Centers for Medicare & Medicaid Services

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

Listening Session
June 8, 2011
2:00 p.m. ET

Operator: Good afternoon. My name is (Sheila) and I will be your conference operator today. At this time, I would like to welcome everyone to the Inpatient Psychiatric Facility Quality Reporting, Programming, Listening Session Conference Call.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be an opportunity for comments. 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 comments, please press the pound key.

I would like to now turn the call over to Ms. Barbara Cebuhar. You may begin your conference.

Barbara Cebuhar: Thank you, (Sheila). Good afternoon. My name is Barbara Cebuhar and I work in the Office of Public Engagements here at the Centers for Medicare and Medicaid Services.

I just want folks to know that I am not an expert on inpatient psychiatric facilities or quality measurement, 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 industry about the best way to implement quality reporting programs in the inpatient psychiatric facility.

The law requires CMS to establish a quality reporting program, otherwise known at the Pay for Reporting Program for inpatient psychiatric hospitals for fiscal year 2014 and each subsequent year. There is a 2 percent payment link

to reporting quality data for inpatient psychiatric facilities. CMS is required to publish the measures no later than October the 1st, 2012. Psychiatric hospitals and psychiatric units shall submit data on quality measures in "a form and a manner and 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 program, 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 endorsements.

Through these listening sessions, CMS seeks input from the psychiatric community about the implementation of this program. This listening session is not limited to quality measures.

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 the psychiatric community have used to drive meaningful improvements in patient care. Areas for consideration include, but are not limited to clinical processes, outcomes, standards, and patient's experience of care or satisfaction. We also seek your feedback on the program benefits and opportunities to improve quality and reduce cost relative to the impact of collecting data on facilities. We value your thoughts and insights about the implementation of this program.

I just want to make sure that folks know that we attached a copy of some proposed measures, and I hope you have that in front of you because we are going to be referring to that often, but just in case you don't have it, you can get it by logging in to your computer at https://www.cms.gov/hospitalqualityinits/05_hospitalhighlights.asp#topofpage. We would appreciate your checking the Website for those measures currently under consideration by CMS.

We will be unable to answer questions during the listening session. So, if more than one representative is participating on the call, we would appreciate

your identifying yourself and your organization when I start asking questions. 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 questions, a copy of which was attached to your invitation letter.

Just so folks know a transcript and a recording of this call will be available in approximately two weeks at www.cms.hhs.gov/center/quality.asp. We will also have an Encore recording of this call that folks will have access to.

The questions to be addressed include, and this is where I would really appreciate your feedback, there were seven proposed measures on the list attached to your invitation, please provide your opinions about the measures currently under consideration. For hospital-based facilities reporting these data, please provide your opinions about these measures and their applicability to your quality improvement efforts. Also please provide your opinion about measurement and data collection, abstraction issues about these measures.

For freestanding facilities, please also provide your opinion about these measures and their applicability to your quality improvement effort. Are these measures applicable to your freestanding facility? Do you anticipate burden issues from the chart abstracted measures from a sample of patient stays each calendar year?

(Sheila), if you could tell people how to get into the queue to help give us a response, I'd be grateful.

Operator: At this time, I would like to remind everyone, in order to make a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the comment roster.

And your first comment comes from Gina Sharp from Linden Oaks. Your line is now open.

Gina Sharp: Hi. Yes, we were wondering, and I apologize, if you could repeat the website where the different initiatives are located. We were typing it in, but it showed an off page.

Barbara Cebuhar: OK. It's https://www.cms.gov/hospitalqualityinits/05_hospitalhighlights.asp.

Our next question, please.

Operator: Your next comment comes Lisa Shea from Butler Hospital. Your line is now open.

Lisa Shea: Thank you. We are a freestanding psychiatric hospital in Rhode Island and we have been participating over the last several years in the HBIPS project through the Joint Commission, and we were one of the original hospitals to be piloting that. So, we have developed our interim structure around that and we do find that those measures and several of the measures that are on the list, five of them, are helpful.

And I guess our thoughts would be that consistency in measurements from different regulatory bodies would be quite helpful to reduce burden and to actually build a meaningful database that could be compared across the country. And that it would be important that, however, the methodology of measuring these things would be consistent. That's our comment.

Barbara Cebuhar: Thank you, Ms. Shea. Our next comment, please.

Operator: Again, if you'd like to make a comment, please press star one on your telephone keypad. Your next comment comes from the line of Tom Dodd from Acadia Healthcare. Your line is now open.

Tom Dodd: Hi. It's Tom Dodd. My comments are real consistent with Lisa's in terms of making sure that we don't overburden the facilities on having multiple sets of criteria or abstracts that we have to pull from the patient records, and that CMS be consistent with Joint Commission.

Barbara Cebuhar: Thank you very much, Mr. Dodd. Our next comment?

Operator: There are no more comments at this time.

Barbara Cebuhar: OK. Now, is everybody able to get access to the list? I did attach it to your invitation, and if not, once again, it's https://www.cms.gov/hospitalsqualityinits/05_hospitalhighlights.asp.

Our next question is, overall, which measures do you feel are meaningful for inclusion in the inpatient psychiatric facility quality reporting program? Which measures do you feel are meaningful for inclusion in the inpatient psychiatric facility quality reporting program?

(Sheila), if you could tell people how to queue up, I'd appreciate it.

Operator: Just a reminder, to make a comment, please press star one on your telephone keypad. We'll pause for just a moment to compile the comment roster.

And your first comment comes from the line of David Markley from Warren State Hospital. Your line is now open.

David Markley: Hi. Yes, I was looking over the list of proposed measures, and again we are part of the HBIPS as well, that we report for Joint Commission. A lot of these are similar, as they mentioned earlier, and all of them are valuable, we report on all of them. But the thing that I thought was interesting is the medication reconciliation that you're referencing. That's actually one of the national patient safety goals under the Joint Commission as well. So, we do collect information on that.

I guess my question when it comes to the value of it is, if we have an outrider, one of the issues we have, we're a freestanding facility, but when patients have maxed out their acute inpatient stay, they're sent to us under a (court order three of four) for their long-term hospitalization, and a lot of them coming with multiple psychotropics and then are subsequently discharged with multiple psychotropics, and definitely costs us to be an outrider when it comes to HBIPS because of the multiple anti-psychotics. And I'm wondering how that would be addressed.

And I know if I can truly look to – to really talk intelligently about it, I'm kind of wondering what, you know, is that going to affect the hospital with CMS? It doesn't have any real bearing with Joint Commission at this point, although

they're aware of it, they haven't dinged us for it, but we're – I'm kind of wondering if CMS (inaudible).

Barbara Cebuhar: Mr. Markley, I don't have an answer to you, but I really will tell you all at the end of this call how you can provide feedback to us, so that if you do have a question we'll try and answer it. But we can't on this call. So, I do appreciate your interest.

The next comment, please.

Operator: Just a reminder, participants, to make a comment, please press star one on your telephone keypad. Your next comment comes from Peggy Perry from the Texas Department. Your line is now open.

