

Moderator: Jill Darling
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2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During today's presentation we will have a question-and-answer session. To ask a question, please press star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to (Tevin Warren). You may begin.

(Tevin Warren): Thank you (Brandon). And thank you everyone for joining today's Special Open Door Forum. We will be giving a status update on the Hospice Outcome and Patient Evaluation Tool. I just want to give a quick disclaimer. This Open Door Forum is open to everyone. But if you are a member of the press, you may listen in but please refrain from asking questions during the Q-and-A portion of the call. If you have inquiries, please contact CMS at press@CMS.hhs.gov. Thank you.

And without further ado I would like to turn the call over to Ms. (Cindy Massuda).

(Cindy Massuda): Thank you very much. Good afternoon everybody. I'm (Cindy Massuda), the Coordinator for the Hospice Quality Reporting Program -- or HQRP -- at CMS's Center for Clinical Standards and Quality.

CMS is hosting this Special Open Door Forum today to provide updates for the hospice provider community on the development of the Hospice Patient Assessment Tool and the HQRP work on quality measure development.

I'm on Slide Two. To walk through these updates, I'd like to introduce our three speakers from our contractor -- Abt Associates -- who support CMS on this work. First is (Zinnia Harrison) -- Senior Associate at Abt -- will provide some background on the origins of our effort to develop the patient assessment tool.

The doctor - we have Dr. (Jennifer Riggs) -- a nurse researcher and Senior Associate at Abt -- who will provide the update on the tool's development to date. (Marian Essey) will present on a closely-related topic, namely CMS's processes for quality measurement and ongoing quality measurement under the Hospice Quality Reporting Program.

Ms. (Essey) is the Senior Director of Clinical Quality and Value at Oasis Answers, which works with Abt, with our helpdesk. We will close with a brief summary of our next steps. And hold two question and answer sessions during the hour so that we can hear your reactions to both updates and be able to answer your questions. And look forward to hearing your thoughts about our progress to date and plans ahead.

I'm on Slide Three, the housekeeping slide. We will begin. I'd like to touch on a few housekeeping points. We are recording this webinar. Please click on the Settings button near the top of your screen to enable closed captioning.

Finally, if you have a question or at any point during the presentation, enter in the - if you have questions. And then on the next slide we have our acronyms for this presentation. So with that I will turn it over to (Zinnia).

(Zinnia Harrison): Thank you (Cindy). As (Cindy) mentioned, I will kick off the presentation with some background on the origins and the process of this work, beginning

with the Hospice Quality Reporting Program or HQRP. Now I'm on Slide Six.

The Hospice Quality Reporting Program aims to promote the delivery of patient-centered, high quality, and safe care by hospices. It was established by the Patient Protection and Affordable Care Act of 2010.

The HQRP currently requires that hospices report on both the Hospice Item Set -- or HIS -- and the Consumer Assessment of Health Care Providers and Systems, or CAHPS. Surveys for hospices -- referred to as hospice - CAHPS Hospice Survey.

CMS is now developing a new patient assessment tool to replace the HIS with no impact on the CAHPS Hospice Survey. The HIS is composed of admission and discharge item sets. The HIS provides basic information about the patient and his or her hospice stay.

From the HIS items, process measures have been implemented since 2014. The HIS items do not support outcome quality measures because it is not a patient assessment tool. And on Slide Seven. While the HIS has served the Hospice Quality Reporting Program well, the Hospice Quality Reporting Program envisions replacing it with the standardized patient assessment tool.

People have asked us why. To compare the data from HIS. Data from the standardized patient assessment tool takes into account three major stakeholder groups. Hospices, patients and families, and CMS.

A standardized patient assessment tool can better help hospices understand the patient and family because it captures not just the clinical preferences of the

patient but also the spiritual, psycho-social, and emotional needs. And goals of care for both patients and caregivers.

These data can support hospices in designing a plan of care to meet those needs. It can provide value to patients and families by helping guide consumer choice of hospice programs. And also engage them in critical decision making about their care.

Finally, the information will also help CMS provide stewardship for meaningful quality measurements. The measures focus on the outcomes of care. And with that, I will turn it over to Dr. (Jennifer Riggs), who will share updates on HOPE tool development.

Dr. (Jennifer Riggs): Thank you (Zinnia) and (Cindy). And thank you all for being here today. I will be sharing updates on our work supporting CMS to develop the new hospice patient assessment tool. I'll begin on Slide Nine with an update on the name of this tool. Hospice Outcomes and Patient Evaluation, or HOPE.

CMS finalized this name as part of the Fiscal Year 2020 Hospice Rule. After reviewing the many great suggestions from rule commenters, CMS chose this name. Both the full name and the acronym captures CMS's goals for this assessment tool.

