TRANSCRIPT / Navigating the Future: HOPE, Wage Index, and CMS Quality Measures

Melody King: 0:01

Welcome to TCNtalks. The goal of our podcast is to provide concise and relevant information for busy hospice and palliative care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host Chris Comeaux.

Chris Comeaux: 0:23

Hello and welcome to TCNtalks. I'm excited today, heck, I'm always excited, but I'm especially excited for this show because we have with us Annette Kiser, who's the Chief Compliance Officer with Teleios. I'm honored and privileged. Annette was employee number one it was and so good to have you, Annette. Judi Lund Person, principal with Lund Person Associates LLC. Welcome to both of you ladies.

Annette Kiser: 0:46

Thank you Chris.

Chris Comeaux: 0:47

Man, I used to dream about a day I'd have both of you on a call at the same time, and now I've gotten to do this a couple of times and so I just have so much respect for both of you and, again, just honored and privileged, I get to work with Annette on a day-to-day basis and, Judi, now I have you kind of in our sphere, our kind of little orbit. We're orbiting around each other, I guess. So good to have you.

Jeff Haffner / Dragonfly Health Ad: 1:08

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Chris Comeaux: 1:55

All right, ladies. Well, we got a lot to talk about. It's an interesting time of the year. You know, Judi, I think she and I were emailing each other on a Friday afternoon and it's like, oh goody, I have a great weekend, the preliminary wage index just dropped, and looking forward to my weekend, I'm thinking there are not a lot of people that would say that.

Judi Lund Person: 2:14

Right, exactly.

Chris Comeaux: 2:16

So we're going to talk wage index, but before we do that, ladies, this is a pretty historical time, and so I remember when I first came into hospice is when home health was going through the whole Oasis thing, and so we've got kind of our version of that which is called HOPE, and we're now about five months out from implementation, and if it goes forward I don't know if you want to comment on that I've heard some people say, well, maybe we'll get it delayed. So what do you have to say about HOPE?

Annette Kiser: 2:42

Well, I would say that we hope for a delay, but if we get one, it's probably only going to be for about three months and we won't know that until closer to time. And so we are encouraging everyone to continue to get ready, and I actually presented a webinar yesterday for some of our tele-us members and we checked in with everybody. We wanted to know how things were going. Everybody's moving along, they're working on their implementation, but I will say that a lot of organizations are at a little bit of a lull because they're waiting on their EMRs. CMS was so late to put out the final tech specifications and it delayed some things, and we are finding some of the EMRs electronic medical records are much further ahead than others are. Some are saying they're not going to be ready until September and others are already doing some testing and starting some pilots, and so it's very intentional, and what we find is those that are using the principles of project management in some capacity are doing better than others.

Annette Kiser: 3:48

Because we don't. Until you really stop and look at it, you don't realize how systemic hope is. It impacts clinical staffing, administrative staffing. Finance has to be involved because people are having to hire some extra staff, and then we have to think about IT and we have to think about all the education that goes into it, the quality aspects, the compliance aspects. So, it is a lot and it is really taking a lot of time. But I will say that I've been pleased with what I'm seeing from organizations and we are continuing to hope that there is some type of delay, just to give a little more time, with all that has to transpire.

Chris Comeaux: 4:27

Do you think that, Annette, that hope for delay is driven if we can have a portion it as a percentage, the majority of the percentage really being related to the EMRs being ready? That's probably the is that the thing that's keeping you up at night? Probably the most?

Annette Kiser: 4:40

It is. It is Because I think if EMRs were ready and the organizations could start today with implementation, they would be great. My hope was that everyone would be able to start by July so that they would have a three-month runway before October, and we are hearing that some of the EMRs will not be ready by July.

Chris Comeaux: 5:01

I have heard a couple of EMR vendors I don't understand enough in the weeds to see if this is possible but like provide their software just to do hope, even though you're not using the EMR, and so kind of which is an interesting strategy on their part. So I don't know if you've heard that enough, but I've run into at least one that has said that.

Annette Kiser: 5:22

Well, we don't have any hospices that we work with that do not have electronic medical records. Therefore, we haven't gotten into that aspect of it. I think that could happen for those that do paper Absolutely, and that would certainly be a good option for them.

