a little bit of comment about the privacy and actually reporting measure. I think, when we make rules about how much information needs to be sent to the next provider, they to be very clear. Obviously, the more things that we have to pass on, the more risk of jeopardizing HIPAA. Not all of the counties and hospitals have the same electronic system so that you can just, you know, go in electronically from provider to provider and look at the record. So, a lot of stuff is still in the day and age being faxed. The more we faxed, the more we put the patients and ourselves at risk for HIPAA.

So, for number two, I just kind of would like — I'm just curious what you're thinking about the discharged with continuing care plan — kind of just be a doctor summary of, you know, this is the plan for the patient or do you want like every single treatment plan that we make during the inpatient stay to be carried forward for the patient. And I think, you know, we just kind of have to look at this. Like what is the exact, necessary information for adequate handoff to the next provider and not be adding too much to that that places a risk for HIPAA.

Lawrence Cualoping: Also, faxing is an issue. It's very difficult to fax like stacks and stacks of paper. And like this whole issue around emailing. If we could email PDFs of patient documents, that would make — I think that would make things so much easier. There's an easy way to email encrypted files that — Yes. That's just another issue that we're coming across.

Barbara Cebuhar: What would be the ideal scenario for you all that would protect privacy and security of patient information but still allow sharing of necessary information so that the care continuum is — or the continuing care plan is communicated to the next level?

Lawrence Cualoping: They have — the way we email confidential stuff is we have to set up a rather cumbersome process where the receiver has to have a password in

coming to our own email system and retrieve that document. And that's cumbersome because some people don't — some of these outside entities don't want to go through the process of setting up their own password and things like that.

If there were some sort of hub, some sort of like a federal government hub where there is this like paper faxed or safe email system, we can easily, electronically send our like a patient information. That might really help streamline emailing and move away from 1980's technology of faxing.

Barbara Cebuhar: Got it. Other issues that you all should consider are security problems in transmission and storage of electronic data. Transmission like emails, fax and couriers of paper copies of medical records to validate accuracy of electronic data and existing legal requirements protecting privacy of specific patient types, i.e., HIV patient status or other. Now, does that help elaborate a little bit more?

Lawrence Cualoping: Yes. Sure.

Barbara Cebuhar: What would you suggest?

Karin Buscher: The less faxing the better. But we need better computer. You know, we need better electronic medical record that are all connected so that — so that they can have a high level of security. Because everybody's got their own programs, their own records, and they're not all interconnected. And, so, you know, it makes reaching very easy.

Lawrence Cualoping: Are we not understanding the question?

Barbara Cebuhar: No. I think you are. I just think that what I'm trying to do is understand the very best way that we might propose. So, a hub might be a place where we can park data and use it and validate it.

Lawrence Cualoping: Or, maybe simply updating. I mean this might be beyond CMS' scope but an updating of the HIPAA law to allow email perhaps.

Barbara Cebuhar: All right. (Sara), do we have another comment?

Operator: Your next comment comes from (Sally Wise), Riverside County. Your line is now open.

Kim Baumgarten: Hi. It's Kim Baumgarten again. Sally is our great secretary who set this all up.

I just want to comment kind of on the first part of this. And we were discussing amongst our group here. And really our — the data being — the public data that will be out there — I don't personally see just with having CMS report data as a HIPAA thing. We report that without patient information. Right? So, I don't see that as an issue.

The issue that we have internally and I kind of go through quite a lot with what the people have been saying which I agree with the speaker before last that, you know, having everybody feel comfortable with and when and how to give information when we actually often times that because of the worries of the HIPAA, maybe the unclear understanding of our health care provider along the way feeling uncomfortable because there's such worries, they actually fail to give pertinent information or fail to receive information.

And then an example would be a patient goes from a psychiatric facility to the emergency department and the psychiatric department then is trying to get information maybe outside of what was returned with the patient as far as paperwork that arrive. So, they're seeking more information about the patient's status or the care that was provided. And there is hesitance from the emergency department to share that information for fear — you know, not understanding the need to know aspect of HIPAA and under the law and understanding that there is a need to know to give that psychiatrist the information or that nurse or what have you that is involved in the care of the patient.

And, so, having all of our staff — all along the way, when you talk about the whole care continuum, understanding the need to know; when can I give information, when do I not give information is a real challenge for all of us I think. And we particularly have it here.