It's a patient evaluation for use by hospices and will enable CMS to develop outcome quality measures that -- when publicly reported -- will help consumers select a hospice. The acronym HOPE expresses the sentiment of hope for patients to achieve quality of life according to their goals and wishes and supported by the hospice.

CMS has two primary objectives for HOPE. First, this tool is intended to collect additional quality data necessary to fulfill the legislative mandate of the Hospice Quality Reporting Program. In particular, HOPE will support the development of outcome measures for hospice, something (Marian) will speak more about later this hour. Second, HOPE is intended to provide clinical data that could inform future payment refinements.

The picture on Slide Ten illustrates the steps involved in the process for developing this tool. It also illustrates how some of these steps are iterative. As previously discussed in past open door forums, we have and continue to conduct multiple activities to gather information from stakeholders, from the literature, and from existing patient assessments.

We are using this information to iteratively draft and refine the first version of HOPE. Part of this work is to establish clear connections from the HOPE tool to the quality measures we may develop for CMS based on HOPE assessment data. Everything we learn from the information-gathering activities also helps us to prepare for cognitive alpha and beta testing of the HOPE tool.

Testing is used to establish the reliability of the items in HOPE. And the results of testing are used to create a final draft of HOPE. CMS proposes this version of HOPE in rule making, and once finalized the tool will be implemented nationally.

On Slide 11 -- as I mentioned earlier -- we have and continue to engage in information-gathering activities to ensure we have a deep understanding of stakeholders' perspectives on the HOPE tool. We consider these perspectives as we continue to develop the tool.

In the last special open door forum, we provided detailed updates on what we learned during listening sessions with representatives of national associations, what we've learned from a review of the literature, and what we learned during interviews with experts. Today we will provide updates on additional information-gathering activities.

Interviews with caregivers. Engagement with electronic health record -- or EHR -- vendors. And focus groups with hospice staff. All of these activities - completed and ongoing -- allow us to engage with multiple diverse stakeholder groups interested in the new hospice patient assessment. Recently we completed interviews with caregivers who are familiar with hospice care.

Looking at Slide 12, you can see these interviews were designed to discuss what caregivers value and what they believe patients value in hospice care. And to learn what caregivers believe hospices should focus on in their care.

And finally to learn what information caregivers do not believe is necessary for hospice staff to collect during the hospice visit. Or what information caregivers believe is burdensome for the patient or caregivers to report to hospice staff.

Highlights of our interviews include that the Patient-Centered Outcomes Research Institute -- or PCORI -- Ambassador Program helped us connect to caregivers with diverse hospice experiences.

The caregivers we interviewed were diverse in terms of geography, caregiver to patient relationships, and spiritual and cultural values and beliefs. These caregivers also had experience with hospice care for health conditions such as dementia and heart failure for example, not just cancer.

CMS also recognizes that EHR vendors have valuable experience working with hospices. Looking at Slide 13 now, we are preparing to hold listening sessions with EHR vendors to better understand the standardized and un-standardized assessments that are used by their clients.

In the short term we hope this engagement will create opportunities for CMS to provide EHR vendors with updates on the HOPE tool. Ultimately, we hope continued engagement with vendors will help us identify opportunities and challenges associated with implementation of the HOPE tool, and will serve as a vehicle for CMS to offer support.

And -- as Slide 14 displays -- we are conducting focus groups with hospice staff selected from a nationally-representative sample to achieve diverse perspectives. The objectives for these focus groups are to obtain input on how assessment items are defined and worded. To identify what participants believe are important hospice assessment concepts that promote and capture high-quality hospice care.

And explain to use which concepts they consider to be of the highest priority for a standard patient assessment. And to obtain feedback on proposed types of assessments, such as admission and discharge. And to learn more about participants' usual workflow for assessment and re-assessment.

We also hope to gain insight from participants on whether some assessment items are appropriate for some types of patients but not others. This information will help us as we construct what are called "skip patterns" in the HOPE tool, a method that allows users to skip some items in patient assessment that are not applicable to that particular patient.

And to review and solicit input on symptom assessment items for hospice patients, including those patients who are actively or imminently dying. Finally, we have some additional updates on Slide 15 from our review of the literature and existing assessments.

One focus of the literature review was to identify the latest knowledge and tools used to measure severity of symptoms -- including pain or shortness of breath for example -- in hospice patients. Common approaches to pain and other symptom assessment require patients to be able to respond.

Many patients receiving hospice care, however, may be unable to describe their own symptoms. Our investigation of scales to assess symptoms is very important for the hospice patient assessment. Multiple scales have been reviewed and one -- the Integrated Palliative Outcomes Scale or IPOS -- was determined to be a good candidate to propose for modification and inclusion in the HOPE tool.