Peggy Perry: Yes, hello. We'd just like to support the comments made by some of the others folks. We also participate in the Joint Commission's NRI, HBIPS program. And we don't have any problem with any of these indicators, we just would like to, if at all possible, maintain the same standard definitions, so that we don't have to do duplicate reporting.

And we also are concerned as we struggle with outcome measures, and maybe this is an opportunity to look at that also. Thank you.

Barbara Cebuhar: Thank you, Ms. Perry. Any other comments?

Operator: Yes, we do. We have a comment from Johan Smith from Horizon Health. Your line is now open.

Johan Smith: Thank you. I just wanted to make a couple of comments about having some more definition around metabolic screening measure and the medication reconciliation measure. I know you mentioned that folks will be able to ask more questions via website, so that would be great.

And we'd also echo the last comment in terms of looking for additional measures around clinical improvement as well as these process measures.

Barbara Cebuhar: I'm sorry, this is not Johan Smith. Your name, sir, please, and your organization?

Johan Smith: Johan Smith.

Barbara Cebuhar: I'm sorry.

Johan Smith: It's Johan Smith.

Barbara Cebuhar: Johan Smith. Sorry. Thank you.

Operator: There are no further comments at this time.

Barbara Cebuhar: OK. Our next question is, what lessons have you learned from your quality measurements and improvement efforts that may be useful to CMS as we begin to implement our program? What lessons have you learned from your quality measurements and improvement efforts that may be useful to CMS as we begin to implement this program?

(Joan), I'm sorry. (Sheila), could you tell people how to queue up, please?

Operator: Just a reminder, participants, please press star one on your telephone keypad to make a comment. Your first comment comes from the line of Frank Ghinassi from University of Pittsburgh. Your line is now open.

Frank Ghinassi: Hi, thanks. You know with respect to the lessons learned, we too are one of the hospitals that were involved in the pilot of the Joint Commission measures and also have been involved in the HBIPS ongoing effort. And I guess in terms of lessons learned, a couple of things.

One is on an optimistic note, and that is that positive changes have been evident at our facility both during the pilot and since then as the definitions have become more formalized from the commission that in fact behaviors have changed, rates are improving, and that we believe the quality of the care has been positively impacted by taking part in this benchmarking initiative. So, we're very optimistic that that's going to continue.

The second one is more of a structure lesson learned, and I would love to ask that CMS to think about this, the usefulness of these exercises as they relate to

the ability to benchmark against one another, and I believe that one of the goals of CMS is to allow for meaningful benchmarking opportunities.

So, I think it's going to be critical that there is sufficient identification of the characteristics of the reporting sites, and by characteristics I mean such things as the size of the institution, whether or not it's in a rural or an urban setting, whether or not it's a primary community-based facility or a tertiary, more specialty based community, and also differences around the diagnostic constitution around symptom acuity, whether they're longer term state facilities versus very acute short term, all of the kinds of characteristics which would distinguish different patient populations, that there are attempts made to allow organizations to benchmark as much as possible against the like institutions, otherwise the benchmarking procedure I think loses a lot of potential positive and very, very positive in terms of quality impact that it might have.

So, those are some of the lessons learned at least so far from our facility. Thanks for the opportunity.

Barbara Cebuhar: Thank you, Frank. Our next comment, please.

Operator: Comes from the line of Lisa Shea from Butler Hospital. Your line is now open.

Lisa Shea: Yes. Thank you very much. I also would echo what Mr. Ghinassi, Dr. Ghinassi said. But one thing too that we've learned is that it's very important to have validation, ongoing validation, of how people are interpreting the measures, to make sure that institutions are collecting and understanding the data and the data that needs to be submitted in a consistent way.

And as we were participating in the pilot, that there was independent validation study done throughout to make sure that the data that we were giving was the right and accurate way of getting the data. Thank you.

Barbara Cebuhar: Thank you, Ms. Shea.

Operator: Your next comment?

Barbara Cebuhar: Yes, thank you.

Operator: You're welcome, comes from Gina Sharp from Linden Oaks. Your line is now open.

Beth Jelesky: Yes, hi. This is actually Beth Jelesky sitting with Gina Sharp, and I appreciate all this information because we were not able to participate in any of the ongoing demonstrations and the early on work that we were in discussions with colleagues.

I guess in terms of consistency in measures, I think what Lisa said is very important in terms of collection of data and being sure that the standards are held across. Validation is important. But we are finding now with our HBIPS issues really have to do with more of the technical side and how the interfaces actually occur between electronic records and vendors. And some of those issues should be able to be worked out, but I just have this vision of, if we're going to get to a national database exchange, what that's going to look like, and are we sure that it can be done in a smooth and easy fashion? So, that would be my comment.

Barbara Cebuhar: Thank you, Ms. Sharp. Our next comment?

Operator: Just a reminder, to make a comment, please press star one on your telephone keypad. Your next comment comes from Deborah Weidner from Natchaug Hospital. Your line is now open.

Deborah Weidner: Thank you. This is Deborah Weidner from Natchaug Hospital.

A couple of lessons, these things were just touched on, we do have an electronic medical record, and as far as lessons, the pieces of HBIPS that we can control electronically have allowed us to have very high success rates. So, that clearly is helpful to be able to build things right into your record that allow you to be compliant with some of these areas.

I also support the comments about making sure that we're comparing similar organizations to each other. For example, the HBIPS-4 about discharging

patients on two or more anti-psychotics, when you're in acute care hospital and community providers are sending inpatients on multiple anti-psychotics and the length of stay is seven days or less, there needs to be some consideration about that. And that would just be one example of comparing different organizations to each other.

Another lesson/request would be that when we report out our data on a monthly basis, the pilot project returns the data to us in a fairly reasonable timeframe. However, we don't get the Joint Commission data back for six months. So, in order for us to do real-time improvement in benchmarking, we would appreciate having turnaround time on that data as quickly as possible.

Barbara Cebuhar: Thank you, Ms. Weidner. Our next comment, please.

Operator: There are no further comments at this time.

Barbara Cebuhar: OK. The next area of questioning is about payment. The Affordable Care Act Section 10322 mandates that the inpatient psychiatric facilities not reporting quality data in a form and manner as prescribed by the Secretary of HHS may be subject to an annual reduction of 2 percent of applicable Medicare inpatient psychiatric facility payments. Given this potential 2 percent annual impact on Medicare payment, would your program participate in a quality reporting program?

If, (Sheila), you could tell people how to queue up again, I'd appreciate it, their feedback.

Operator: Just a reminder, to make a comment, please press star one on your telephone keypad. We'll pause for just a moment to compile the comment roster.

Again, to make a comment, please press star one. Your first comment comes from Peggy Perry from the Texas Department. Your line is now open.

Peggy Perry: Yes, thank you. Well, first of all, we certainly will participate because we need every nickel that we can earn (inaudible) keeping up with Texas, but we're struggling.

I guess the other comment we had is we wish your system to have a caret, so be so punitive, like you could earn some additional benefit if you participate, rather than be penalized if you don't participate, but I'm sure that's not possible.

But anyway, we feel like we already are participating in this type of program now and we, as I think the person from Pennsylvania mentioned we found it to be a benefit, so we certainly would want to participate, and we'll participate, if it's required.

