

Centers for Medicare and Medicaid Services
Special Open Door Forum
Developing a Hospice Assessment Tool---Goals and Status Update
Moderator: Jill Darling
Wednesday, September 26, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Mariama) and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum: Developing a Hospice Assessment Tools -- Goals and Status Update Conference Call.

All lines will be placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during that time, please press star and then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

I would now like to turn the call over to Jill Darling. You may begin your conference.

Jill Darling: Thanks, (Mariama). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications, and thank you for joining us today for the Special Open Door Forum.

Before we get into today's presentation, I have one brief announcement. This Special Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And for those who have today's announcement, there is a link for the slides today. So if you have access to the announcement, you may follow along with the slides. If not, you may get the link after today's call.

So, I will now hand the call off to Cindy Massuda.

Cindy Massuda: Thank you very much, Jill. Hello, everyone. I want to welcome you to the Special Open Door Forum on the Hospice Evaluation and Assessment Reporting Tool. This is going to be a discussion to get to discuss the HEART tool. I am Cindy Massuda and I'm lead for the Hospice Quality Reporting Program for the Centers for Medicare and Medicaid Services.

Today is the first of quarterly Special Open Door Forums on HEART. On behalf of CMS, we value and appreciate stakeholder input as we develop HEART. Thank you for joining today's discussion. We can only do this important work with your input. This is why we set up the quarterly Special Open Door Forum, a new e-mail box for continuous communication and other opportunities for stakeholder input.

I have worked on hospice issues at CMS for almost 15 years. I have led the hospice demonstrations, designed the Medicare Care Choices Model, and now lead the Hospice Quality Reporting Program. This work on HEART is one of the most important work for the hospice industry, and I am excited to work on it. The goal is to make the tool, the hospice assessment tool, useful to hospices for your plan of care and for our use for quality measures.

As we get started on today's discussion, I'm going to walk through the acronyms you'll be hearing during this presentation, the Hospice Evaluation Assessment Reporting Tool affectionately known as HEART; the Hospice Quality Reporting Program, HQRP; the Hospice Item Set, HIS or H-I-S; the Consumer Assessment of Healthcare Providers and Systems Hospice Survey known as the CAHPS Hospice Survey; and Electronic Health Records or EHRs.

So the objective of today's HEART discussion is to provide a state of where we are on the Hospice Evaluation and Assessment Reporting Tool. So we're going to – I'll be talking about the background and purpose and goals of the Hospice Evaluation and Assessment Reporting Tool. I'll provide a summary of our Pilot A test that was done earlier this year, and highlight the findings and lessons learned to be implemented for further testing; provide a status

update on the development of HEART and identify the immediate next steps for continued development and future testing. Of course, this information is all provided in order to have a robust discussion with you during the question-and-answer session for the Special Open Door forum call.

To set – I'm on slide five for those following along by the slides. To set the stage for HEART, it helps to (steep) this conversation in the larger Hospice Quality Reporting Program. HEART would become part of the Hospice Quality Reporting Program once it's implemented through rulemaking.

The Hospice Quality Reporting Program promotes delivery of person-centered, high quality, and safe care by hospices. Sections 3004(C) of the Patient Protection and Affordable Act that amended the Social Security Act established the Hospice Quality Reporting Program. CMS has adopted measures that were recommended by multi-stakeholder organizations and developed with the input of providers, payers, and other stakeholders. So, HEART would become part of the Hospice Quality Reporting Program when it's ready.

Currently, though, we have two requirements for the Hospice Quality Reporting Program -- the Hospice Item Set, which is HIS; and the Consumer Assessment of Healthcare Provider and Systems, the CAHPS Hospice Survey. All Medicare-certified hospice must comply with the submission of these two reporting requirements for all of their hospice patients.

So the Centers for Medicare and Medicaid Services is interested in developing a standardized patient assessment tool for hospices and that's what we're discussing today. A key goal of this comprehensive patient assessment tool, which is going to be known as HEART, is to understand the care needs throughout the patient's (dying) process and provide hospices with important information to help them understand and address patient and family needs, and ensure delivery of high-quality care throughout the patient's stay.

HEART is intended to be multifunctional such that it's used by hospices as part of their plan of care and by CMS for quality measure calculation. The point of HEART is to capture information throughout the dying process in

order to achieve a fuller understanding of patient care needs throughout the hospice stay. That's the key progress we want to make with bringing on HEART here at CMS as part of our Hospice Quality Reporting Program. It is to be able to look at patient care needs for the hospice patient throughout the dying process. This means, we plan on assessment at admission and discharge like we have currently in the Hospice Item Set, and to include interim assessments in order to provide a fuller picture of hospice patient and family needs.