In our information gathering activities, stakeholders have been very supportive of this symptom assessment scale for hospice patients. On Slide 16, the assessment scale for this modified IPOS is displayed.

The hospice clinician assesses the patient for each symptom using this scale with options ranging from Mild to Overwhelming. There are also options for None and Cannot Assess.

Each option that characterizes the severity of a patient's symptom -- whether it be Mild, Moderate, Severe, or Overwhelming -- is described according to the symptom's effect on activities critical to the patient's quality of life, such as sleep, day to day activities, and interactions with others such as family and friends.

For example, a patient experiencing pain that significantly impacts their ability to sleep, their day to day activities, and their ability to interact with their family meets the description for Severe pain. While a patient experiencing pain that only has a little impact on sleep, day to day activities, or interacting with others meets the description for Mild pain.

Patients may certainly report on their symptoms using this scale. But caregivers and hospice clinicians can also use the descriptions in this scale to more accurately assess the severity of symptoms the patient may be experiencing when the patient is unable to respond for him or herself.

This ends my portion of the presentation today. And I'm turning this over to CMS for the next.

(Cindy Massuda): Thank you very much, (Jen). We would like now to pause here for any questions on the updates we presented on the HOPE tool development.

(Tevin Warren): So (Brandon), we would like to open the lines for questions.

Coordinator: Thank you...

((Crosstalk))

(Zinnia Harrison): So (Cindy), while we're waiting for the questions to queue up I'd like to ask you a question to kind of get things started. Some participants may wonder well, why is CMS wanting to move to a patient assessment tool?

(Cindy Massuda): That's a good question, thank you (Zinnia). So a patient assessment tool captures not just the clinical preferences of patients but also the spiritual,

psycho-social, and emotional needs and goals of care for both patients and caregivers.

This information is informed by regular encounters with patients and families throughout that - throughout the dying process. Given these features, patient assessment tools can support many types of quality measures including outcome measures, which assess the results of health care experienced by patients. Not just whether a process was done.

When a patient assessment tool is standardized, a hospice can use the quality measures to compare their performance on each quality measure to the report - to the performance of other hospices -- and to the national average -- to identify areas for improvement. The information collected on the tool is then used to calculate the quality measures that will be publicly reported.

This allows consumers to use the information that originated on the patient assessment tool to inform their choice of hospice providers in their area. CMS will be able to use the information collected on the patient assessment tool to inform the future of the Hospice Quality Reporting Program and other programs within CMS.

So we are looking forward to being able to expand beyond where we are now, which is with the Hospice Item Set that are process measures. Being able to expand to a broader set of measures, particularly outcome measures. So...

(Zinnia Harrison): Great.

(Cindy Massuda): ...I appreciate that.

(Zinnia Harrison): So let's check with (Brandon), see if anybody has queued up.

Coordinator: Yes. And we have a question from (Anya Miller). Your line is open.

(Anya Miller): Yes, hi. I'm sorry, but I'm not seeing the slides. I didn't get (a) email link to get to the slides.

(Cindy Massuda): They are located on the CMS Quality - it's the CMS Quality Initiatives Patient Assessment Instrument. The Hospice - if you go to the Hospice Quality Reporting Program web page...

(Anya Miller): Okay.

(Cindy Massuda): ...and you get onto HOPE, where the HOPE web page is within that Web site.

(Anya Miller): All right. And what - I'm sorry, what was the Web site again?

(Cindy Massuda): The Hospice Quality Reporting Program. If you just put in your browser CMS HQRP - CMS space HQRP -- for Hospice Quality Reporting Program -- you should see the CMS Hospice Quality Reporting Program Web site.

And once you get onto that Web site you will see HOPE at - you will see what -- on the left hand side -- you'll see a bunch of links, one of them saying HOPE. If you click on the HOPE link...

(Anya Miller): Yes, I'm there. Okay. I'm on the HOPE link.

(Cindy Massuda): Okay. Scroll to the bottom where the downloads are. And the very first download -- at the very top -- says HQRP Special Open Door Forum Presentation September 2019. That's what we're working with.

(Anya Miller): Got it. Thank you so much.

(Cindy Massuda): Thank you.

Coordinator: Once again I would like to remind all participants, if you would like to ask a question to please press star one. Our next question is from (Colleen O'Keefe). Your line is open.

(Colleen O'Keefe): Good afternoon. I have a question - a couple of questions. One, the words that are there -- None, a doctor Cannot Assess -- those are all descriptive words that I would think are certainly valuable for a symptom screening. Are we going to hear more about the characteristics of the symptoms, a further assessment? That's one question.