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

Operator: Comes from the line of Dr. Ghinassi from the University of Pittsburgh. Your line is now open.

Frank Ghinassi: Thank you. Yes. We too fully intend to participate and look forward to this opportunity. Thanks.

Barbara Cebuhar: Right. Next comment, please. Thank you, Dr. Ghinassi.

Operator: Comes from the line of Lisa Shea from the Butler Hospital. Your line is now open.

Lisa Shea: Yes. Butler Hospital also would intend to participate, but I agree anything that can also be positively incentivized would be greatly appreciated.

Barbara Cebuhar: Thank you, Ms. Shea.

Operator: Your next comment?

Barbara Cebuhar: Yes.

Operator: Comes from David Markley from Warren State Hospital. Your line is now open.

David Markley, your line is now open.

David Markley: Yes, I'm here, I'm sorry. Speaking for our facility, I believe that we will be interested in participating. We are kind of a CMS facility as well because we're under the state mental health system. So, I believe that we'd be participating.

The interesting thing, and the Texas mentioned a caret, one of the things that we're looking at here, and I don't know if this would rise the level of a caret for you folks, our current HBIPS has come through NRI and we actually pay for that service, and I'm assuming that with CMS this would not be a service that we need to pay for. Instead it almost looks like we're going to be getting some kind of, you know, reinforcement for actually participating in it. And so, you know maybe saving that $600 a year or whatever it is is enough for the caret, I'm not sure, right.

Barbara Cebuhar: Thank you, Mr. Markley. Our next comment?

Operator: Comes from the line of Nicholas Bradfield from Torrance State Hospital. Your line is now open.

Nicholas Bradfield: Yes, hi. I wanted to chime in and say that we definitely plan on participating in this, given the opportunity for the bonus there. And that's all. Thank you.

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

Operator: Your next comment? Comes from Tom Dodd from Acadia Healthcare. Your line is now open.

Tom Dodd: Yes, on behalf of all the Acadia facilities, we would definitely participate and would look forward to having to report in a timely manner and actually having to increase as well for the rate.

Barbara Cebuhar: Mr. Dodd, could you tell me what timely manner would be defined as? If you could give us an ideal situation for you.

Tom Dodd: Ideally, it will be within the same quarter.

Barbara Cebuhar: Same quarter? OK, thanks.

Tom Dodd: Correct.

Operator: Your next comment comes from the line of Johan Smith from Horizon Health. Your line is now open.

Johan Smith: Yes. We would just want to repeat the idea of having a bonus associated, not just a punitive piece. And then secondly and certainly aligns with the idea of those programs that are child and adolescent focused, so you want to make sure that you're driving some benefits for those programs to participate.

Barbara Cebuhar: Great. Thanks. I just have been encouraged to ask for feedback from facilities not currently reporting HBIPS data to the Joint Commission. If you could give us an idea of how and what you might participate. Thank you.

The next comment?

Operator: Comes from the line of Deborah Weidner from Natchaug Hospital. Your line is now open.

Deborah Weidner: Yes, I'm sorry, I was already on in the queue before you just asked that question.

Barbara Cebuhar: Don't worry. That's helpful. Please give us your insights.

Deborah Weidner: OK. Well, we already do report HBIPS and we would very much like to participate. And I agree with the other comments about the incentives component being built into this as well.

Barbara Cebuhar: Great. Thank you. Our next comment?

Operator: Just a reminder, to ask a – or make a comment, please press star one on your telephone keypad. Your next comment comes from Gina Sharp from Linden Oaks. Your line is now open.

Gina Sharp: Yes. We are beginning to report HBIPS this year and we would participate in this type of program. We are trying to clarify based on what we heard a minute ago, in terms of the cost to us, in terms of participation, not just the

reduction in payment if you don't, but what is the actually interface cost going to be.

Barbara Cebuhar: Thank you. Our next comment?

Operator: There are no further comments at this time.

Barbara Cebuhar: Our next question basically, and we would really encourage people who are not reporting HBIPS to answer this question, I'm interested in everyone's feedback, so I don't want to preclude anybody from providing feedback, but do you believe that the monetary incentive would outweigh the burden and the cost of data reporting? Do you believe that the monetary incentive would outweigh the burden and cost of data reporting?

(Sheila), could you have people queue up, please?

Operator: Just a reminder, to make a comment, please press star one on your telephone keypad. We'll pause for just a moment to compile the comment roster.

Again, just a reminder, please press star one to make a comment.

There are no comments at this time.

Barbara Cebuhar: So, there is no burden, or does it far outweigh the cost of – does the incentive make sense, the 2 percent incentive makes sense, to encourage people to report? If you could press star one to give us comments that would be very helpful. Thank you. Any comments?

Operator: We have a comment from Tom Dodd from Acadia Healthcare. Your line is now open.

Tom Dodd: I would just say that any incentives or payment to help offset would be greatly appreciated. I think that we are at a point that you know the industry; we're going to be required to produce data, look at outcomes, et cetera. So, any incentives that we can have to help offset that is greatly appreciated.

Barbara Cebuhar: Thank you, Mr. Dodd. Our next comment?

Operator: Comes from the line of Gina Sharp from Linden Oaks. Your line is now open.

Gina Sharp: We are wondering if the interface is direct with CMS.

Barbara Cebuhar: I'm sorry?

Female: I think it depends on how well the interfaces worked and the time involved on our end to put that in, otherwise I think the 2 percent would be worth it.

Barbara Cebuhar: Could you give me an idea of what the perfect picture would look like for you all? And maybe if you could describe a little bit about your facility, that would be helpful, and what would work best.

Gina Sharp: I think that it would work best if the information passed directly through Joint Commission, the reporting through Joint Commission.

Female: And then you just have to do one download and it gets sent to CMS.

Barbara Cebuhar: OK. That's very helpful. Do we have any other comments, (Sheila)?

Operator: Yes, we do. Your next comment comes from the line of Peggy Perry from the Texas Department. Your line is now open.

Peggy Perry: Yes. I guess it's kind of a difficult answer – question to answer because we estimated that had this in effect for our fiscal year, FY10, we would have lost about $500,000 had we not participated and it certainly doesn't cost us that much a year to do what we're doing now. If we were starting from scratch, I don’t think it would even cost that much.

And then I guess the second part of your question is, yes, what were doing now, if we could continue to do that and it could pass through the Joint Commission, we would think that would be a great thing to do.

Barbara Cebuhar: Great. Thank you for your help, Ms. Perry. Our next comment?

Operator: Comes from the line of Cory Nelson from South Dakota. Your line is now open.

Cory Nelson: Hi. As a hospital that's not Joint Commission accredited, that obviously won't work for everybody. We have a number of hospitals in our western region out here that's part of the Western Psychiatric State Hospital Association that are not Joint accredited. So, we would need some other interface through direct reporting to CMS to make that work.

Barbara Cebuhar: Thank you for your help.

Operator: Just a reminder, to make a comment, please press star one on your telephone keypad.

Your next comment comes from Lisa Shea from Butler Hospital. Your line is now open.