I'm on slide eight. HEART would include admission and discharge assessments as well as interim assessments, standard of practice checklist, and additional clinical items that could be used to develop new quality measures to provide a fuller picture of the hospice patient, family, and caregiver care needs. Since HEART will have its own admission and discharge assessments, HEART would replace the current HIS once implemented. It would not replace other Hospice Quality Reporting Program's data collection efforts such as the CAHPS Hospice Survey.

HEART would be designed to complement data that are collected as part of a high-quality clinical care and would not replace or conflict with existing requirements set forth in the Medicare Hospice Conditions of Participation, the CoP, such as the initial and comprehensive assessment.

HEART might be considered for future payment refinements as a – that would be a secondary goal. But that is not planned for at this time. It is planned completely as a quality measure program.

HEART is envisioned to capture quality, clinical, and resource intensity throughout the patient's day by collecting HEART assessments at various times during a patient's hospice stay from any Medicare certified hospice provider. And of course, HEART is subject to change as we test and receive stakeholder input. The process we're using to develop HEART is meant to be a fluid process in order to capture stakeholder input and lessons learned as we go – as we develop HEART.

As I move in to discussing HEART – the Pilot A testing findings, it's important to appreciate that all work related to HEART and the HQRP program is done with stakeholder input. For Pilot A, the concepts for HEART were based on the recommendations of the Technical Expert Panel (TEP). We held that TEP for two days beginning on November 2nd, 2017, which was almost a year ago. We posted the TEP report and it's on our Hospice Quality Reporting Program website. And that link is provided here on slide 10 in the handouts for this Special Open Door Forum for your convenience.

So now, talking about the Pilot A study. Pilot A was designed to identify issues associated with item wording that may require refinement to best capture the item concepts.

Pilot A was conducted to evaluate the feasibility of implementing the HEART instrument by examining provider data collection methods, current clinical practice, and experiences of provider burden. The study was intended to give insight into matters that could impact the reliability and validity of HEART data item prior to national testing.

Since with the pilot, we worked with nine hospices. The nine hospice sites were chosen based on a variety of characteristics to promote diversity. The idea when we do pilot testing was to select nine pilot sites that could represent – be representative of the nation so that we have the hospice characteristics that are looking at this on a national – as a view – as a lens into the national hospice community.

So, the diversity that we looked at for these nine hospices was geographic, urban and rural, the size based on average daily census, patients of various lengths of stay, care in different settings, the business or tax status of the hospice, the clinical records, hospices having both EHR and paper-based systems. And each pilot site participated in a pilot test process and data collection training in order to prepare for Pilot A testing.

So Pilot A items that were determined by the Technical Expert Panel that were tested in Pilot A. We have the HEART admission, and that was to provide a comprehensive picture of patient and family care needs at

admission, quality of care related to identifying and beginning to meet the needs of the patients, and the resources the hospice anticipates it would – as if it would have – if when we deployed this admission assessment.

The HEART discharge was a retrospective capturing the care that was delivered towards the end of the patient's hospice stay and is an expanded discharge assessment to capture a broader view of hospice-patient care at discharge.

The new assessments to test out interim assessments, the TEP recommended that we do a hospice 60-day interim assessment, and this was an interim with a new assessment to capture the care needs every 60 days after admission to capture major changes in patient and family care needs during the hospice stay and to enable a more comprehensive view of hospice care.

The other interim assessment that was recommended by the TEP to test out in Pilot A was a HEART interim assessment for the imminently dying. And this was a new assessment for hospice focused on patient physical and psychosocial symptoms, as well as family and caregiver needs once the patient is transitioning to imminently dying.

So the pilot sites were asked to collect the data and complete eight to 12 of the assessments of each type – of each of these four types of assessments -- the admission, the discharge, the 60-day interim assessment, and the imminently dying interim assessment. And they sent this to us through our contractor via a secure website on a rolling basis. All pilot sites participated in a total of six weekly check-in call during, which they discussed their experiences with each of these assessments and collecting HEART data.

So findings about the – from Pilot A. So for the HEART admission assessment – in general, for the HEART admission assessment, it was reflective of the hospice's current assessment processes with the addition of some details added such as the patient (distress).