Chris Comeaux: 5:38

Well, actually, what they're saying is that, no matter who your EMR is, you could use theirs just for the hope submission.

Annette Kiser: 5:44

Okay, I don't know how that would work.

Chris Comeaux: 5:46

Yeah, that's what I was wondering.

Annette Kiser: 5:47

There's a lot of demographic information and clinical information that has to be pulled in and you would end up double documenting if you went that route. But they do have to have a vendor if they don't have an electronic medical record that will submit their data to CMS for them, and so it's good to hear that some of those are really working on that.

Chris Comeaux: 6:09

All right, well, good deal. Well, I'm sure there'll still be a lot, obviously, to talk about this as we go throughout the year. But also we have the 2026 proposed rule that was dropped just not too long ago. It brings attention to just several key issues for hospice providers, and so I'd love to hear from both of you. But what are the most pressing changes that our hospice community needs to pay attention to, especially in relation to these RFIs? And the one, maybe, where we should start with is about the future quality measure concepts for hospice quality reporting program. Those are all big words, and CMS is asking for feedback on three of the concepts of the HQRP.

Annette Kiser: 6:52

Well, and Judi's had the privilege of being out on the circuit, so to speak, and has been talking.

Judi Lund Person: 7:00

Privilege. I think we should put in air quotations Exactly.

Annette Kiser: 7:01

There we go, absolutely. And has had an opportunity to talk to a lot of organizations about this. I'm going to let her start.

Judi Lund Person: 7:09

Well, I think one of the really interesting things about this grouping of three RFIs is the three topics that we'll be talking about today. The first one is interoperability, the second one is well-being and the third one is nutrition. So maybe we should start with interoperability. It's a lot more complicated than the other two and you know we could certainly reflect on what hospices, what all of us, should be saying to CMS about interoperability in the hospice space. I'll just start by saying you know, we can't even tell CMS, we can't tell each other how many hospices have an electronic medical record at this time.

Judi Lund Person: 7:56

When I was doing some digging the other day, I was trying to figure out do we know what that number is, and the only thing I could come up with was information from 2007. So, we know that you know, if we had to sort of guess, we're thinking that perhaps between 80 and 90 percent of hospices are on some kind of EMR. But I think our real challenge is does that EMR talk to any of the other EMRs, like a hospital EMR, like Epic or Cerner or any of those things? And that's really where I think we need to be headed as we're thinking about interoperability.

Annette Kiser: 8:41

Well, and one of the challenges just day to day, we have trouble getting interoperability between the EMRs and our pharmacy vendors and their software.

Annette Kiser: 8:51

And that's small when you start thinking about all the health systems out there and there's not one. Judi and I had a conversation the other day about some of our own personal issues and how one health system cannot communicate records to the other health system and these are health systems and we're talking about small hospice organizations and for them to be able to do that and to have the money health systems have been given money to be able to work on interoperability.

Judi Lund Person: 9:20

Absolutely, and I you know, I think the other thing, as we're kind of thinking about this, is okay. So acute care providers got millions and millions of dollars to get interoperability, get EMR systems up and running, but the post-acute care space not just hospice but other post-acute care providers have zero dollars coming from the federal government to implement this. And I think you know, first I think that's a travesty, but second I think it's like OK, so you want us to have interoperability, but there's no way for us to do this without some funding from somewhere and likely this should be the kind of thing that the federal government should be supporting.

Chris Comeaux: 10:10

You know, Annette, you probably remember, and so maybe intuitively, I was just bumping into this. So, we use one of our visioneering meetings earlier this year and I brought an outside expert just to give us some principles of the language of inoperability, and so we were just bumping into this more and more. And just to maybe put a highlight on what you just said, Judi, that the acute healthcare system's got millions of dollars. The interesting thing is that you take your post-acute providers, so home health, hospice, we receive everything from the rest of healthcare, so it's even more complicated. And then also it's much more mobile as far as, like, where the electronic tools are existing, we're not in one four walls location, so therefore you're even more mobile, which creates a whole nother complexity.