Barbara Cebuhar: Is there a preferred way to approach this and what would be your suggestion?

Kim Baumgarten: Well, I know internally — I mean we're constantly giving education to our staff and do stepping — you know, doing case scenario-type thing. So, that is not a logistical approach nationally or what have you. So, from a CMS standpoint, I would say I think we do need to look at the law and maybe look at some of the wording. I'm not in agreement with the emailing of information. That's unsecured way of doing it. But kind of what the previous speaker was speaking to. Sometimes the law gets us kind of bundled up in a bunch of yarn and then we're afraid to stick our arms out or we can't get the knots out because it's so cumbersome to see our way through.

You know, I wish I had the answers. Maybe I would have a different job. But, at the end of the day, I know that we have challenges that are — this is one of the many challenges that HIPAA has — you know, for instance, emergency department. And I'll just kind of use this. We have an emergency treatment services for our psychiatric facility. And, even in our main ED, you have those incidents — you're discussing with a patient behind the curtain their care and the people next door and the visitors are hearing what's being said. You know, there is not an intent for anybody to hear information but they hear information.

And, so, sometimes the law sets a standard that is impossible to meet 100 percent of the time. And, so, it's just a constant awareness and challenge that we really struggle with. I think patient privacy of information is of the extreme importance. And, so, I think the intent of the law is very valuable. But I think — I think we need to look at what is our intent and what are we getting. Because I don't think the intent of the law is being captured at the end point because of those — of the problems that are infused with just the standard itself.

It's really hard for the health care providers to provide. And, of course, we, in leadership, are just constantly pounding it, you know, to our staff. Not literally. But, you know, saying, "Hey." You got — you have this constant situational awareness of patient privacy and their information. And, so, staff then becomes somewhat paranoid and, you know, like no way to give the information whenever the appropriate time to give it because they're so

worried that they're going to breach out HIPAA. And it's become a huge issue with I think all health care — large topic amongst my colleagues. And it's something that we're talking about every day actually.

Barbara Cebuhar: Kim, that's very helpful. Thank you. Any other insights about transmission and storage of electronic data and the best way to share information.

Operator: There another line on queue and that's from Alfred Chiplin from the Center for Medicare Advoacy. Your line is now open.

Alfred Chiplin: My comment goes back a few turns in the conversation. One is I think privacy should be privacy. And what I mean by that is that we should necessarily have — you know, I think we've never come up about a person with HIV or AIDS and privacy around that. We should really consider whether the same level of privacy should apply across the board in discussions. I don't know the real answer to that. But I am concern that we look at that.

Barbara Cebuhar: How might that work? If you can just elaborate a little bit for me about what would it look like?

Alfred Chiplin: I think if we have a privacy standard, it should apply to that patient in total. Not just certain elements of the person's medical record or types of services.

Barbara Cebuhar: Then how would we share data with the psychiatrist or other people who need to know who might be in the next step of care.

Alfred Chiplin: Well, that's why I think more training needs to be done around what really HIPAA says to really clarify what is permissible under HIPAA and its application to the electronic transmission of medical information as opposed to oral transmissions —

Barbara Cebuhar: All right.

Alfred Chiplin: And the like. So, I think those clarifications needs to be explored. And, of course, you want adequate information given to the people who will be treating the person next. I have no — that, you know, is something that is

very, very important. But I do wonder about the reasonableness of having levels of privacy depending on the type of information it is.

Barbara Cebuhar: Thank you, Alfred. Do we have another comment?

Operator: There are no other comments queued up at this time.

Barbara Cebuhar: OK. Our next line of inquiry is about public reporting. How often do you visit the data website such as Hospital Compare or the CMS website? How often do you visit the data website such as Hospital Compare or the CMS website? And how do you use it?

If you could, (Sara), instruct people how to queue up again please.

Operator: To queue up for comment, press star one on your telephone keypad.

There are no lines queuing up at this time.

Barbara Cebuhar: All right. What I'm trying to get to is understanding how you all might use existing data set that CMS is currently working on and how often or if you use it at all and why not. If you could please queue up by hitting star one and letting me know, that would be very helpful.

Operator: First line queued up is (Sally Wise) of Riverside County. Your line is now open.