Currently most of us are, you know, we're able to use credible surrogates for patients that are, you know, non-verbal. Whether they're adults or certainly infants, if you have pediatric hospice like we do. So will this assessment tool take that into consideration as well beyond just Cannot Assess? Because with the tools we're using right now -- with the FLACC or the Pain Add -- we certainly get into that.

So I guess I just want to verify that the words here -- the descriptors, the verbal descriptors -- are just part of a screening and that there may be more detailed or in-depth assessment of the pain characteristics? Severity, what makes it better, duration, all that good stuff?

(Cindy Massuda): (Jennifer), do you want to address that?

Dr. (Jennifer Riggs): Certainly, thank you (Cindy). And thank you for the question, that's an excellent question. For your - the first part of your question -- where you're

asking about further assessment of symptoms -- you're absolutely correct. The HOPE tool in and of itself is not intended to be a complete, comprehensive patient assessment.

The item that you're talking about -- the descriptors for the symptoms -- would be one piece of information that's part of a comprehensive assessment of symptoms. And although the entire comprehensive assessment won't be on the HOPE tool, it's expected that you would be completing the comprehensive assessment as part of your routine care.

For the second part of your question, again you're correct. The intent is for patients to be able to express their symptoms when they're able to do so. But in the event that they're not able to do so, credible surrogates - this item is designed so that credible surrogates can report on this. And so that would be the next step before selecting the option Cannot Assess.

(Colleen O'Keefe): Can I ask a quick follow-up?

(Cindy Massuda): Certainly.

(Colleen O'Keefe): So for each - for the hospice item set questions for symptoms, the - both the numerator and the denominator for patients screened as well as patients assessed, you know, is reported and is measured. Will there be some type of bridge between hospices' assessment, you know, the components of a comprehensive assessment for these symptoms and the HOPE tool?

Or will that just disappear from the HIS measurement? Will HIS measurements look completely different too?

Dr. (Jennifer Riggs): I'm not sure I completely understand your question. I think I hear you asking about the HIS quality measures?

(Colleen O'Keefe): Yes.

Dr. (Jennifer Riggs): Okay. Yes, I think you might get some more information -- a little clarity on that -- in the next part of the presentation, where (Marian) is going to talk about quality measurement.

(Colleen O'Keefe): Okay, great. Thank you.

Dr. (Jennifer Riggs): Okay.

Coordinator: Our next question is from (Andrea McFadden). Your line is open.

(Andrea McFadden): Hi. We're a hospice EHR vendor. And very interested in the engagement with EHR vendor sessions that you're going to do. How do we get signed up for that?

(Zinnia Harrison): Hi, this is (Zinnia). So yes, we are planning to have some engagement, listening sessions with EHR vendors. And we'll be reaching out in the next week or so.

(Andrea McFadden): Okay, so if we are on this email list we'll just be notified through that? Is that how we would know?

(Zinnia Harrison): Yes. Or you can also email Hospice Assessments at CMS dot HHS dot gov. And there's a slide at the very end that also has that email.

(Andrea McFadden): Okay. Thank you very much.

(Zinnia Harrison): Thanks.

Coordinator: Our next question is from (Robert Miller). Your line is open.

(Robert Miller): Thank you. Yes, I just wanted to make an observation about the qualified surrogate. Just to follow up on that issue. One of the things that I think - that I hope -- and pun intended -- the tool will take into account is the surrogate's evaluation of the patient's symptom may have more to do with the surrogate than it does with the patient.

So as an example, if I have a cough. It may bother my wife more than it bothers me. And so I'm just hoping that -- as this tool helps lead the organization toward a care plan -- that that part of it is taken into account that it might actually - the issue may actually be with the surrogate, not with the patient. Does that make sense?

Dr. (Jennifer Riggs): It does. This is (Jennifer Riggs). And yes, it makes complete sense. And I completely agree, you're actually completely correct. Surrogate assessment of a symptom does not necessarily only reflect the patient. It reflects their perceptions as well...

(Robert Miller): Right.

Dr. (Jennifer Riggs): ...and so yes, that would certainly be taken into consideration.

(Robert Miller): Thank you.

Coordinator: Our next question is from (Maureen Henry). Your line is open.

(Maureen Henry): Good afternoon. I wanted to just focus on the role of the patient. It does have some relationship to the use of surrogates in responding to this. But my question is whether there is any plan to engage patients in this as opposed to caregivers and patient advocacy groups?

In doing this research in the past I've found that you almost always get insight when you talk to the person receiving the care rather than people who are speaking for that person.

Dr. (Jennifer Riggs): Yes, that is completely...

(Cindy Massuda): Thank you...

((Crosstalk))

Dr. (Jennifer Riggs): ...oh, sorry. (Cindy), go ahead.

(Cindy Massuda): ...go ahead (Jen). No, go ahead (Jen).