Chris Comeaux: 11:01

And then we know that the complexity of the billing has gotten just more complex. You've got to have the forms, you've got to have the DME, everything that we do, all these ancillary services, all have to be on the bill, which means there's other ancillary softwares. And then how do you get that on the bill? And so it's just gotten infinitely more complex. And to know that they actually gave millions to health care systems, we know that the margins are very bifurcated at the for-profits versus non-profits and so even having margin to be able to invest in this. It's just into interoperability. They're just not there. So, I'm just putting an exclamation point on what you guys are saying.

Judi Lund Person: 11:38

Absolutely.

Judi Lund Person: 11:39

I think one of the things that Annette and I were talking about in terms of how do hospices get information from health systems, for instance, and so we had the example the other day of one health system will fax over 100 pages of a patient's inpatient record because they have no way to send it and share the information, while another health system says, oh yeah, you can go in and pull the information you need.

Judi Lund Person: 12:07

All of that is fine, so, and you know, we can think about our own personal situations where one health care provider doesn't have the way, have a way to share information with another, and that's going to be for our patients as well. So, you know, if we are thinking and of course, I always will want to go back to what do we say to CMS about this issue, when we respond to this RFI and with comments that are due on June, the 10th, then I think we really have to like, hit home what does this do for staffing? What does this do because it's mobile? What did this do for equipment and IT? And I think we've got to be very, very global in what we say back to CMS responding to this, because it's complicated and I think that's maybe CMS knows that. Maybe the folks who do IT know that, but we have to share that so that we've got some grounding for our response.

Annette Kiser: 13:19

Well, and I'm not sure, Judi, that CMS does know that, from the perspective of the challenges and organizations that we work with and it's not unique just to ours, but the interconnectivity is a problem, but we even have organizations that have trouble getting a text out because of Internet problems, mobile problems, cell towers, mobile problems, cell towers and it is an extreme challenge sometimes just to get a message to your staff member when they need to call into the office, much less be able to real-time get the information they need to take care of a new patient. Organizations are trying to be very responsive and admit patients as needed as quickly as they can, and that means being able to get that information and it makes it very difficult with all the technology challenges that they have. Yeah, couldn't agree with you more.

Chris Comeaux: 14:12

Judy, do you know the statistic of what percentage of hospices that are still less than either 180C or 50 ADC? I know it still used to be the majority.

Judi Lund Person: 14:23

Yeah, I mean I think it's definitely the majority. I haven't seen the data recently, but the ADC, or average daily census of 50 or less, is a very large number. It's certainly 50%, but it could even be larger than that. I haven't seen the data in a year or so.

Chris Comeaux: 14:44

And the reason why I ask that, like I remember being at a large healthcare system many years ago when I was still the CEO of Four Seasons and we were talking about ONC certification and just the resources he had and just his background and training. And so like I think of you two ladies, and how you've gotten to be the experts you are. You had all these, you know, you had these regs, you poured yourself into it. There are not many experts in our country on the IT side, unless it's the much larger hospices and I'm just looking at some of these. Like you know, does the typical hospice leader know what HL7 is, what FHIR, the FHIR standards are Exactly? And then if you even kind of like I at least know the acronym and I generally understand what they're about, but the inside details of what that means in terms of interoperability, I mean you're talking about a handful of people, probably nationally in the country, and then saying that we have to have that type of interoperability. The reality is we just don't even have the expertise.

Judi Lund Person: 15:42

Well, we don't even know what the language is. I think your point is very, very well taken and it's aggravating. I mean, I think my first response is darn it. Why can't you speak English? This is really really frustrating.

Annette Kiser: 15:58

Well and again, give us some funds to be able to get the help we need.

Annette Kiser: 16:02

Chris is talking about the small organizations, and we work with a lot of organizations. They cannot afford in-house. We have very few that have in-house IT. They outsource Some are able to outsource to a larger organization that has more capabilities and more understanding. Some are using a local mom-and-pop IT vendor and they don't have anybody that can help with these types of things and there's going to have to be some funding for that to be able to happen. And I just want to mention we keep using the term RFI and that's request for information.