For the HEART discharge assessment, which is again similar to Hospice Item Set, pilot sites were able to retroactively obtain information via chart

abstraction. The data came from a mixture of sources including assessment data, administrative data, and clinician notes, and the data collections were typically chart extractors rather than bedside clinicians.

So for the newer – the new assessments that were being tested, the HEART interim 60-day assessment, the pilot sites advise us that a long-stay interim assessment is feasible. But the content and timing of doing it at a 60-day period was not aligning well with their work flow. And so, it was recommended that we follow this – at times of re-certification that based on patient needs – as patient's needs change and there was a need in the change in plan of care that would be another appropriate time to do an interim assessment. And they recommended having skip patterns on this assessment to identify the decline and function so they could focus on the plan of care needs.

The HEART interim assessment for the imminently dying, the pilot sites provided feedback that when patients are identified as imminently dying, the pilot sites need to focus or hospices need to focus their time on providing support to the patient and family rather than working on filling out a standardized assessment.

Since a large portion of patients are minimally responsive at the time of imminent death and cannot respond to questions that was another reason why the assessment was not thought to be useful. And content should fit with current workflows and processes so as not to require additional time of resources to complete an assessment. Instead, a checklist was identified that should be developed rather than using assessment for the imminently dying.

Feedback that was relevant to future testing and implementation. Training and messaging, the sites supported the training approach that embraces resources similar to those used for the Hospice Item Set, including a manual and webinar training. And this was for burden. They said that data collection for Pilot A was time-consuming, and data needed for HEART were often spread across structured and unstructured fields of the clinical records. In

short, the pilot was too paper-based and needs to be conducted in a more electronic fashion to better fit the electronic health record system.

So, going with that, they recommended that in order for HEART to become part of the hospice practice, sites felt that integration into the electronic health records would be necessary, such that (vendors) should be part of the process as early as possible and even as early as we're doing the development of HEART.

So, as a status update, the efforts are currently underway. We're developing a comprehensive hospice assessment tool to be beneficial to hospice providers, patients and their families, and CMS. We're trying to assure that we address issues raised during Pilot A. Further testing phases will incorporate these findings. And CMS is working diligently to re-tool the HEART following lessons learned from Pilot A.

As we move into our next steps, we're obviously conducting these Special Open Door Forums like the one today. We will have another one in December. And we are committed to doing them quarterly. So through the calendar year 2019, they will be in March, June, September, and December. And it will be announced very similar to the way today's Special Open Door Forum has been announced.

We will continue to provide regular updates on CMS's web pages including how to get involved and allow an open forum for stakeholders to provide feedback. We will explore options to determine how to make an assessment to a more electronic, non-redundant, and fit hospice's business model; identify whether some assessment should remain an assessment or become a checklist such as the imminently dying checklist.

In preparation for further pilot testing, we will develop the best practice model for assessment instrument training. We also have a mailbox dedicated to HEART for you, our stakeholders, to communicate with us as we work on HEART.

I'm on slide 19 where we're showing the interrelated activity for developing HEART and just give you a status update where we are with HEART. So as you can see, we started out with our Technical Expert Panel last November. We did pilot testing in January through March of this past year. We're holding Special Open Door Forums. We will continue to be holding Special Open Door Forums in March, June, September, and December of 2019. We will continue to develop the hospice assessment tool based on stakeholder input. If we need additional Technical Expert Panels, we will be conducting them and doing further pilot testing and then planning for rule making and implementation for HEART into the Hospice Quality Reporting Program.

So with that background, I'd like to move into a discussion with you and share focus questions to help focus the discussion during this question-and-answer session.

So, what are – on slide 20, we have the questions. What are your initial thoughts on the hospice assessment tool that covers the complete hospice patient stay? Related questions to that are, what would like to see in the admission assessment? What would like to see in the interim assessment? What would you include in a checklist to identify patients who are imminently dying or other checklist? What would you like to see in a discharge assessment? And what else should be addressed in a hospice assessment tool?

So with that, I'll turn it over for questions and answers.

Operator: At this time, I would like to remind everyone in order to ask a question please press star and then the number one on your telephone keypad. We'll pause for a brief moment to compile the Q&A roster.

You have a question from the line of (Kay Cox), North Carolina Department. Your line is open.

(Kay Cox), your line is open.

(Kay Cox): Sorry. I hit it by accident.