Dr. (Jennifer Riggs): I was going to say yes, I completely agree. And the patients play a very important part in testing items so that we can learn from people who are receiving the care. Their perceptions about the assessment that's being completed. And we certainly use that information as we continue to make refinements to the assessment tool itself.

(Maureen Henry): Thank you.

Coordinator: Our next question is from (Toby). Your line is open.

(Toby): Thank you. I'm an EHR vendor as well. And I guess one of the questions I have with the IPOS is, is this a tool that we anticipate handing to the patient family to fill out? And then would have to some way electronically put that in with the other information from the HOPE assessments? And merge that all in to send up?

Or what were your thoughts about - or are these questions that the clinicians would ask and capture that data through interview type process?

Dr. (Jennifer Riggs): Part of what we're working on right now is determining exactly what format the assessment will take. And certainly what we're hoping to accomplish -- sorry, no pun intended -- is a mechanism that will allow assessment that follows the usual work flow and that is not overly burdensome.

So for example -- as you indicated -- rather than having hard copy tools that you hand to patients, you know, what we would ultimately like to accomplish is an ability for information to be collected with -- for example -- a point of care device so that it could be electronically saved and transmitted. But that's part of the work that's ongoing right now.

(Toby): So we would hope that the patient family would do the point of care? Or that it would -- again -- be captured through the interview process from the clinicians on admission and discharge?

Dr. (Jennifer Riggs): I don't think we have real specific answers to that...

(Toby): Specifics on that. Okay. Okay. Perfect.

Dr. (Jennifer Riggs): Right.

(Toby): Thank you.

(Cindy Massuda): And just to appreciate one of the benefits of HOPE is that it's broader than just at admission and discharge. That we're looking throughout the patient's stay at critical - at key times. And that's one of the benefits of, as we move over toward HOPE.

And I just want to thank everyone for these questions. We do have another update to provide. So I'd like to now turn it over to (Marian Essey), who would discuss updates on the quality measures for the Hospice Quality Reporting Program.

(Marian Essey): Thank you (Cindy). Hello everybody. As was mentioned previously, I'm going to be providing some background on CMS's process for quality measurement before then speaking specifically about quality measures and measure development under the HQRP. So let's look at Slide 19.

This slide presents some core concepts on quality measurement and some key definitions. And - beginning with the term Quality Measure. So CMS defines Quality Measures as calculations of health care quality data to promote health care organization accountability.

And there are multiple types of quality measures. And here I'd like to focus on two in particular, since these are both discussed frequently. Process quality measures. This term indicates actions taken to maintain or improve health care quality that is experienced by patients.

So for example, screening for pain. And currently the HIS provides us with only process measures. However -- as has previously been stated with the

HOPE tool -- we'll be able to move to have outcome measures. So what are outcome measures and why are they important?

Well outcome measures assess the results of health care that are experienced by patients. So for example, the - reducing the severity of pain. Outcome measures changes - outcomes measures change - measure change -- excuse me -- between two or more time points. For example, measuring the patient's status from admission to discharge or death.

The CMS Meaningful Measures Framework promotes more focused quality measure development towards outcomes that are meaningful to patient's families and their providers. And the HOPE tool will allow CMS to develop more meaningful quality measures to then better support patients' families and hospice providers.

So through measure development, all quality measures -- regardless of the type -- become what we call fully-specified. This means they've been thoroughly tested against multiple pre-established criteria. Each quality measure includes a numerator, denominator, and exclusions. And many quality measures are percentages.

So let's briefly review some of these definitions. Denominators and exclusions indicate the patients that are eligible to be counted under the measure. Numerators indicate the number actually meeting the measure criteria. So for example, what percentage of hospice patients that have less severe pain or that have improvement in pain.

So let's move on to then Slide 20. This graphic represents CMS's timeline for the life cycle of a measure. And that is, it's depicting each step in the process

for taking a measure from a concept through implementation and continuing evaluation.

The first step in measure development is measure conceptualization. This step includes gathering information through environmental scans, gap analysis, or developing a measure framework. This foundational information is then used to develop a business case for the measure to ensure the measure is evidence-based.

The next step in measure development is measure specification. In this step the public has an opportunity to comment on the measure. Technical expert panels can be used to gather more specific recommendations related to the measure. And then in this step CMS partners with patients, front-line clinicians, professional societies, and clinical experts to help develop the measure.

In the third step in the measure development process -- measure testing -- the measure is tested to help assess the strengths and weaknesses of the measure. Then in the fourth step -- measure implementation -- the measure's prepared for the national quality forum -- or NQF -- endorsement process.