Annette Kiser: 16:35

And for those of you that are not used to that. That is CMS saying to us. We need you to help us understand this. They give us the questions they want us to answer and it's important that we do that and we have to take advantage. It's not often that CMS has an open invitation for us to send, typically with a rule. We can comment on what we want to, but they're only going to pay attention to what's in the rule. When it comes to these RFIs, we have the opportunity to take them and think a little more globally, even than the questions they give us. So it's very important that we hear from you, that you talk to your state associations, your national associations, reach out to any of us and let's make sure that we let CMS know exactly how we feel about these issues and what our challenges are.

Judi Lund Person: 17:27

I couldn't agree with you more, Annette, and I think the other piece of this is where does this RFI response go? And so I'll use the example of last year's RFI, which was how many hospices do palliative radiation, chemotherapy, dialysis or blood transfusions? And we responded Lots of people talked about the cost, lots of people talked about the ability of the hospice to provide that service. But last month MedPAC started their investigation of how many hospices provide those services and what should we do about it. So it could and in this case it could as well, it could move very quickly into something where there is an investigation, a study, some policymaking body that's going to come up with recommendations for us to follow, and if we can't provide really solid examples of why this is a problem, then we won't have that as the next step for whoever the policymaker is that's going to start looking at this. So, I think I want to underscore 100 times how important it is for us to share exactly how this is going to help us or hurt or be very difficult to implement.

Annette Kiser: 18:53

Well, we want to make sure within tele-hospice, we have organizations that have an average daily census of 15 and those that have an average daily census of over 700. But we always want to make sure that the voice of the small hospice is heard, and that's why we're trying to get this information out and really be able to hear from everyone.

Chris Comeaux: 19:15

Yeah well, let me try to attempt a summary, and, Annette and Judi, you guys correct me. So, number one, we get this request for information. Interoperability is critical to the future because you want to make sure that there are I'll give you an analogy, a picture of like our EMR is a superhighway. You actually want all these on-ramps from all these ancillary services. We agree. The challenge is you gave millions of dollars for hospitals to get there. Post-acute is even more complicated because the number of on-ramps are exponentially much more, because we are further downstream of what happens in the rest of healthcare, which means we're interacting with a lot of other parts of healthcare, especially if you have a palliative care program, et cetera, and then your palliative care is then providing patients going into hospice. So all that to say.

Chris Comeaux: 20:00

The interoperability is that much more complicated. The margins very bifurcated, nonprofits close to break even, for-profits maybe 12%, 14%, and so the capital is not there to invest in this. And then, in addition, you need financial funds to invest in the expertise, either locally or through partnerships. All of that takes dollars. You put it in other parts of health care. We agree with you. It's important, it's super complicated. So you want the right people to the table. We also fully agree. Going into the future, the baby boomers are going to want much more convenience. They're more tech savvy, so we need to be there. We're with you, but you got to have the funds to get us there. You can't just demand it. And you can't demand it on squeezing blood out of a turnip that's already getting squeezed pretty dry, would you?

Judi Lund Person: 20:44

say that any differently. Oh, that was perfect, that was absolutely perfect.

Chris Comeaux: 20:49

All right, perfect. Well, let's keep going because there's a lot more stuff in here. So, one of the future quality measure concepts that CMS is considering is a measure of well-being, which I find fascinating. CMS is seeking comments on the tool and measures that assess overall health, happiness, satisfaction at the end of life. So, what suggestions do you two ladies have for responding to this RFI? And I just got to make one comment. I just finished reading this fascinating book about Socrates, and even back in Socrates' day he was wrestling with the concept of the overall good life, and there's a concept that dates back, way back, and you think about how far back in history Socrates is, and I'm probably going to say it wrong, but it's E-U-D-A-I-M-O-N-I-A, e-u-m-a-n-a. It's basically described the good life which he believed was achieved through wisdom, morality, self-knowledge rather than material possession. So, my point is this mankind has been wrestling with what is overall the good life for quite a while, and now CMS wants us to measure it.