Lisa Shea: Yes, thank you. And as we are Joint Commission accredited, I would echo those institutions that are having one process would be greatly helpful, and it does sound like another process for those that are not would need to be developed as well. Thank you.

Barbara Cebuhar: Thank you, Ms. Shea. Any other comments?

Operator: Yes, sir. Your next comment comes from Johan Smith from Horizon Health. Your line is now open.

Johan Smith: We also represent a performance measurement system called Mental Health Outcomes and would just suggest too that you could use performance measurement systems regardless of whether they're sending that data to Joint Commission or to CMS.

Barbara Cebuhar: And this is a proprietary product?

Johan Smith: That's correct.

Barbara Cebuhar: All right.

Operator: There are no further comments at this time.

Barbara Cebuhar: OK. Our next area of inquiry is program and data infrastructure. Describe your previous experience in reporting data to the Joint Commission, registries or other entities. If you could provide some insight to us about your experience providing information or data to the Joint Commission, registries or other entities, that would be helpful. (Sheila)?

Operator: Just a reminder, please press star one on your telephone keypad to make a comment. We'll pause for just a moment to compile the comment roster.

Your first comment comes from the line of Brian Jaworowski from Natchaug Hospital. Your line is now open.

Brian Jaworowski: Well, you certainly don't want to hear all my stories about submitting data. But the primary issue that we run into in submitting data is the changing of specifications without providing adequate time to address the various systems issues. As any organization with an electronic medical record and as Dr. Weidner spoke of earlier, we use our electronic medical record to do what we call clinically-assisted coding, and making changes to an electronic medical record generally is not something you can do in a week or two, if you want to do it adequately and tested appropriately.

So, that's primarily the issue, which would be specification creep and not enough time to make the appropriate changes. Thank you.

Barbara Cebuhar: Thank you. Our next comment, please?

Operator: Just a reminder to press star one on your telephone keypad. Your next comment comes from Dr. Ghinassi from University of Pittsburgh. Your line is now open.

Frank Ghinassi: Thank you. Just a couple of brief statements. One, we are, like many places, we are in the middle of the transition from what had historically been a paper-based system to one that is a completely electronic system and we are probably as far down the road as many and maybe a little further than many. And still it's important to realize that there are aspects of this kind of reporting. And this is not a complaint; it's just a description that require human beings with hands on charts. And I realize that the CMS always makes

an attempt to try to find measures that are, you know, more easily retrievable, often linked to claims data or data that's already being compiled at the state level.

But the difficulty is that the relevance sometimes, the quality of those kinds of measures, while they're easy to glean, they often don't give you much insight into what's happening at the level of the interaction between clinicians and patients. And that's where a lot of quality lives.

So, I don't want to overestimate the burden of that, but I know that from our experience, it is not as simple and easy process and it often involves, like I said, assigning clinical staff who might otherwise be doing other duties to do chart abstraction because it's not often something that you can do or have a clerical or a non-trained person do.

The other clarification I guess and I realize you can't answer any questions, but I may have misheard, I didn't understand that there was an incentive for doing this. I heard – I thought I understood there was a disincentive for not doing it. So, if I'm not mistaken, it's not that institutions are going to get more funding to do this; it's that they'll maintain their current level of functioning if they add this responsibility. I just want to make that – make sure I was clear on that.

And then the final point is, the one that echoed what the gentleman just spoke, as places are scrambling to meet some of the other federal guidelines and requests to try to use electronic systems, these places are putting in place a format and structure of those systems which involve fairly expensive programmer time, and you know the electronic medical record build is never a quick one. And so, if these come out dramatically different from other standards or if there are multiple reporting streams required, it's going to involve a lot of reprogramming time which converts to dollars. And again, these are – that contributes to the burden both financially.

So, simplicity of reporting using an existing stream and trying to get these in place quickly enough so that as people evolve systems, they're able to build in these measures, and that there's an appreciable amount of time that they don't

change, and that when they do change, sufficient warning is given, so that that reprogramming can occur.

Barbara Cebuhar: Dr. Ghinassi, what would be the ideal notice time …

Frank Ghinassi: To reprogram?

Barbara Cebuhar: To reprogram.

Frank Ghinassi: Well, I mean in a shop like ours, since our priority list for I.T. time is usually far longer than the resources, we try to plan our I.T. implementation six to nine months in advance, because we have to pull people – I mean, it's probably the same way CMS works.

When we reassign resources internally to do programming, it means we're pulling them off some other job. We don't sort of bring in new people. So, we usually have six to nine months lead time. I'm not sure what they are for other folks, but that's usually what it is for us.

Barbara Cebuhar: That's helpful. Thank you.

Frank Ghinassi: You're welcome.

Barbara Cebuhar: Our next comment, please.

Frank Ghinassi: Your next comment comes from the line of Johan Smith from Horizon Health. Your line is now open.

Johan Smith?

Johan Smith: I'd echo a six to nine months development time as a minimum. And just a recognition on the part of CMS, that while a number of hospitals are moving towards electronic records and whatnot, a number of them aren't, and a lot of these systems, in terms of your question about previous experience, assume a certain level of electronic data capability on the part of hospitals beyond claims data. And what we find as a PMS vendor is simply that capabilities may not be out there that support that structure to the extent that the

accrediting bodies or CMS might like to avoid them too. So, just an awareness there.

Barbara Cebuhar: Great. Thank you for your time. Our next comment?

Operator: Comes from the line of Anita Peterson from HCA Behavioral Health. Your line is now open.

Anita Peterson: Yes. I would just like to echo the previous two commenter's' remarks meaningful use currently is taking up much of the I.T. resources in our facilities. And the timing for development and implementation has to take into consideration your hospital's I.T. and its resources.

Barbara Cebuhar: Thank you. Any other insights, Ms. Peterson, about previous experience reporting data?

Anita Peterson: Overwhelmingly, the response from our facilities was that they really had not experienced any issues with uploading that information.

Barbara Cebuhar: OK, great. Thank you. And which registries would you suggest would have been used?

Anita Peterson: I'm sorry, I don't have that level of detail to share with you right now.

Barbara Cebuhar: Great. Thank you. If anybody has an insight about which registries or other entities might be useful or identified as potential reporting, that would be very helpful. Any other comments please, (Sheila)?

Operator: Yes. From Lisa Shea from Butler Hospital. Your line is now open.

Lisa Shea: Thank you. And this might be a little off-topic, but I echo what people have said about the level of – that these are helpful, they are quite time-consuming to set up. Definitely having an electronic medical record helps, and anything that could be done to help freestanding psychiatric hospitals be able to be eligible to have incentive payments to have an EMR maybe would help offset some of the burden of this reporting. Thank you.

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

Operator: Comes from the line of Robert Nykamp from Pine Rest. Your line is now open.

Suzanne Bolt: Hello. This is actually Suzanne Bolt; I'm sitting here with Mr. Nykamp. And just wanted to add that even though we have an electronic medical record, it's still a very cumbersome process because we have to – we can't run reports to get these numbers, so we are manually reviewing each chart for each indicator.

Barbara Cebuhar: Wow. Any other insights about other reporting or other uploading of data?

Our next comment, please?

Operator: There are no further comments at this time.