- Operator: You have a question from the line of Deborah Frank with Hospice of Marion. Your line is open.
- Deborah Frank: Hi. I would like to ask about the burden on patient's families at the time of the imminently dying assessment. And I'm wondering if you could share some of the questions that are on that checklist currently and whether those could be kept really to a minimum just because of the timing and the emotional issues that patient's family are going through at that time. And is it really necessary?
- Cindy Massuda: Sure. Thank you for your question. So, for the imminently dying, in the Pilot A, it was not done as a checklist. It was done as an assessment. And that's where we found it was burdensome for families. What we're thinking about doing – what we are looking for and would like input on is moving toward a checklist; having a checklist of identifying when a patient is imminently dying. This is something that the hospice staff would be using to help them when they are at their interdisciplinary team meetings to help identify patients who are imminently dying. And what we found while the assessment that was used for the Pilot A for imminently dying in itself was not appropriate at that time, the kinds of questions or the way it identified helped hospices, especially hospices that didn't necessarily have a protocol in place for imminently dying. It helped them to identify patients that would be imminently dying so that they could work across their teams, their interdisciplinary teams, to share that information so that the appropriate – the kinds of care that they want to implement at that point got in place.
- It also helped them to identify patients who they hadn't necessarily thought were imminently dying. And that's why the thought of doing a checklist and if we – the way – was something we're strongly considering as part of the hospice evaluation and reporting tool.
- Carol Schwartz: This is Carol Schwartz at CMS. If there were such as checklist, what would be the items that you would think would be particularly important to have? If you would like, we also have a web that have a link and later you can respond

to that question – anybody can respond. We're looking for any and all insights.

Operator: Your next question comes from Nancy Gelle with Park Nicollet Hospice. Your line is open.

Nancy Gelle: Yes. The question I have is, was there ever any consideration for the interim assessment to coincide with the certification of terminal illness requirements? So, the first one would be at 90 days. (It's sort of a workflow). It seems like it might be helpful to have those match up?

Cindy Massuda: Thank you. And that was actually one of the takeaways, one of the lessons learned from the Pilot A. When we had our TEP meeting back in November of last year, we discussed different times of doing the interim assessment. And one of them was whether we did it at specific times like recertification, like you're saying at the 90-day or other points of recertification, and also when there could be changes of plan of care or should we do it at specific time intervals.

And the TEP at that time had recommended that we test out this 60-day time interval. We were going to test – and so that what was tested in Pilot A. And if you want to look at the TEP report, we do have it posted on our HEART website on our webpage if you want to look at that report to get more information. But one of the takeaways (of Pilot A) is exactly what you're saying that if we're going to do an interim assessment, we need to do it to fit the business model of hospices so that it fits your workflow. And that doing it during recertification is the recommendation (for further pilot testing).

Nancy Gelle: Thank you.

Operator: Your next question comes from Marisette Hasan with Carolinas Center. Your line is open.

Marisette Hasan: Hi. Good afternoon. Thank you for the opportunity. I'm curious to know how you were delineating between the admission assessment with the HEART tool and the comprehensive assessment that the hospice team is going to be

putting together at the same time. And a lot of those question is about assessment tool is really going to have some similar information, I would think. So curious to hear how the pilots responded to that.

Cindy Massuda: Sure. So when we – the work that we would be doing on the admission assessment because we want to make it part of the electronic health record, it may well be pulling things from a comprehensive assessment. So that's actually what we are looking to coordinate to make whatever we do on our admission assessment flow as best as possible with the workflow. So if we – where it makes sense we would be so we are non-redundant being able to pull data from the comprehensive assessment.

Marisette Hasan: All right. And could that also work the same way for the recertification time as the team is coming together to make those changes in the care plan? They're doing updates to that comprehensive assessment. Would the same principle apply?

Cindy Massuda: That's the same principle. You're thinking exactly along the same way of thinking that we are here, that we are very much trying to make this fit your business model, fit your workflow so that so it is non-redundant and can capture information that it's in your electronic health record and information you're already capturing if you're on paper based.

Marisette Hasan: Thank you.

Operator: Your next question comes from Josh Lamkin with Meditech. Your line is open.

Josh Lamkin: Hi there. CMS already has a tool called HART, H-A-R-T, the Hospice Abstraction Reporting Tool. And I'm wondering if you plan to change the name of that? Or if it will be discontinued or you're worried any way about the confusion that this probably going to arise with – or like on some level with the nomenclature there? I already had one conversation with someone where we were talking about the two different things. I was talking about the assessment we're talking about today. And they were talking about the abstractions reporting tool. Wondered if you thought about that all.