Judi Lund Person: 22:00

Well, you know, yeah, this is a hard one and you know, it is comforting. I think, in a lot of ways, that Socrates is wrestling with this as well, because I think all of us wrestle with this, and I guess there are, you know, certainly, as I've been talking to providers around the country there are people who say what in the world are we going to? How in the world are we going to respond to this particular question when well-being is the topic? And so, I thought Annette and I might want to just kind of throw some ideas around and try as hard as we can not to go kind of roll our eyes too much about this and also try to make sure that the folks who are reading our comments, wherever they come from on this topic, understand what hospice is. So, I think that's our first task is, if we're thinking about overall health, happiness and satisfaction at the end of life. I think we have some things we could share with CMS, and Annette and I were talking the other day about does CMS know what hospice really is? Well, it's our opportunity to start at the beginning and say, cms, here is what hospice is, here is how it was created, or why it was created the way it was Person-centered care, patient and family together as the unit of care. We know these things, but we want to make sure CMS knows it.

Judi Lund Person: 23:33

And maybe I'll stop Annette here just for a second and just say what is the purpose of comments. And so, the purpose of comments? One of the purposes is to make sure that we respond to the questions. They have that as fodder, if you will, for what they move on for. But the other one is to get information on the record and so really, really important for us to be able to say us to be able to say here's what hospice is and here is how we already identify things that we do that are connected to happiness and satisfaction at the end of life. So a couple of ideas just to get us started, and then, Annette, I'll throw it your way.

Judi Lund Person: 24:19

But let's think about satisfaction. You know, let's think about satisfaction and this is one of the pieces for me and I think we could all dig into patients that we've known, family members that we've known. Satisfaction also is connected to. Are we planning for the end of life? Are we thinking about advanced care planning, having conversations with our family? Are we thinking about how we want? What are our goals for the end of our life? What are the you know? So this is that goals of care conversation, and I think you know we should put in our comments Anybody who's writing should be putting in here what can we do, either while the patient is still in palliative care or when the patient first comes to hospice. We should put in what we already do for goals of care conversations and advanced care planning conversations at Advanced Care Planning.

Judi Lund Person: 25:27

If we think about that, median length of stay is of 18 days and you know, 25% of our patients are here with us for five days or less. What can we do when the patient is very close to death, and I think that's we should be writing something about that in this section. So I went on a little too long, Annette, so please go ahead.

Annette Kiser: 25:47

Well, but the point of all this with this RFI is to think about future quality measures and when we think about what you just said, Judi, with so many patients dying in such a short time and sometimes it's minutes they die, we watch them take their last breath before we open the door and to think about how we might address satisfaction and well-being. And we need to help CMS understand the short length of stay that we have and how it's going to be difficult to measure that for a patient who is hours away from dying or days away from dying and that's what we need to do. And stories from hospices about the number of patients they have, not just numbers but a little bit more about the intensity of what they're dealing with their patients and families. And we think about those patients that reside in community facilities assisted living communities, skilled nursing centers and being able to go in and address the well-being and the satisfaction of those patients can be very difficult. But you're right when it comes to the goals of care and that advanced care planning, we still don't have upstream what we need. We still don't have the understanding and if we did, we wouldn't have as many patients who were dying.

Annette Kiser: 27:04

I made the comment to someone yesterday.

Annette Kiser: 27:06

I've been at this for almost 40 years now and we still have the issues with length of stay that we did 40 years ago and it's not going to be solved, I don't know, ever in our lifetimes.

Annette Kiser: 27:20

But CMS needs to understand the complexities of that when we're dealing with that. And I think one of the other things is families and the dynamics of families that we see these days, the dysfunction that we see and more mobile society and may not have the family close by like we used to have, and being able to impact well-being for those patients who are living alone or the patients who have family that pops in once a week to check on them. It's important for CMS to understand all the differences when it comes to really trying to make an impact. But I think hospice, with what you said around holistic care and person-centered care and that interdisciplinary team and really being able to impact many aspects of a patient's life we're not just going down and taking care of their physical needs. We're addressing the psychosocial and the spiritual, the emotional, the financial and it's important for us to tell those stories.

Chris Comeaux: 28:22

Well said to both you ladies. I'm just sitting here processing. I'm so glad I did bring up the Socrates thing. So 2,500 years ago the man was struggling with the same question, wrestling with the same question as what is the definition of well-being? Interestingly, you might not know this, the rest of Paul Harvey, rest of the story. They actually put him to death because they actually said he was trying to corrupt Athens youth by pushing his beliefs on other people, which was really about living a good life Now. So that had a really bad end.