Kim Baumgarten: Hi. It's Kim Baumgarten again. And we use — just to answer your question and I'm sure the other hospitals do this. We compare under HCAPS. We look at that — I look at that weekly to see where we're at and at least quarterly I would think most hospitals look at it. But I usually am going back and checking on different measures. It kind of let us know how to benchmark: What are other like facilities, where are they at on different things.

And I'll just use the example of — we were happy to be number one for quite some time on pain managements at our hospital. And, so, that was something that we actually looked at very closely and wanted to know, really kind of look at what are we doing right, what are we doing wrong, how can we

improve. If we look at local hospitals, where do we stand compared to the other — for instance in our case as an academic teaching facility trauma center, where do we stand in comparison to the others. And it gives us goals. And I know there's a lot of hospitals that run in competition. So, it really kind of sets the standard and helps us know where we're at. And, so, it's very valuable from that angle.

Barbara Cebuhar: That's very helpful, Kim. Thank you. Any other insights from the commenters please.

Operator: The next line queued up is Alfred Chiplin fromthe Center for Medicare Advocacy. Your line is now open.

Alfred Chiplin: We use Hospital Compare and the other services regularly. And we try to refer families and patients to them when they're making decisions about facilities and different kinds of treatment and services. We think it's a useful tool. I like that you can drill down for more in-depth information about specific things. The one thing is to continue to look at ways on how to make the data reliable and verifiable. But I think it's a good system on the whole.

Barbara Cebuhar: How else do you use the data on the website?

Alfred Chiplin: You mean Hospital Compare?

Barbara Cebuhar: Or any of the other CMS data sets.

Alfred Chiplin: Oh, well, we look at everything from a PO to — we use — we use the site quite a lot. It's a very important resource. You know, we always grumble about we'd like to have it more user friendly. But we use the site a lot. And there are all kinds of research issues, trying to figure out how to pull together informational pieces about a particular service or access to service. So, we use it quite a bit especially the Nursing Home Compare. We use that a lot with families who are trying to figure out what nursing homes in their communities might meet their needs.

Barbara Cebuhar: Thank you very much. Do we have any other comments, (Sara)?

Operator: There are no other comments queued up at this time.

Barbara Cebuhar: All right. How do you use or how would you propose to use data on the website that might deal with psychiatric facilities? If you all could let me know, that would be very helpful.

(Sara)?

Operator: Alfred Chiplin is queued back up from the Center for Medicare Advocacy. Your line is now open.

Alfred Chiplin: One of the things that I run into a lot as I work with — and I'm a part of the National Academy of Elder Law Attorneys. And we often run into people who are trying to figure out psychiatric facilities for their clients. And they use Hospital Compare and other resources to do that. So, that kind of try and define facilities and services that match particular conditions of patients and clients with a key piece.

Barbara Cebuhar: Thank you very, Al. Any other comments.

Operator: No other comments queued up at this time.

Barbara Cebuhar: OK. Our next question is what should be publicly reported in addition to quality measures. What should be publicly reported in addition to the quality measures?

(Sara), if you could help people queue up again please.

Operator: To queue up for comment, press star one on your telephone keypad.

There are no lines queuing up at this time.

Barbara Cebuhar: What I'm trying to understand is what other information do you think should be publicly shared about inpatient psychiatric facilities. If you could press star one and let me know what you think would be useful for public reporting, that would be very helpful.

Operator: First line queued up is (Sally Wise) for Riverside Country. Your line is now open.

Kim Baumgarten: Hi. It's Kim Baumgarten again. You know, I would like to just say — somebody mentioned it before — patient experience. I think that's a really good thing to look at, you know, as a compare, as a benchmark. And I think also things such as length of stay. You've already got the return — you know, readmissions within three days. Those kinds of things that — I think so that there could be valuable data one hospital to look at the other of, you know, how are we doing — you know, and we really don't have those things to benchmark against.

I mean we have some loose standards that we look at as we do our own investigation with fellow hospitals and psychiatric facilities but I don't think there's — I think it would be nice to have it come from this angle and really have a benchmark that we can all look to kind of compare ourselves against and set higher standards, quite frankly, within the group.

Barbara Cebuhar: Kim, that's most helpful. Thank you very much. Do we have any other comments?

Operator: The next comment comes from Karin Buscher of San Mateo Medical Center. Your line is now open.