Cindy Massuda: We have thought about that. And it is something we can consider if we – to move to change the name of the tool used in the IT system to a different name. But it's something that we can consider. Because I do agree with you there can be confusion since obviously they're both used in hospice.

Josh Lamkin: Sure.

(Inaudible)

Cindy Massuda: Sure.

Operator: Your next question comes from Christine Nidd with (Hospice of the North). Your line is open.

Christine Nidd: Hi. Now, when HEART was initially presented to the Technical Expert Panel last November, there was plans to have more of a two-way conversation after the pilot test and then an in-person meeting. These haven't happened. But I don't see any reference to the TEP on slide 19 and the plans that come before the rulemaking. And I wonder if there's no longer a plan to involve the TEP.

Cindy Massuda: So, that's why I was saying this is two-way arrow. And I was saying as I was speaking – well, I mentioned that TEP – it shows the TEP at the beginning last November that I was saying that as we continue to develop the hospice assessment tool that if we need to do additional TEPs or additional follow-up, we would be doing that.

Christine Nidd: But there's no plan really at this point?

Cindy Massuda: Well, it's not that it's not planned – we don't have a specific one planned at this time. But as we develop it, if it's needed, we would be doing that yes.

Christine Nidd: OK. So, it's a maybe/maybe not.

Cindy Massuda: I mean, I can't – we'll leave it as a maybe.

Christine Nidd: OK.

Cindy Massuda: It's a – yes.

Operator: Your next question comes from Tammy Leak with Hospice of Cincinnati.
Your line is open.

Tammy Leak: I apologize. That was a mistake.

Operator: I apologize. Your next question comes from Ann Ackerman with Hospice &
Community. Your line is open.

Ann Ackerman: Good afternoon. Thank you. I just have a comment to start. I would just encourage that whatever assessment tool is developed includes all the disciplines. My experience with these kinds of tools tends to be very medical and not taking into account the interdisciplinary approach. So, I would just, as a comment, encourage that we make sure we capture interventions from all members of the team.

And then I also have a question about the change of plan of care assessment. So how big a change in the plan of care? I mean the meds could change hourly. So, I'm just – what that might – definition of that might look like and how big a plan of care change? I'm just curious.

And also I'm struggling with the imminent death checklist. And you commented to help us identify who's imminently dying, and I'm not quite sure what – how that would help. I'm just struggling with the concept and defining imminently dying, how long do you think? I mean – and it's not an exact science. Thank you.

Cindy Massuda: OK. So, your – one question was about the imminently dying. I'll start with that one first. And the checklist. I mean we are just looking to – it's meant to help – it's meant for the hospices to help them identify who is imminently dying. It's also to help – if you look at it from the perspective of – we're trying to look at this tool as an ability to get a fuller picture of patient care needs throughout the dying process.

And so right now, we have admission and discharge. So, it's trying to understand what are the care needs; between those periods and if there's appropriate things for a short-stay patient, if there's appropriate things for the longer-stay patient.

And so for the imminently dying, the idea was to provide a checklist more to help – determine to help identify patients who, one, may not be at the time recognized be imminently dying. But as you look at checklist and with your kinds of experience, you would be saying, yes, this patient who I haven't thought about makes sense – actually probably is imminently dying. I need to look at that patient more carefully. And it's a way to help get the teams together so that the care needs for the imminently dying are considered because obviously those needs are going to be much higher. So that's the purpose behind the checklist.

And obviously, we're looking – I know they're looking for the input from the industry when we did the Pilot A testing. Some of the sites gave us ideas of what they were thinking about in terms of a checklist for imminently dying. And we can – it's something that the – as we develop it, it would be developed in tandem with stakeholder input and for – and to get feedback because we obviously can't develop this work without input.

Your other question was about the interim assessment and looking at when it would make sense with the plan of care change. I mean this would be – these assessments are meant to help identify when you have a major plan of – change in plan – a change in care that requires a plan – a change in the plan of care.

So, there would be skip patterns. So that you're only focusing – the idea would be only to focus on that which is causing the change in the plan of care to get insight into the patients and their needs like I was saying through their dying process. It's to understand that. And to also be sure that – so that it would help hospices as they are providing the care needs for their patients and then coordination with CMS being able to get a sense as to what are those care needs at the end of life.

Operator: Your next question comes from Mary Helen Tieken with Nurses in Touch.
Your line is open.

Mary Helen Tieken: Hi. Good afternoon. Appreciate this discussion very much. I too had a question about the changes to the plan of care and what those triggers might be. And I thought maybe GIP status, risk status, continuous care status, is that what you're looking at?