This step includes federal rulemaking and the selection of a quality measure. So for hospice, CMS determines if the measure should be included in the Hospice Quality Reporting Program. The fifth and final step of the measure development process is measure use, continuing evaluation, and measure maintenance.

This represents the ongoing analysis and re-evaluation of the measure. In this step, CMS and the measure developers must provide strong evidence that the measure that is currently in use continues to add value to the quality reporting

and incentive programs and that its construction continues to be sound throughout its measure lifecycle.

So now let's review Slide 21. So far I've provided general information that's true for all of CMS's quality measures. Now I'd like to turn to quality measures for the HQRP. Currently the HQRP reports ten measures based upon the H-I-S and one measure based on multiple hospice CAHPS items.

Most of the quality measures based on the H-I-S -- which are all process measures -- do not allow for meaningful differentiation between hospices. So looking ahead we're actively engaged in linking the HOPE tool with future quality measures.

And as (Jennifer) previously mentioned, one of the core objectives of the HOPE tool is to collect data for quality measures. Compared to the process measures that are based on the HIS, the outcome measures based on the HOPE are expected to help consumers better differentiate between hospices and provide a more meaningful window into hospice care throughout the dying process.

So currently we're also engaged in the development of claims-based measures. And -- as discussed in the FY 2020 rule -- claims-based measures are complementary to current measures based on HIS, and future measures based on HOPE. As well as the CAHPS-based patient experience metrics.

We are taking comments from the FY 2020 rule making under consideration in refining existing claims-based measures and advancing new measure concepts. So this concludes my part of this presentation. (Cindy)?

(Cindy Massuda): Thank you very much (Marian). We would now like to pause again for any questions on this quality measure update.

(Devin Warren): (Brandon), you may open the lines for questions.

(Zinnia Harrison): So (Cindy), while we're waiting for people to queue up a question came to my mind as I was listening to (Marian). So will the HOPE quality measures replace the HIS quality measures? Or will we have both HOPE and HIS quality measures?

(Cindy Massuda): That's a good question. So ultimately, you know, CMS would like to replace the Hospice Item Set and capture data with the hospice outcomes of patients' evaluation tool, the HOPE tool.

And CMS also aims to continue developing a portfolio of complementary measures that best serve the needs of all stakeholders and satisfy the objectives of the Hospice Quality Reporting Program. To this end, CMS will continue engaging in routine evaluation of its component measures and propose any changes it recommends through rulemaking.

(Zinnia Harrison): Thanks.

(Cindy Massuda): Do we have anybody queued up at this time, (Devin)?

(Devin Warren): (Brandon), are there questions queued up?

Coordinator: Yes. Our first question is from (Cathy Niberding). Your line is open.

(Cathy Niberding): Yes, we are curious to be able to see a draft version of where you are with the HOPE tool.

(Cindy Massuda): At this - we are - we will be sharing it as we get through the testing phase.

We are at the very, very early stages now where we are looking at it from concepts and cognitive testing. And with our focus groups.

If you go back several slides -- where we were showing visually -- that's where we are. So as we're able to test it in the beginning of calendar year 2020 we will be sharing the tool at that point.

(Cathy Niberding): Thank you.

(Cindy Massuda): Sure.

Coordinator: Our next question is from (Samantha Sugarman). Your line is open.

(Samantha Sugarman): Hi. So I have a couple of questions but they're closely linked.

And the last comment you - somebody had made was about developing claims measures.

And I was curious to know why these claims measures were going to be continued to be developed? Or what the purpose they would serve, knowing that they have limited clinical information?

(Cindy Massuda): Sure. So claims-based measures work with the perspective of giving - broadening a portfolio of measures for C - for the Hospice Quality Reporting Program. So it's part and parcel of a much larger set of measures, including outcome, process, the CAHPS hospice survey metrics, and so on.

But by being able to capture some claims-based measures, it is - it benefits from, you know, there's a very low level of burden to providers because we're

using claims. And there's a lot of - there is some good information. And so -- in areas where there is good information from claims data -- we would like to be able to - we plan to use it for quality measures in the future.

(Samantha Sugarman): And just pardon my not knowing this because it's literally the first time I'm joining this call. Are there current claims measures in this - in the Hospice Quality Reporting Program? Or no?

(Cindy Massuda): At this time there are not any claims-based...

(Samantha Sugarman): Okay. Okay.

(Cindy Massuda): ...measures. Yes.

(Samantha Sugarman): And then, I'm sorry, I don't want to hog anyone else's time. But is there the infrastructure available right now to be able to eventually accept quality measures that are developed off of the HOPE tool? Or even - well obviously the claims measures there are. But for the, you know, for these outcomes patient-reported quality measures?

(Cindy Massuda): To - do we have the infrastructure? So that's what the...