Judi Lund Person: 28:52

Yeah, we don't want that end. No, we don't want that end. But the point is this right?

Chris Comeaux: 28:56

I appreciate the question.

Chris Comeaux: 28:57

In fact, I'm kind of channeling my inner Peter Benjamin and when he and I were on the podcast and Peter's like here we are 30 to 40 years later and we're still wrestling with what is the measure of a good death, I get it, it's actually good pushback.

Chris Comeaux: 29:11

But the problem is we're wrestling with the essence of a question that mankind has been wrestling with for 2,500 years. But then you take all the wisdom that you guys just said number one, what is at least their goals and then, looking at it holistically and bringing the whole IDG team. That makes it complicated. And then I love the things that you brought in, Annette that we have societal things that are making this even more complicated collapse of family support, societal breakdown, just challenges in our society that maybe even get heightened at the end of life because of just the intensity of the fact that someone's at the end of their life, and so all of that just makes this complicated. But I do applaud CMS for asking the question because I think good hospice, we're actually after that question, because I think good hospice, we're actually after that. We're after that elusive thing that we call the good death, the good outcome, and we have those beautiful mission moments whenever it does occur, but it doesn't occur every time because of all these other complications.

Annette Kiser: 30:12

Well, and how do you measure that?

Chris Comeaux: 30:14

And that's the tough part to think about this being a quality measure.

Judi Lund Person: 30:18

Right, that is really the question, and I think part of the narrative in this well-being one is social connections, and when I was first looking at it I was going, oh for heaven's sake, social connections for a patient at the end of life, what in the world are you talking about? And then I started thinking, like you were mentioning, Annette, is you know, we should be putting into our comments the fact that we do spiritual care, the fact that we do have volunteers. I know, you know, many of our volunteers are folks who stay and sit with patients could be 11th hour volunteers as well and so what kind of thing can they provide as a way to address social connections, for instance?

Annette Kiser: 31:04

Well, I talked to an organization yesterday just asking a question, and they started during the days of COVID, when volunteers were not going into homes, with doing a card ministry. So, to speak and volunteers send cards to patients, and it's very intentional. And volunteers send cards to patients, and it's very intentional and they have continued that you know years later now and that is social connectedness for a lot of people.

Melody King: 31:27

I love to get a card in the mail, and so it's ways to do it, but it's again.

Annette Kiser: 31:33

it's something else that we have to stop and think about and for those patients that are not able to enjoy that, then we look at it to see how else can we make a difference in that social aspect.

Chris Comeaux: 31:46

You know, something occurs to me though, listening to you, Annette, that you know, if someone gives me an idea and I take that idea and I do it for my wife and my wife knows someone else gave me the idea it's not as meaningful to her. My point is this If the beauty of hospice has always been that individualized care, getting to know that human being and what speaks to them and loving on them and their kind of own love language, that's what our volunteers and IDG teams have done beautifully. When you start trying to prescript stuff, that's when you kind of lose. Years ago, I remember the Stephen Covey story that they tried to cut open the goose who laid the golden eggs. And they cut open the goose and they found out they just killed the goose that laid the golden egg because they tried to dissect it, and I think that's a little bit of the risk with this.

Judi Lund Person: 32:34

So, I want to just add one last thing before we move on to the next one. But I want to talk about the role of hospice in providing care to families. If we are thinking about Medicare provider types and we say, okay, what happens here in hospice, that is different. Certainly, volunteers are different. Certainly, the interdisciplinary team is different, but volunteers are different.

Judi Lund Person: 33:02

But we've said from the beginning, and I've been going back to some of the very early days of hospice, where we talk about the patient and family are the unit of care, and so when we start talking about that, we also are talking about social connection for the family, social connection for how that family can connect with other people so that they get the support they need, either before the death or after the death. And I think we've got to be mentioning in the well-being comments that we write that we talk about what kind of support we do for families, including bereavement support that will help families cope better and not have some complicated bereavement response or grief response that triggers a health issue. So, I think that's a really important thing and it is not. You know, I sometimes feel like some people say, oh yes, they pat you on the head and they go oh yes, that's hospice. You're holding their hand and I'm like no, no, no, no, no. That's not what we're talking about here, so just throwing that in so we are sure to include it.