Karin Buscher: I agree also that the patient experience needs to be publicly reported and further defined. The idea about recidivism I think if there's also an obligation for services in the outpatient area that takes the patient and provide housing, I think there should be a way to measure, you know, how often you discharge a patient to actual place; a board and care with an actual appointment. How does that affect recidivism rate versus hospital that, you know, don't really make sure has a place to live when they leave because that affects your length of stay too and how hard you try them a place to live when they leave.

So, I'm fine with measuring length of stay with recidivism but I'd like to know, you know, where is that patient going and how did they fair afterwards. Because I think that's a more — that's a better outcome for the patient.

Barbara Cebuhar: Thank you, Kim.

Kim Baumgarten: I think that's really what we're after.

Barbara Cebuhar: I appreciate it. Some other items that might be included that include for public reporting purposes would include cost per patient, patient volume by diagnosis, serving and certification status, and freestanding versus hospital psychiatric department — other things that would be useful to be reported.

If you could hit star one and let me know, I will be grateful.

Operator: First line queued up from Ray Bridge, Mental Health America. Your line is now open.

Ray Bridge: My question was and you may have mentioned this because you mentioned certification status.

Barbara Cebuhar: Right.

Ray Bridge: OK. Yes. I think that's — that is very important because I know on a public hospital system — I assume this would cover public psychiatric hospitals as well as private.

Barbara Cebuhar: Yes. It would.

Ray Bridge: It would. Sometimes when staffing rates fall, hospitals are decertified by federal agencies. So, that is a very important thing to know.

Barbara Cebuhar: What about the cost per patient, patient volume by diagnosis, and differentiated between freestanding and hospital psychiatric department? Are those issues that would be most useful to know about?

Ray Bridge: Absolutely. That would be very helpful.

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

Operator: The next comment comes from Karin Buscher, San Mateo Medical Center. Your line is now open.

Karin Buscher: Hi. Thanks. Regarding the freestanding versus the acute, if you're going to compare, it would be nice to have some comparison rates on the staffing ratios and the medical. You know, how many — how often the doctor is there and is it 24/7 or not, you know, who's providing the care.

I think especially, if you're going to put cost per patient in there, you have to add those considerations in there and possibly compare them to, you know, some of the quality outcomes or seclusion restraint rates or assault rates if you would measure those. And, so, I just think if — it can't just be about cost.

Barbara Cebuhar: Thank you, Karin. I appreciate it. Any other comments?

Operator: The next comment comes from the line of (Sally Wise), Riverside County. Your line is now open.

Kim Baumgarten: Hi. It's Kim Baumgarten again. We were discussing amongst us. I'm not sure if you mentioned in your first comments about demographics, in other words, the patient population, financial status, or, you know, where they stand in the community, or, you know, as we compare different sites. Somebody had mentioned staffing which I — we would be very interested in as well.

We discussed the voluntary versus involuntary admissions would be helpful. It's something that we would like to know. And, also, dual diagnosis I think would be a good thing to be looking at that will cover psychiatric populations.

Barbara Cebuhar: Thank you, Kim. I appreciate it. Any other comments.

Operator: No other comments queued up at this time.

Barbara Cebuhar: OK. Our second to the last question is do you have concerns or considerations that you would like to share with CMS regarding the implementation of psychiatric hospital quality reporting programs. Do you have concerns or considerations that you would like to share with CMS regarding the implementation of psychiatric hospital quality reporting programs?

Star one if you have a comment and I would appreciate your insights.

Operator: Again, if you would like to queue up for a comment, that's star one on your telephone keypad.

There are no lines queuing up at this time.

Barbara Cebuhar: I think that we have an opportunity to talk to the regulators about situations that would make sense in terms of public reporting, data infrastructure, and quality measurements for the psychiatric inpatient or freestanding communities. I am interested in hearing what else you might have to share with CMS, any thoughts about how this should be implemented and best case scenarios would be great to understand.

So, if you could hit star one, I would appreciate it. Thank you.

Operator: First line queued up is from (Sally Wise) of the Riverside County. Your line is now open.

Kim Baumgarten: Hi. You know, we're talking here. And I think I heard from one of the previous speakers that there is always a large concern with the resource — the amount of resources it takes to accomplish all these data collection and so forth when you don't have sophisticated electronic systems to be able to do a lot — catch a lot of these data easily.