Barbara Cebuhar: The next question involves, can your facility's current data infrastructure support this program? Can your facility's current data infrastructure support this program?

(Sheila), if you would instruct people how to queue up again.

Operator: Just a reminder, please press star one on your telephone keypad to make a comment. We'll pause for just a moment to compile the comment roster.

Again, please press star one on your telephone keypad to make a comment. Your first comment comes from Brian Jaworowski from Natchaug Hospital. Your line is now open.

Brian Jaworowski: We actually participated in the pilot program, and our infrastructure didn't require any upgrades at that time to participate, other than the additional programming required for the submissions, is actually relatively minor in the terms of upgrades, as opposed to programming time.

Barbara Cebuhar: Thank you. Our next comment?

Operator: Just a reminder, please press star one on your telephone keypad. Your next comment comes from Robert Nykamp from Pine Rest. Your line is now open.

Suzanne Bolt: Yes, this is Suzanne again. I just wanted to make a comment that we are still really struggling with getting data for medication reconciliation other than being a very manual process. And I am just curious with other organizations out there, how they're doing that, because I think we might be able to benefit from that.

Barbara Cebuhar: If anybody has any thoughts, if you could queue up by hitting star one that would be very helpful. Thank you very much.

Operator: There are no further comments at this time, but we will pause for one moment. Lisa Shea have queued up to make a comment, from Butler Hospital. Your line is now open.

Lisa Shea: Thank you. I guess what I would echo is that right now our facility's data infrastructure supports, our submissions for the HBIPS, but we don't have a lot of extra and I don’t anticipate getting that. So, in as much as measures are different or additional or being added, that would actually be a burden.

Barbara Cebuhar: So, the other measures that are proposed of the metabolic screening for patients on anti-psychotics and medication reconciliation might be very difficult?

Lisa Shea: Yes. It would depend on how they are. Right now, I would echo what the previous woman said, that our – we do do that, but we do it manually and it is very time-consuming. So, this would require, you know if these were going to be standardized measures that needed to be reported in a certain data format, it would be burdensome.

Barbara Cebuhar: Have you got other measures that you think would be more useful than those two?

Lisa Shea: No. I mean I think they're good measures, I think it's just about the data requirements and then the lead time to do that, you know. So, it would just be

additional. So, we would have to figure out a way to make it more systematic in our system. We don't have an order entry system yet, computerized order entry, which would help with medication reconciliation.

Barbara Cebuhar: OK. Thank you. Our next comment, please, (Sheila)?

Operator: Comes from Johan Smith from Horizon Health. Your line is now open.

Johan Smith: Horizon Health also works with Med Surg hospitals as well as the freestanding hospitals, and the majority of smaller or rural programs or within our urban programs will struggle with data collection and submission, so you really do want to make sure that you're getting considerable lead time for the development of the infrastructure.

And as has been mentioned before too, making sure that, as consistent as it can be with current data, submissions and making sure that those requirements get out very early I think would be very important to these hospitals that are, as I said, with limited resources, whether they're urban or rural.

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

Operator: Just a reminder, please press star one to make a comment. Comes from Deborah Weidner from Natchaug Hospital. Your line is now open.

Deborah Weidner: Thank you. Again, I just want to echo the other comments about medication reconciliation. My comments and comments from Brian Jaworowski that have already been made on this call reference our electronic medical record, but med reconciliation is not yet electronic because I think it's a real challenge to figure it out.

The category of medication reconciliation is a very broad category as well, so I would hope that there would be some specifics and clarity about exactly what would be measured, but we have a paper process currently.

Barbara Cebuhar: Thank you, Ms. Weidner. Our next comment?

Operator: There are no further comments at this time.

Barbara Cebuhar: OK. Our next question is how can CMS efficiently collect data from all the psychiatric facilities including freestanding facilities? How can CMS efficiently collect data from all the psychiatric facilities including freestanding facilities? (Sheila)?

Operator: Just a reminder, please press star one to make a comment. We'll pause for just a moment to compile the comment roster.

Again, to make a comment, please press star one on your telephone keypad.

And your first comment comes from Robert Nykamp from Pine Rest. Your line is now open.

Suzanne Bolt: Yes, this is Suzanne Bolt again. I'd just – I guess I'd rather just tell what we're doing. I can't really say how to do it. But we use an outside vendor who has a program that we enter all of our information into and they help us with that process and transferring that to the Joint Commission. So, I guess a similar process I think would be something that we would prefer.

Barbara Cebuhar: Thank you. Our next comment?

Operator: Your next comment comes from Gina Sharp from Linden Oaks. Your line is now open.

Gina Sharp: I think we said this once before, I just want to clarify and kind of maybe piggyback on what was just said. I do not want to do any more data entry. I'd like to, and I know there are people that are not Joint Commission accredited and I don’t know how that would look, but I'd like to be able to submit exactly what I submit for the Joint Commission.

The other measures are perfectly wonderful, I'm fine, but ideally I wouldn't add anything because the ones that you discussed, I think Lisa mentioned before, med reconciliation, is a very labor-intensive, even with electronic records it can be – there are so many aspects of that, what that makes – that quality measure work. And we're measuring it anyway, but I'd just like to not add an additional download, if I could just have it be one button push and the

government gets what they need and Joint Commission gets what they need, and it should be the same stuff.

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

Operator: Yes, we do, from Cory Nelson from South Dakota. Your line is now open.

Cory Nelson: Again, for those of us that aren't Joint accredited, we'd just really echo something very simple, whether it be a web-based program or a very simple interface that's built to give an opportunity for us to interface it with our existing EMRs to transmit it directly would be fine too, but it's just got to stay very, very simple because we don't have the staffing and the time to do the extra data entry either.

Barbara Cebuhar: Thank you, Mr. Nelson. Our next comment?

Operator: Comes from Johan Smith from Horizon Health. Your line is now open.

Johan Smith: Again, just iterating I think a couple of folks who have mentioned this and we mentioned it earlier as well, PMS vendors are already in place at a lot of facilities and I don’t think it matters regardless of the vendor. I suspect that the vast majority of them would be able to send directly to CMS or to the Joint Commission anything that was set up. So, I think using a vendor, so that you know that you're getting a standardized process and putting less work on the hospital for the development to then support the data collection and submittal regardless of whether it goes to the Joint Commission, whether it goes to CMS or anywhere else would be, in terms of efficiencies which your question is aimed at. So, as a PMS vendor, that's what we would recommend.

Barbara Cebuhar: Thank you. Our next comment?

Operator: Comes from the Robert Nykamp office, Pine Rest. Your line is now open.

Suzanne Bolt: Yes, thank you. Just two comments, the first one is regarding echoing that you know one process would be definitely preferable as we have very limited resources in this as it is.

And then also just a side note, it's a little bit off-topic, but in looking at the indicators, just curious as for number one, the evidence behind doing that screening for patients on anti-psychotic meds, what is the evidence to support that? We feel that that might become an unnecessary increased cost for patients.

Barbara Cebuhar: Thank you very much. And our next comment.

Operator: Peggy Perry from Texas Department, your line is now open.

Peggy Perry: Yes. Sorry, it’s (Phil Mallard), who's with our hospital data management protection, to comment.