((Crosstalk))

(Samantha Sugarman): ...of the user. Like with the facility. Or, you know, whomever is implementing the quality measures. Will they - do they already have the infrastructure developed to be able to collect this level of data?

(Cindy Massuda): Okay, so we've - that's part of what these - we are - we're obviously in the very early stages. And we've been holding special open door forum calls for about a year now. And we do it about once a quarter.

In addition to that, we provide other educational materials. And that's part of what we'll be doing as we keep developing this tool. We continue - we will be continuing with education and training and development with the hospices so that when we are - it's ready to be rolled out and put into place.

This is obviously after rule making and we finalize the HOPE tool. We will make - we're working to have that training in place so that it - the infrastructure and everything's there. Which is why we're also working with our EHR vendors...

(Samantha Sugarman): Okay.

(Cindy Massuda): ...through this process.

(Samantha Sugarman): Great. Thank you.

(Cindy Massuda): Sure.

Coordinator: Our next question is from (Susan Mayo). Your line is open.

(Susan Mayo): Hello. My question is how the HOPE tool will be different from the quality measures that we gathered even prior to HIS? When -- prior to HIS -- when we did the quality measure about acceptable pain in 48 hours, that seemed to be an outcome measure. But it seemed not to gather enough data to show what kind of patients we were assessing.

It seemed to benefit a hospice that had lots of patients who were maybe dementia patients who didn't have pain in the first place. And not take into account the type of more critically - a patient who required more critical interventions.

(Marian Essey): (Cindy), would you like me to take this? It's (Marian).

(Cindy Massuda): Sure, go ahead.

(Marian Essey): Yes, I think that's a great question. We are at the beginning phases of the measure conceptualization process. We're testing the instrument or the items in the HOPE and looking to develop quality measures based upon those.

So I - we can't specifically say exactly what those quality measures will look like. But what we can say is that there are going to be plenty of opportunities in the future to provide feedback on those measures and any concerns that you might have. So please stay tuned to the Hospice Quality Reporting site, because we are looking for feedback.

(Susan Mayo): Okay, excellent. Thank you.

Coordinator: Our next question is from (Colleen O'Keefe). Your line is open.

(Colleen O'Keefe): Hi. Hi again. Will there be an application for this HOPE tool to pediatric hospice patients? That's number one. And number two -- and this is a much larger question -- will there be any - is there or do you anticipate coordination application of this model for palliative care in home health? And that's of interest I'm sure to those of us that operate multiple programs.

Dr. (Jennifer Riggs): (Cindy), this is (Jennifer). Would you like me to take that?

(Cindy Massuda): Sure.

Dr. (Jennifer Riggs): So thanks for the question. The first question you asked -- about application to pediatric -- we're still in the point of instrument development where we don't have a firm answer on that yet. So stay tuned. We certainly - it's certainly under consideration exactly how that will work.

And then the second part of your question, can you help me understand just a little bit? You're asking about application of the model in home health, but I'm not sure exactly what you might mean by that.

(Colleen O'Keefe): Well, palliative - the palliative care program and home health program obviously are under different regulations and have different measures. I'm just curious, in the bigger picture or longer term is the - are - is CMS looking at how those programs too are measuring - looking at their measures?

And really looking at -- as you referenced before -- applying a meaningful measure framework to other programs? I apologize, I know it's bigger than hospice right now. But it's certainly worth considering. Or maybe you're thinking let's do this first, test it, apply it, and then see if it could be applicable to other CMS programs.

(Cindy Massuda): I will say that it's - as we, you know, we're actually - we're obviously developing this for the hospice setting. But if there is applicability to it or an appropriate need to apply it in other settings, that is something we would be, you know, we -- as an agency -- we would obviously want to do. To make the most appropriate use of our measures across multiple settings as appropriate. But at this time it's being developed for the hospice setting, and that's where it's being tested.

(Colleen O'Keefe): Okay. I'm just thinking in terms of populations that move, often between these programs. That it might be something to consider down the road.
Palliative...

((Crosstalk))

(Cindy Massuda): All right. Well I will - then I will say like the Impact Act of 2014 -- which resulted in the SPADEs being developed across the different post-acute care settings of home health, SNFs, in-patient rehab, and long-term care hospitals - those settings - that Act, that - those set of measures that were set up.

We are -- while hospice was not a part of the Impact Act -- we are looking at those SPADEs measures that were just recently rolled out in those other four post-acute care settings to see if there's any applicability to apply them in the hospice - in this HOPE tool. And if there are, where we see applicability we are planning to test it.

But all - not necessarily everything that's in SPADEs makes sense to be testing in hospice. But again, because we want to see continuity of care across settings we are looking at that and being thoughtful about that. And I mean if you have ideas or you have thoughts you're always welcome to send them.