Cindy Massuda: So I mean that would be an area where you would have – and we talked about – this is one – whether it would be going to higher levels of care would cause – I mean this is really looking at decline in the patient, things that would cause the patient to be declining that would be a plan of – a change in the plan of care that could lead to identifying those parts on an assessment.

But like I said, we would be – this is obviously something we're in the development stages on, and we're looking at from the perspective of having skip patterns so that we're really only looking at where is the issue that's causing the plan of care change, typically the decline in care.

Mary Helen Tieken: It's just an observation on my part but it seems to me that it's CMS who needs this information. Hospices already have a pretty good idea of what we do and when we make these changes to the plan of care. So it seems like CMS needs some factual data from us to begin to develop some other things. Am I on the right track with that?

Cindy Massuda: I mean it's done for quality of care needs. I mean we're looking at this from a – from quality measure development. And so – because – I mean, in the Medicare program, I mean, we've had the hospice benefit. But we really do not have at CMS the ability to appreciate the needs of the patient throughout the dying process. So that's the rationale behind the interim assessment.

Mary Helen Tieken: OK. Thanks.

Operator: Your next question comes from the Eugenia Smither with Bluegrass Care.
Your line is open.

Eugenia Smither: Hi. Yes, thank you. In reading your report, you made reference to the patient and family work group that you pulled together. But I really was struggling to find some information or feedback that you received from that group which you've identified would be an important aspect to help inform this process because – so could you talk a little more about that?

Cindy Massuda: Sure. So our contractor has a patient and family workgroup that they coordinate with. And so that's who they speak with and get feedback from as they are developing the assessment tool that was tested out in Pilot A.

Eugenia Smither: So, I'm sorry, you're saying that the – that workgroup helped inform what was on the assessment tool? Is that what you said? I'm not sure I understood.

Cindy Massuda: They get their feedback from their perspective, from the patient and family perspective.

Eugenia Smither: OK. But that information wasn't included in the report. It just helped inform the assessment. Is that what I'm hearing?

Cindy Massuda: Yes. Yes.

Eugenia Smither: OK.

Cindy Massuda: I will say we are interested in much more patient and family input as we're developing and re-tooling on HEART.

Eugenia Smither: Yes. I mean some of the points that were brought up about the – what burden could – how that imminently dying tool, whatever it is, can impact that process during a very vulnerable time. So did they help provide feedback in that space as well?

Cindy Massuda: Well, we got – that feedback the hospices provided – the pilot sites provided to us based on family input that they had received in addition to their being working on these assessments during the pilot, and having the patients and families with them.

So, we got very clear feedback as to how it was impacting the kind of work they wanted to be able to do, which is why we're looking – we're being very thoughtful about how to think about what to do for the imminently dying if we do a some sort rather than assessment--- a checklist.

Eugenia Smither: OK. So, is that patient-family work group being asked that question at this point, too, I guess?

Cindy Massuda: Well, at this time, we would be working with further patient. We would be reaching out to further patients and family to get their feedback.

Eugenia Smither: OK. Thank you so much.

Cindy Massuda: Sure.

Operator: Your next question comes from (Rena Osborne) with (Integrus Miami). Your line is open.

(Rena Osborne): In reading this, it says that these assessments are going to replace the HIS. Is that correct?

Cindy Massuda: Well, what would happen is that these assessments – this will become a standardized tool that would include, which – the admission and discharge assessments?

So, if we're going – once we have an admission and discharge assessments through and the hospice assessment tool we wouldn't need to repeat it through the Hospice Item Set. So, that's what it's meant by it would replace it.

(Rena Osborne): OK. Thank you.

Operator: Your next question comes from (Mary Prusky) with Hospice Buffalo. Your line is open.

(Mary Prusky): Good afternoon and thank you for the opportunity. I wanted to ask or suggest if we're looking for interdisciplinary team input into the patient's care. Could this not be structured into the regular team meetings? We team our patients at least every two weeks and kick them up to every week as they're having

changes. If there was a tool built into the IDG documentation, maybe we could capture it as a regular part of the meeting because we probably already do speak to it. It's just not formalized for abstractions. What do you think?

Cindy Massuda: I think that's an excellent idea and something for us to be considering. I very much appreciate your insights there.