(Phil Mallard): Yes, I just want to I guess support a couple of the other comments about at least having the ability to use existing performance measurement systems to submit the data rather than creating a whole another system to submit to CMS.

Barbara Cebuhar: Thank you.

Operator: Your next comment comes from Lisa Shea from the Butler Hospital. Your line is now open.

Lisa Shea: Thank you very much. I guess I would support what's said before, particularly by the Linden Oaks that in as much as we could keep it standardized and not have additional measures added for data submissions required that would be very helpful.

Barbara Cebuhar: Thank you.

Operator: There are no further comments at this time.

Barbara Cebuhar: Our next question basically is which of the data collection modes would you consider using – claims-based, registry, chart abstracted or other modalities? Which of the data collection modes would you consider using – claims-based, registry, chart abstracted data, or other modalities? (Sheila)?

Operator: Just a reminder, please press star one on your telephone keypad to make a comment. We'll pause for just a moment to compile the comment roster.

Again, please press star one on your telephone keypad to make the comment.

Barbara Cebuhar: I'm really trying to understand what is going to be easiest. Is there a claims-based process that you have used? Is there a registry effort? I know chart abstracted data takes an intense amount of effort. Or are there other modalities that would work better? Thanks for your help.

Operator: Your first comment comes from Brian Jaworowski from Natchaug Hospital. Your line is now open.

Brian Jaworowski: I'm not really sure how you would use a claims-based submission for this process without significantly changing the pair files, you know, that would require a significant amount of rework than the various systems, billing components of your behavioral health system or your hospital-based billing system. So, it would have to be very similar to a registry approach or a simple web-based upload of, you know, various file types, XML, comma-delimited and so forth.

Barbara Cebuhar: Great.

Brian Jaworowski: But claims-based will be a significant amount of rework and burden on the providers.

Barbara Cebuhar: Thank you for your help. Next comment?

Operator: There are no further comments at this time.

Barbara Cebuhar: All right. Our next line of inquiry is about public reporting. What facility level quality information do you recommend reporting to the public in support of these programs? Items might include cost per patient, patient volume by diagnosis, survey and certification status, and freestanding versus hospital psychiatric department. Those are just a couple of ideas.

(Sheila), if you could tell people how to queue up, that would be very helpful.

Operator: Just a reminder, to make a comment, please press star one on your telephone keypad. We'll pause for just a moment to make – to compile the comment roster.

Just a reminder, please press star one on your telephone keypad.

Your first comment comes from Cory Nelson from South Dakota. Your line is now open.

Cory Nelson: I'd just say you may want to add one thing in there. I mean there's a potentially a significant difference in state hospitals versus freestanding versus incorporated, so that may be something that could skew the data if you don't really lay that out separately.

Barbara Cebuhar: Thank you. Our next comment?

Operator: Comes from Deborah Weidner from Natchaug Hospital. Your line is now open.

Deborah Weidner: Yes. Unfortunately, I did not put a lot of thought into this question because I didn't look at all the questions before the phone call, so I apologize. This I think is a huge, huge question. What gets publicly reported seems to me, we need to think about what is it that consumers are interested in hearing about or what would be helpful to consumers or families when they're looking at a website and trying to understand this data?

I don’t know how important it is to people, the cost per patient. I think they want to see how satisfied other consumers are. They probably want to know about restraints, maybe marginally interested in the number of anti-psychotics that somebody is discharged on, but maybe that's important because of people don't want to be over-medicated. So, I wonder if there's an opportunity here to pull in clients' families and what would be – what would they be interested in knowing about.

Barbara Cebuhar: That's very helpful. Thank you. Our next comment?

Operator: Comes from the line of Michele Gougeon, McLean Hospital. Your line is now open.

Michele Gougeon: Yes, this is Michele Gougeon from McLean. I think very important aside from the measures to be disclosed to the public would be the real opportunity here to provide some educational information around the measures and also to give them a real clear context for the variety of people that might be accessing that data. I think it's so important for us to take any opportunity we can to clarify what we're saying, what we're doing, and how we are always interested in trying to improve it and provide information in a way that's really going to be useful to patients and their families.

Barbara Cebuhar: Thank you, Michele. Any other comments?

Operator: From Johan Smith from Horizon Health. Your line is now open.

Johan Smith: I just wanted to reiterate a comment that was made earlier about clinical improvement would be an important item to report to the public, and none of these measures are really getting directly at that.

And then to give additional support to the satisfaction measure as well. At the end of the day, you know we tend to think that the general public is interested, "Do people get better at your place?" and "Do they like being there?" And so, I think those are some key measures you may want to publicly report on.

Barbara Cebuhar: Thank you very much, Mr. Smith. Do we have another comment?

Operator: There are no more comments at this time.

Barbara Cebuhar: All right. Our next question is do you support measures segmented by health disparity concerns? For example, age, race or gender and locality; for example urban versus rural amongst psychiatric patients? (Sheila)?

Operator: Just a reminder, please press star one on your telephone keypad to make a comment. We'll pause for just a moment to compile the comment roster.

Again, please press star one on your telephone keypad. Your first comment comes from the line of Robert Nykamp from Pine Rest. Your line is now open.

Robert Nykamp: You know one indicator that I think that we don't talk about a lot, especially when it relates to patient satisfaction data and if we are going to begin to become more transparent as an industry related to that, and that is the variance between voluntary and involuntary admissions. And I don't know how well that information is tracked, but it certainly has an impact on satisfaction scores and potentially other variables such as length of stay, waiting for court appointments, et cetera. So, that's just a scenario that I want to continue to keep out front.

Barbara Cebuhar: Thank you. Our next comment?

Operator: Comes from Johan Smith from Horizon Health. Your line is now open.

Johan Smith: We'd agree that you'd want to invest some time in looking at these characteristics, the four that you've mentioned. We do find differences in our data sets by these different characteristics, so we do recommend further review for potential impact on measures there. While we don't find anything with regard to admission status, whether involuntary or voluntary, again, it would make sense to just keep an eye on those things that may have significant impacts here, whether it's the hospital type such as state or private hospitals, or hospitals – or units that are part of Med Surg hospitals. So, there's hospital characteristics and some of these patient characteristics.

So, I think it would be very important for you to look early on at that data to decide whether or not we really did need to segment out these measures.

Barbara Cebuhar: Thank you.

Johan Smith: Some of the measures that really only lend themselves to – don't really lend themselves to case mix because, you know, screening, continuity planning, med reconciliations, things along those lines are really process oriented by the facility and shouldn't be impacted by any kind of patient characteristic.

Barbara Cebuhar: Thank you, Mr. Smith. Our next comment?

Operator: Comes from David Markley from Warren State Hospital. Your line is now open.

David Markley: All right, thank you. I would like to mirror the last caller. We're a state facility and we have a 13-county catchment area, which is largely very rural. We have one urban center, so – and all of our patients are involuntarily committed. The age, race, gender demographic really doesn't seem like it's going to have too much impact on us one way or the other, although when we look at urban versus rural, where we're going to run into issues is where they're coming from and where they're going back to – if they're coming from a more urban setting and returning to a rural setting.