But I can say, in our facility, things that are in line with what is already being collected. And that really is the first — let's see. It's from two to seven. These are already suggested by the Joint Commission. And, so, we're already collecting a lot of that data. So, I think streamlining the data collection should not have extra inclusions in it that would require us to go back to the drawing board and then rethink how we're collecting the data. You know, because we're already — we're already collecting data already for the regulatory body.

I don't know if I'm making sense because —

Barbara Cebuhar: No. You are, Kim.

Kim Baumgarten: Because it really makes it — it really is labor intensive. And, like I say, a lot of these — we recognize the importance of the data collection that helps us

and helps other entities as well. And we appreciate the data that other entities are collecting that we can benchmark. And, so, I see it as a win/win but sometimes, when it becomes so daunting and so intricate, it becomes a daunting task for facilities to really keep up with and to meet the mandates.

And, so, that's the one worry I would have. And cost — I think CMS I would hope is looking at — are having an understanding of the cost to individual facilities that these activities really cost. And is ultimately to health care cost at the end of the day.

Barbara Cebuhar: Thank you, Kim. I appreciate your insight. Lawrence, did you have anything to add?

I'm sorry. Our next comment please.

Operator: There are no other comments queued up at this time.

Barbara Cebuhar: Nobody has any other insights to add to the idea of which quality measures — by the way, medication reconciliation is a concept for future measure consideration. It is not a JACHO measure that has been proposed and that has already been reported. So, any other insights.

Star one if you have a comment or would like to share your perspective with the office of clinical standards and quality that would be very helpful.

Operator: There is a comment queued up from Ray Bridge, Mental Health America. Your line is now open.

Ray Bridge: Yes. I'm going to return from a naïve perspective. But, looking at those quality indicators as a consumer, it doesn't — it doesn't give me a lot to go on in terms of knowing how significant those are and how — whether I'm going to get a good quality hospital which depends on a number of things. I think also that I know that the government has involved — in past years, has involved the consumer community in defining quality measures, getting a lot of consumer input on what are quality measures of care particularly outpatient treatment not in inpatient treatment that I am aware of.

So, I think this a wonderful opportunity to really think all that through with a lot of consumer input. And that's a chore I realize. And what — what really makes for a satisfactory inpatient experience and what are measurable outcomes in terms of — because we haven't really talked about outcomes.

Barbara Cebuhar: If you could elaborate a little bit more, Ray, I would be grateful about outcomes.

Ray Bridge: I am — you know, I'm thinking many years ago we had a daughter who went through a quite a series of hospitalizations. And there were without — and it took years to find answers. So, I think — I think there are some patients who get help in the course of the hospitalizations and some for who outcomes are measured in a long period of time. So, I'm not quite sure how to measure those.

I mean I think there are negative outcomes. There are deaths at hospitals. Our daughter was suicidal and we couldn't get anyone to listen. And she tried to kill herself. So, there are — you know, there are very negative outcomes. And I'm not sure in terms of resolving the problems that people come in for exactly what constitute good concrete outcomes for inpatient hospitalization. So, I'm raising the question without knowing the answer.

Barbara Cebuhar: All right. I'm grateful for the insight. And any best case scenarios that you can offer would be very useful.

Ray Bridge: I think that in public hospitals there has been such a long history and care of custodial and care that involves a lot of coercion and little patient input. And I'm — the question is how one gets at care of a person where there is room for input from the person and from their family that informs the decisions that are made and helps the person move on after the hospitalization — helps them have some insight into their own condition. And I'm — again, these are needs that people have.

I think, you know, in rating the many hospitals that I've been inside of, I think the degree of listening to the patient and the degree of communicating and the degree of access to doctors in trying to communicate from the family or the patient's perspective, often times, they have very important information what

has worked for them in the past, what doesn't work, and what their preferences are. Sometimes, those are listened to and sometimes not. In which case, it becomes a very frustrating experience and there may not be — they maybe reinventing the wheel when it need not happen.

Barbara Cebuhar: So, the patient experience of care or maybe even family experience of care would be useful to have measured.

Ray Bridge: Yes. Very much so.

Barbara Cebuhar: All right. (Sara), do you have any other comments?

Operator: The next comment queued up is Karin Buscher of San Mateo Medical Center. Your line is now open.