(Mary Prusky): Thank you very much. My last question, for the imminently dying, I also agree with the other responders that it's difficult sometimes to intervene with the family and all the emotional feelings that they're going through. And a checklist would be fine because we check in on these things and maybe our answer is addressed or not needed. But we often have patients who are at palliative care for 40 percent. They're out of bed. And suddenly the next day, they pass in their sleep during the night. And we would have no warning that they were going to slip away that quick. And speaking to the others, we know pretty well if we can see something suddenly coming at us.

So, I'm hoping that the tool would address that need as well as families who say we're prepared. Thank you. You don't need to come every day. And we just call and check on them every day.

Cindy Massuda: Yes. I mean – and just to help level set, I mean our thinking – and obviously this is fluid thinking which was why we're having Special Open Door Forums and working with the stakeholders. I mean clear feedback that we got from our pilot sites was that on the imminently dying, they don't want anything set up that could ding a hospice for missing a patient who is dying that they – because it doesn't – it's not always that obvious, and we completely understand that. And that's part of what we are sensitive to.

We are also sensitive that we want the time spent with the families during the imminently dying process to be with the families and not some paperwork for – to fill out for purposes that don't help the patient or the family.

The checklist concept was something meant more for the hospice to have as a – literally that – a checklist for them. It's not something they have to sit there and go down -- did I do this, did I do that. It's a checklist to help them

identify patients as best as they can. And the idea would be that it's meant to be a best practice or as close as we can get to a best practice for identifying imminently dying. It's meant to help the industry.

It is not meant to be an assessment in itself. If anything, as an example and this is purely as an example to give a sense, it would be – did you – were you – did you use a checklist for the imminently dying?

Not – so, it is not – it's not meant to give a ding or to impact the hospices. It's meant to actually be useful. And we're very sensitive to that issue from both the Pilot A and obviously through the kinds of questions that are coming through along today's call.

So, I very much appreciate. And I just hope you appreciate that we are very sensitive to that issue and would not be moving forward on something in a further testing without a lot of input from the industry.

(Mary Prusky): Thank you. We'll look forward to give you more input as you wish.

Cindy Massuda: We look forward to that. Thank you.

Operator: Your next question comes from Rochelle Webster with Asante Hospital. Your line is open.

Rochelle Webster: Hi. Regarding the checklist to help staff identify who's imminently dying, it's – I've taken a look at the palliative care literature about what these folks look like maybe in the last week of life for the purposes of educating our nurse, and it's really not easy. And that's why you're talking about doing it because it's not easy, right? If it were easy, then we wouldn't need a checklist.

So, I would hope that in addition to talking to the industry, you'd be looking at the literature and some of the researchers out there who've really put work into identifying what those characteristics are.

Cindy Massuda: Absolutely. I mean we don't – we do our work in conjunction with research; what's out there in the literature; what's in grey literature. We obviously hold Special Open Door Forums. We hold Technical Expert Panels as we need

them. And we obviously listen to the stakeholders very carefully. And as we develop a checklist, it maybe something that we – obviously, we’re going to be piloting it to try to see – to get it as right as possible recognizing we probably have to refine it along the way.

But the goal is to help get to the point where we have as strong a practice as to be able to help identify imminently dying, if possible recognizing. It’s an art as more than it probably is a science. So, there’s a balance there; so trying to find that balance to get something in place for the industry.

Operator: Your next question comes from (Jeni Albans) with Consumer Direct. Your line is open.

(Jeni Albans), your line is open.

(Jeni Albans): Hi. Good afternoon and thanks so much for holding this open door forum. My first question is what suggestions were there about the imminently dying checklist? You said that there were a couple of suggestions what to put on the checklist? And it must be really hard to – for everyone listening try to quantify something that is not quantifiable really. It is an art. And I so appreciate you saying that.

Cindy Massuda: So, it’s not meant to be like – we’re more – like questions to if you saw these qualities, would that patient be considered – would you then consider the patient imminently dying?

(Jeni Albans): Right.

Cindy Massuda: So, it’s looking through – yes. So, it’s that kind of a checklist. It’s not any quantifying assessment but rather a checklist for use by hospices to help identify patients who are imminently dying.

Cindy Massuda: Go ahead.

(Jeni Albans): Right. And also to what – you’re looking to find out what the patients and families need at the end of life. And it varies so much as I’m sure you’re well aware of what the patients and families need at the end of life. So, how are

we going to – so, how are we going to capture that when everybody is so different in what their needs are at the end of life?