I mean in our local community, we have very limited services, but in the one urban center we have is a tremendous amount. So, it kind of depends on individual choice when they leave and stuff like that. So, that's going to impact length of stay, those kinds of things. So, I think the urban/rural piece is going to be important as to how they break that out.

Barbara Cebuhar: Thank you very much, Mr. Markley. Our next comment?

Operator: Comes from the line of Dr. Ghinassi from University of Pittsburgh. Your line is now open.

Frank Ghinassi: Thank you. I wanted to agree with Johan and others about trying to capture as much of these patient level disparity concerns as possible. I think the involuntary commitment issue is an important one to at least acknowledge.

Joint Commission try to capture some of this I believe with their age bands, but I do think for some of the measures, as Johan pointed out, some are not affected by this but others could be, such as the use of anti-psychotics in certain variations and also issues around potentially restraints, seclusions. So, some attempt to measure diagnostic ratios to allow for some awareness of institutions that have highly specialized patient populations that are often not sent to or accepted by the facilities.

For example, these people who are living with severe eating disorders, places who treat folks who have, in addition to psychiatric issues, had head injuries or pervasive developmental delays that complicate the presentation, units that deal for example with medically compromised geriatric patients and/or hospitals, which often tend to cluster in urban centers. Hospitals have a high ratio of accepting transfers from other hospitals because of patient complexity, and that can often change the fabric of the presentation and the acuity of facilities.

So, I think as much as you can to discern some of those and incorporate that into the benchmarking initiative, I think it has a dramatic opportunity to improve quality by again allowing facilities who are trying to provide best-class services to similar clinical populations to benchmark with one another. Otherwise what happens is all of that sort of gets lost in the noise and it makes the benchmarking effort less helpful in improving quality.

Barbara Cebuhar: Thank you very much, Dr. Ghinassi. Do we have another comment?

Operator: Yes, we do, from Anita Peterson from HCA Behavioral Health. Your line is now open.

Anita Peterson: Yes, thank you. We would also agree that there – it would be important that there be some stratification of the data that is reflective of the characteristics of the facilities that are reporting and the patient populations that they serve. That's one of the reasons we had some challenges around our thoughts around what the facility level quality indicators that would be reported that we should recommend. And because of this very discussion, it really feels like it's too early to us to make any recommendations at this time, and until we can come up with definitive plans for how that data can be segmented, so that all the facilities are represented as to the complexity of the care that they deliver.

Barbara Cebuhar: So, you're talking about risk stratification?

Anita Peterson: Well, taking the data and stratifying along the lines of all of the comments that those – that the other participants have shared. When you're looking at, for example, a facility that has a very large geriatric population, frequently there's a significant amount of medical co-morbidity that complicates the care of

those patients, resulting in longer length of stays than facilities that might defer accepting those patients. So, there needs to be some segmentation of the data that allows for a valid comparison of the publicly reported data.

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

Operator: There are no further comments at this time.

Barbara Cebuhar: OK, great. Our next line of question is about monitoring and evaluation.

What data privacy and confidentiality issues do you anticipate from reporting patient-level data to a CMS designated entity? Examples of issues include security problems in transmission and storage of electronic data. Transmission, for example, email, fax and courier, of paper copies of medical records to validate accuracy of electronic data; and existing legal requirement protecting privacy of specific patient types, for example, HIV patient status. What data privacy and confidentiality issues do you anticipate from reporting patient-level data to a CMS designated entity?

(Sheila), if you could tell people how to queue up, I'd appreciate it.

Operator: Just a reminder, to make a comment, please press star one on your telephone keypad. We'll pause for just a moment to compile the comment roster.

Again, to make a comment, please press star on your telephone keypad.

There are no comments at this time.

There actually is a comment from Lucille Schacht from NRI. Your line is now open.

Lucille Schacht: Thank you. You did mention a few things actually, there's going to be a lot of contracting issues in that for many of the private – for freestanding hospitals they've not previously sent data onto CMS, so it's not actually part of their contract relationships in sending on patient-level data to CMS, so they'll be contracting requirements that would have to change.

There's a whole data stream process that has to be incorporated in that kind of transmission where a freestanding psychiatric hospitals have not been involved in that transmission and there'll be a lot of folks involved in that whole stream to ensure that the data is protected during the stream, who has access, why it's actually being sent, the whole works, sort of the same process that hospitals went through when Joint Commission first started taking in anonymous patient-level data. And whether of not CMS's data is actually going to be considered anonymous patient-level data or is it actually going to be considered identifiable patient-level data, in which case there's a whole business associate agreement, you know, and all those kinds of issues.

I'm a vendor, so I also support a lot of the comments that Johan had mentioned earlier in terms of the vendors doing a lot of the work to make the burden easier on the hospitals.

Barbara Cebuhar: So, Lucille, the contracting would be with your vendor, is that it?

Lucille Schacht: Yes, the hospitals would be contracting with their vendor and adding in a clause to allow us to submit that data on to CMS, that that data is actually identifiable, that's not part of our current contracts, we do not – our hospital is all just purely psychiatric, so none of their data previously went to CMS, that's not part of any of our current contracts.

Barbara Cebuhar: OK, that's good to know. Any other comments?

Operator: There are no comments at this time.

Barbara Cebuhar: So, our next question is, what potential unintended consequences do you anticipate from public reporting of inpatient psychiatric facility, specifically facility-level data? (Sheila)?

Operator: At this time, I would like to remind everyone, please press star one on your telephone keypad to make a comment. And we'll pause for just a moment to compile the comment roster.

Just a reminder, please press star one on your telephone keypad to make a comment. Your first comment comes from Cory Nelson from South Dakota. Your line is now open.

Cory Nelson: Again, I'll just make a comment on behalf of state hospitals in that many times obviously we work with individuals that no other facilities will work with, and the unintended consequence could be the public believing that we're providing inferior service because some of our numbers might be higher than other places simply because they're not equipped to handle some of the individuals that we work with. So, just want to keep that in mind, which makes the stratification and explanations of the stratifications very important.

Barbara Cebuhar: Thank you very much, Mr. Nelson. Our next comment?

Operator: Your next comment comes from Lisa Shea from Butler Hospital. Your line is now open.

Lisa Shea: Yes, thank you. I would echo that, and that I think going back to what McLean Hospital said about it's very important to have this opportunity to have – to make sure people understand what exactly is being reported, so that you don't have the unintended consequence of having more barriers to care and on people being reluctant to come to care because they don't quite understand or understand what it means. So, that the measures need to really be clear and explicable to the public.

Barbara Cebuhar: Thank you very much, Ms. Shea. Do we have another comment?

Operator: Yes, we do, from Johan Smith from Horizon Health. Your line is now open.

Johan Smith: I think one of the things that we see that is likely an unintended consequence is a movement or more of laser focus on those items that are publicly reported from a more broad-based performance improvement sort of viewpoint with hospitals. So, we see hospitals moving from a wide variety of performance improvement processes and plans and strategies that they're putting into place, and really zeroing in and focusing in primarily if not solely on publicly reported measures.