Lawrence Cualoping: We would like to echo the outcomes measure to — I think that's simply something that we really need to focus on. We are thinking of things — more concrete things like the goal of psychiatry is really to make patients high functioning enough to function without psychiatric care. So, maybe in the vein as like cancer survival, what is the five-year survival rate, or what is the five-year rate of patient who make, you know, $20,000 per year, or what is the five-year rate of patients who make 40,000, or what is the five-year rate of patients who make above the —

Karin Buscher: Poverty level.

Lawrence Cualoping: Federal poverty level. Right. So, outcome measures like that or 20-year survival rate or 20-year $40,000 annual income rates — things like that might be really interesting to see but also probably extremely difficult to collect as well unless you can cross reference the IRS or something like that.

Barbara Cebuhar: That's very helpful, Lawrence. Thank you.

Operator: The next comment queued up comes from the line of (Sally Wise), Riverside County. Your line is now open.

Dr. Patel: Hi. This is Dr. Patel. I'm just making comments on comment previous to the last one. They comment about the coercion of treatment in public setting and

I challenge that that's not true. Actually, in public, there is more scrutiny by the patient right and other entities than the private psychiatric hospital. So, there's little coercion for the treatment.

Regarding the outcome measure, I think the real outcome would be preventing the re-hospitalization on 30 days or a year if you can collect the data about how many patients who did not get back with the chronic emphasis on mental illness. That would be a real outcome measure for the hospital setting. But that also includes the how good the outpatient services that are available. Because, a lot of times especially in the last year or so, we have more re-hospitalization because the patient did not have any services outside the hospital.

Barbara Cebuhar: That's very helpful, Dr. Patel. Any other insights that you would like CMS to know and understand as we look at this whole issue of measurement, public reporting, and program and data infrastructure.

Kim Baumgarten: Is that question for Dr. Patel specifically?

Barbara Cebuhar: It is. I just — I —

Kim Baumgarten: We were thinking that it was a general question. So —

Barbara Cebuhar: It's a general question but if you could — Dr. Patel, if you have some insights about what can be publicly reported and what is useful for CMS to understand about how we should look at this whole issue of quality measurements.

Dr. Patel: I think what the public thinks would be more important is the patient satisfaction or patient experience. That would tell the other patients or general public how good care the patient get or at least how satisfactory care they get.

The other measurement more important for the — including the quality that are the hospital do or participating hospitals but for the public I think it is more important. The other factor would be the re-hospitalization rate especially within shorter period of time because that shows that the patient did not get well before they were discharged. Those are the two important measures that the public might be interested in.

Barbara Cebuhar: Thank you very, Dr. Patel. Do we have anybody else on the queue for comments, (Sara)?

Operator: The next comment comes from Alfred Chiplin,the Center for Medicare Advocacy. Your line is now open.

Alfred Chiplin: My comment is to ask you all to think about the measures that look at the conditions of confinement in the facility both public and private.

Barbara Cebuhar: Could you elaborate just a little bit, Alfred? That would be very helpful.

Alfred Chiplin: For example, how much space people have, single room, double room, the cleanliness, the food, access to recreation, other services, etc.

Barbara Cebuhar: OK. That's very helpful. Thank you. (Sara), any other comments in the queue?

Operator: There are no other comments queued up at this time.

Barbara Cebuhar: OK. Great. We are very grateful for your insights and hope this session has provided an opportunity to further illustrate what the advocacy community has done thus far to increase the quality of care received by psychiatric patients. Remember that you will be able to review the transcript of this call and listen to an MP3 file by going to www.cms.hhs.gov/center/quality.asp after about two weeks.

If you know someone who wasn't able to make a call, they can listen to it until midnight on June 6 by calling 1-800-642-1687 and asking for call number 66779237. You can also provide insights and ideas about the measures, or data reporting, or data infrastructure, or anything that you all think would be useful for CMS to know and understand as we tackle this task. You can send information to the following email addresses: barbara.choo@cms.hhs.gov or james.poyer@cms.hhs.gov.

And, if we could get your comments by June 30, 2011 by close of business, that would be very helpful. We are very grateful for everybody's insights and ideas and would appreciate receiving them by June 30th if you have additional

written comments. Thank you again for your time and thoughts. We can now disconnect.

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

END