Cindy Massuda: Right. Well, I mean, it's – obviously it's pain and symptom management is the focus. So, I mean, it's really to help with the care planning. It's not – I mean I get the sense that people think we're trying to use this for some ulterior motive which we're not. It's really meant to be – if you have – if you're able to identify a patient that's imminently dying to help so that then the care needs of that patient are met not ...

(Jeni Albans): Right.

Cindy Massuda: ... what needs did you do or – we don't have some – we're not sitting here determining – we're not the clinicians. You are. And we're providing a tool that could include a checklist.

(Jeni Albans): Right. And I understand that. And I respect what you guys are trying to do. And I think – I feel that most hospices already have a checklist of what they do when someone is imminent.

I know in our hospice we do. It's not really a checklist. But we have a protocol when someone is imminent, and how we're getting the team out there and how we're identifying the needs of that family during that period when someone is dying. So, I feel that the tools already might be out there from various hospices.

Cindy Massuda: Right. And I agree with you. I think that's the thing that – what we are learning is not all hospices have that – have that in place. So, it's to help in that process and to offer what we can. So as we – and obviously it's a fluid process to start developing that and see where it makes sense and how it makes sense. I mean it's not etched in stone.

(Jeni Albans): Yes. Again, I understand how hard it is to try to capture measures where you're working with feelings and emotions.

Cindy Massuda: Exactly. But yes. I mean I feel like the kind of – I mean we're looking at having measures that are value added to the industry. We're not looking – we're not looking to have measures that are dinging. It's a way to have insight into the hospice to help the hospice with that continuous quality improvement process model. So I mean it's meant to be a collaborative effort and be part of that with the hospice industry.

(Jeni Albans): Thank you.

Cindy Massuda: Sure. Thank you.

Operator: Your next question comes from Ionne Velasco with Walla Walla. Your line is open.

Ionne Velasco: Hi. Thank you so, so much again like everyone is saying for hosting this such a great opportunity. And I have two questions. One is pertaining to the imminent death checklist. One of the things that the Walla Walla Community Hospice has done is considered this new HIS which doesn't have a number necessarily right now. But when we found out about this last June, we thought we would track it via (APIP) and start just looking up data in terms of visits.

And one of things that we discovered is that it's very difficult to look at this as a measure. And what it came down and many of the – all of the disciplines were involved in this discussion as this culture shift and change in communication and expectation between the nurse and the hospice aide communicating with the chaplain and the social worker. And it seems to me that this checklist – somebody already mentioned there are already checklist in place, not necessarily officially but there are systems in place where we're trying our best to predict.

And one of the things that you mentioned as it pertains to this new – these new measures is that there really aren't other needs for this other than to get insight. But the reality is as you yourself mentioned earlier is that at some point as a secondary option funding will be considered with this.

So, my question is how can this be something that is not a – like receiving a ding. Or how – can it be presented to the hospice staff in such a way where there isn't going to be action taken against the hospice if we don't meet the numbers or what have you?

Cindy Massuda: Well, so I think – I appreciate your question. I think the best analogy – although I don't want this taken to be like this is where we're headed because it's not but as an analogy would be to think about the OASIS instrument for home health. A standardized – since a lot of hospices have home health agency, this should be – it would be more a familiar tool. But that is – OASIS is a standardize tool used in the home health industry. And I think the home health industry is very comfortable with it.

So, it would be bringing an assessment tool into hospice not OASIS but analogous in a sense that you have a standardized assessment tool for the hospice industry that helps with and incorporate into the flow of the work done by the provider.

So, that's the perspective that we were – we – the concept of having an assessment – a hospice assessment tool is. The idea that it would be used for payment is – has to – I hope you can appreciate it – we have – do not have plans for that at the agency at this time.

It is something that would be so far off into the future because at the level of – first off, we have to get the hospice – the HEART tool set up. But even once it was set up, it would have to be in existence for several years because you need several years for the ability to test out the work before it could ever be used in payment. And it would be the payment side of the house not the quality side of the house that would be doing all of that work independent of us to determine whether or not the work of HEART would ever belong as part for payment policy. It is – I can't emphasize enough. It is not something that is under consideration at this time.

So, at this point, we have no more time for questions. But we do appreciate this time with you today. And if people have questions, we do have – or they want to share information such as different checklist or anything they want to

share from – about HEART or about the planning for this, we do have our own mailbox. It's the CMS HEART mailbox, which is CMSHEART@cms.hhs.gov. It's also listed in the materials for the Special Open Door Forum. And we would appreciate very much hearing from you. I very much appreciate hearing all your questions today. Thank you very much.

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

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