And I think that's probably a bit of an unintended consequence, while we do want publicly reported measures to give some sort of standardized comparison point to the public, at the same time you're probably not wanting to diminish any additional effort on the part of hospitals. So, this is something to keep in mind.

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

Operator: Yes, we do. And just a reminder, to press star one to make a comment. Peggy Perry, Texas Department, your line is now open.

Peggy Perry: Yes, I just wanted to share with the group that we have been publishing our performance indicators, which would include the information we report now to Joint Commission as well as our other performance indicators on our website since 1996. And we have had some dealing with our own legal staff that some of the data, because of the people we serve, could be identified. If we have a forensic patient who's been identified in the newspapers, you know, could somehow that information be related to them for events that might have happen.

But that went through our state attorney general and he ruled that we could publish all this data. And I don't think – I think that this is – this kind of culture which is more of an open culture has served us well. Probably the people that it's created the most problem with is our own legislature, sometimes having to explain some of our data. But generally I think that we have not had any problems.

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

Operator: Yes, we do, from David Markley from Warren State Hospital. Your line is now open.

David Markley: With respect to releasing information to the public, the only real issue we see here, because we are a state facility, all of our patients come involuntarily based on catchment area, it's not going to really improve or change the way our patient flow comes to our door. It's not going to give patients the opportunity to pick and choose which hospitals they want to go to based on

outcome measures or anything like that. It really is geographic more than anything else.

Where I see a potential problem is we have an incredibly strong advocacy movement in Pennsylvania and that if they use that data to misinterpret for their own rationale, there is a strong movement at this point to try and close all of our state hospitals in Pennsylvania. That would be my concern as far as unanticipated, you know or unintended outcome is that they use that information to misrepresent further their initiatives.

Barbara Cebuhar: Thank you very much, Mr. Markley. That's very helpful. Do we have any other comments?

Operator: Yes, we do, from Cory Nelson from South Dakota. Your line is now open.

Cory Nelson: Just one other thing, I want to – I guess I'd like to make sure this doesn't lead us down the road to a five-star rating system like they have for nursing homes. And keep in mind, I mean I have a nursing home in my state hospital right now and it is a five-star rated home, but I don't think people should be making decisions on where to access services based on a movie rating system versus actual quality rating, so they should call and find out what type of patients that are being served, how they're being served, and then making a decision what the best facility is.

Barbara Cebuhar: Thank you, Mr. Nelson. Any other comments?

Operator: Your next comment comes from Peggy Perry from the Texas Department. Your line is now open.

Peggy Perry: Yes, just in response to the advocacy issue and now I guess they're called Disability Rights Texas, I think because of the culture we have that many times they have come to our rescue and have been advocates for us in our state hospital system here because of, you know, they are well-informed about what's happening with us.

Barbara Cebuhar: Thank you, Ms. Perry. Any other comments?

Operator: There are no further comments at this time.

Barbara Cebuhar: OK. We're winding down, and if you haven't had a chance to comment, I'd really appreciate hearing from you. Do you have concerns or considerations that you would like to share with CMS regarding the implementation of psychiatric hospital quality reporting programs? (Sheila)?

Operator: Just a reminder, to make a comment, please press star one on your telephone keypad. We'll pause for just a moment to compile the comment roster.

Again, star one to make a comment. Your first comment comes from Tom Dodd, Acadia Healthcare. Your line is now open.

Tom Dodd: The primary concern that we would have would be that it will be a redundancy of reporting for other agencies. And so, as we've seen on the theme of this call, is the more closely aligned you can make it with currently or pre-existing kind of report and reporting requirements, that's ideal.

Barbara Cebuhar: Thank you. Our next comment?

Operator: Comes from the line of Jayne Chambers from Federation of America. Your line is now open.

Jayne Chambers, your line is now open.

Jayne Chambers: Hi. This is Jayne Chambers, Federation of American Hospitals. Hi, Barbara.

Barbara Cebuhar: Hey.

Jayne Chambers: I just wanted to reiterate what some of the other speakers have said, is that to the extent that you can align this program with current reporting systems that are already out there, that would be I think important to our members who represent the psychiatric hospital community.

And the lessons that we've learned in implementing other quality programs across the board, whether it's inpatient hospital quality or what we're doing now with ESRDs and what's happening, the various other programs that are coming online, in terms of making sure to the greatest extent possible that all

measures are into us, endorsed, and that they're well-specified and well-understood by the community, that's going to be implementing them I think would be very important. Thank you.

Barbara Cebuhar: Thank you. Other comments?

Operator: Yes, from Lisa Shea from the Butler Hospital. Your line is now open.

Lisa Shea: Yes, thank you. I would echo what the other two had said. I would also advocate that whatever the bench – how the benchmarks are going to be determined would be really important and would advocate for like facilities being compared to each other. And that maybe instead of – since there's going to be a fiscal impact, that they be – that values would be weighted so that it's not an all-or-nothing, if you're at or above the benchmark, you get it all; and if you're not, you don't get anything. So, some sort of weighting of that would be helpful, if it's going to be performance-based.

Barbara Cebuhar: Thank you, Ms. Shea. Other comments?

Operator: There are no further comments at this time.

Barbara Cebuhar: I wanted to give everyone an opportunity to weigh in on anything else that you think that CMS needs to know and understand or be aware of as we launch this process. If, (Sheila), you could instruct people how to get in the queue, we'd appreciate your feedback.

Operator: Definitely. To make a comment, please press star one on your telephone keypad. We'll pause for just a moment to compile the comment roster.

Again, please press star one to make a comment.

Your first comment comes from Lucille Schacht from NRI. Your line is now open.

Lucille Schacht: Yes. I think it's really important – we've talked a lot about stratification, and I think that it'd be really important to have analysis be done for a period of time before the stratifications actually get posted, so they become meaningfully useful stratifications. And when analysis indicates that those groups, you

know, if there's no difference by gender, then gender doesn't get posted. And I think that's important for that analysis to be sort of foundational in those kinds of stratifications.

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

Operator: There are no further comments at this time.

Barbara Cebuhar: We are very grateful for your insights and hope that this session has provided an opportunity to further illustrate what the industry 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 the MP3 file by going to www.cms.hhs.gov/center/quality.asp. And it will be available in approximately two weeks.

If you know someone who wasn't able to make the call, they can listen to it until midnight on June 10th by calling in about two or three hours, by calling 800-642-1687 and asking for call number 66782690.

I also want to make sure that folks know that you may not have had an opportunity to speak, but we are very interested in your insights and ideas about measuring. And you can forward those comments to barbara.choo – C-H-O-O – @cms.hhs.gov or james.poyer – P-O-Y-E-R – @cms.hhs.gov by June the 30th, 2011, by close of business.

I also want to make sure folks know that the Joint Commission measures are available, if you haven't had a chance to see them at http://manual.jointcommission –all one word – .org/releases – plural – /tjc2011a/. Please refer to the measure information forms in Section 2 of this link about the seven hospital-based inpatient psychiatric services. So, that's HBIPS for those of you who don't currently submit information that way.

I think we are grateful for all of your help and look forward to your feedback by email. And if there are no other questions or issues or comments, we will go ahead and disconnect from the call. Thank you very much for your help.

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

END