I mean we're happy to hear them here on this call, but also we do have our mailbox. The HospiceAssessment@CMS.HHS.gov mailbox, which is listed at the end of these slides. Always welcome to send your comments, your thoughts. We - the people who are on these calls are the people who look at those comments. I appreciate your thoughts.

(Colleen O'Keefe): Thank you so much. Thank you.

Coordinator: Our next question is from (Maureen Henry). Your line is open.

(Maureen Henry): Thank you. Just to follow up on the earlier call or question about the claims-based measures. Do you have any specific concepts that you're exploring with claims-based measures at this time?

(Cindy Massuda): We - I mean we are looking - we are at the concept stage. And we haven't really developed a path to concept because we're - I mean to think about it further than that at this point.

So is wanting to -- at the time when we're ready to think about it broader than that, where we feel it has more potential -- we will be sharing it. But at this point we're just really looking at different concepts. I mean if you have ideas, again we're very interested in hearing ideas that you may have.

(Maureen Henry): Thank you.

(Cindy Massuda): Sure.

Coordinator: Our next question is from (Rochelle Webster). Your line is open.

(Rochelle Webster): Hi. My question is about - you said that claims measures broadened the portfolio of hospice measures? And I'm wondering if you can explain what the value is in that besides job security for me as a quality professional?

I often think that simpler is better. And allows us to - I strongly support CAHPS and it makes sense to do visits at the end of life. And I really question a broader portfolio.

(Cindy Massuda): Okay, so when I say broader I don't mean in the sense of just bigger for the sake of bigger, as bigger would be better. That's not the thought. The thought is, is that we need a set of meaningful measures in hospice.

And right now what we really have is a - the composite measure of representing the comprehensive assessment. That's showing - there's measures that are showing variability right now, is that measure. And then we have the CAHPS measures. So the other seven hospice item set measures right now are not showing variability across hospices.

So trying to - so we are looking at developing measures that give us that level of variability. But at this point really having - and then we have the hospice visits when death is imminent measure. So there's three measures at this time that are showing variability in the program.

So obviously we would like - we believe there is other areas of hospice to be measuring and to be looking at, which is what the outcome measures of HOPE gets to. And then claims-based. I mean even when you look at something like hospice visits when death is imminent, the part, you know, what parts of it could be, you know, could look at that is are there ways to do that claims-based?

So it's not - it's just what can be done on a claims-based approach, which would reduce burden to the providers and provide meaningful measures to the hospice community -- our consumers -- and obviously make the program stronger. So when we say "broader", it's not meant - it's meant to be more meaningful. So maybe I should use the term more meaningful to - in hospice.

(Zinnia Harrison): So thank you (Cindy). And I want to thank everybody for all your questions. This has been really a great discussion. So as we begin to close the session I'd

like to share some of the next steps in CMS's development of the HOPE tool and quality measures.

If we go to Slide 24. So first CMS is organizing a technical expert panel -- or TEP -- on the HOPE tool and related quality measure concepts. We're actively recruiting for this TEP and would greatly appreciate your interest. So please visit the link to learn more about the application process.

Applicants or nominees must submit materials by September 30. Just a few weeks - couple weeks away. This TEP will play a key role in helping the Abt team to refine future QM concepts that are linked to the HOPE tool item.

We're also preparing the HOPE tool for testing. And we'll keep everyone informed through the Hospice Quality Reporting Program web page and other sub-regulatory communication channels. And finally, we'll continue to develop claims-based quality measures -- as we were just talking about -- to complement the current and future quality measures as well.

And just to clarify, when someone asked about -- as an EHR vendor -- how to contact us for the listening session or additional engagement if you are an EHR vendor, please use HospiceAssessment@CMS.HHS.gov.

(Cindy Massuda): Yes, we always appreciate hearing from you. And as I said, this mailbox is actively monitored. The people who were on this call today -- presenting the Special Open Door Forum -- are people who - the people who look at the questions that come in.

So please continue to send your questions in, your comments to the HospiceAssessment@CMS.HHS.gov. And thank you very much for participating in this Special Open Door Forum. We look forward to

continuing our engagement with you on our work to develop the HOPE tool.
And portfolio of quality measures for the Hospice Quality Reporting Program.

Please continue to feel free to contact us at any time with your feedback, again
at the HospiceAssessment@CMS.HHS.gov . And with that I'll turn it over to
our moderator, (Devin).

(Devin Warren): Yes, thank you ladies. And thank you all for joining today's special open door
forum on the HOPE tool. (Brandon), thank you for your assistance as well.
This concludes today's Special Open Door Forums. Have a great day.

Coordinator: Thank you for participating in today's conference. All lines may disconnect at
this time.

END