Annette Kiser: 34:20

Hospice is the only healthcare provider that's following after the death. Others end and hospice follows for that 13 months, and it is important for us to make sure that we talk about the fact that we're caring for the family, in some cases more so than the patient, based on what those needs are.

Chris Comeaux: 34:40

And they're definitely who remembers us afterwards. In fact, that was with a group of guys that are part of the John Maxwell Leadership Organization and them asking me a lot of great questions about what we do. Do you know? That's actually was their point to me. They say I bet you matter more to the family than maybe you even do to the patient. I'm sure you serve the patient in a beautiful way, but they quickly got it and got to that. That felt weighty to me, that they like oh wow, that matters more to the family, probably, than the patient.

Judi Lund Person: 35:08

It's amazing.

Chris Comeaux: 35:08

All right. Well, we need to keep talking and so also in this RFI they're requesting feedback on a second concept on nutrition. So, including safe eating habits, exercise nutrition activity appropriate for end on nutrition. So, including safe eating habits, exercise nutrition activity, appropriate, friend of life care. So, what do you guys have to say about that part of the RFI?

Judi Lund Person: 35:26

Well, let's start by saying all right, how many of you are rolling your eyes at this one? So, let's start by doing that. But I think I'll just get us started. But, Annette, you're the clinical person on our team today, so we'll throw it your way as well. But I think this is the opportunity for us to both say to CMS the nutritional needs of patients are individualized, so sometimes it's a normal, you know, the patient is still eating and drinking whatever. But then we also have other patients who either are no longer interested in eating or drinking or it is difficult for them.

Judi Lund Person: 36:14

And my favorite thing and I'll throw it out there because you and I have talked about it, Annette, it out there because you and I have talked about it, Annette is if the patient is diabetic and has never been able to choose whatever they wanted, and now they're at the end of life, choose what you want to eat. If you want ice cream, then ice cream is what you think will be wonderful for you. Go for it. So, I think this is another part of our education of CMS is nutrition for patients at the end of life is different than it is for the patient who is a Medicare beneficiary and is dealing with a chronic disease, but not an end-of-life situation. Dealing with a chronic disease, but not an end-of-life situation.

Annette Kiser: 36:59

Well, and you mentioned ice cream, Judi. That's well-being, yes, and we can do that. And we have those patients who are eating things they probably shouldn't be eating for a healthy diet. But we're all about do what makes you happy, right? And I have to say, if I'm given a choice of a bowl of pureed meat as a patient in a skilled nursing center versus my family bringing in a milkshake or a candy bar, I'm going to eat the candy bar or drink the milkshake. I'm not going to have the pureed meat sitting there in that bowl. That I'm not real sure what it is and I think that's a lot of it is looking at that and I think that's a lot of it is looking at that.

Annette Kiser: 37:44

But when we think about nutrition, it's not about trying to get X number of calories in a patient and X number of grams of protein in a day. It's about doing the best that we can. And I'm always told, if you have a choice of, you know, having some protein versus having some carbs, certainly the protein's a good way to go with the skin impairment issues that we deal with our patients. But I would rather them have something and it be a piece of cake than to say I don't want anything, and if we need to start to dessert, we all should start with dessert more often, and so part of it's looking at that. But it goes beyond that and part of this is, you know, CMS mentioned exercise and for some of our patients, just being able to lift a cup is all of the exercise that they can get, and we need to make sure in our comments to CMS that we let them know what it looks like for our patients. I think they have some sense of that, but day to day, what does that look like? And to think about exercise, I don't know how we would go about that for many of our patients, especially those who are living less than two weeks. And to think about what that looks like, thinking about this RFI and how you might even measure that quality around nutrition, and for a lot of patients it's about what their needs are.

Annette Kiser: 39:04

I had a nurse share a story with me via email yesterday, after I mentioned this RFI, about a patient who had a lot of joint pain, had a lot of things going on, and she's a nurse who focuses on wellness and nutrition and understood that inflammatory processes impact, of course, our joints and a lot of that comes from the food we eat, and the patient was very high carb, very high sugar, so she helped her adjust her diet and the patient started to feel better. And who would have thought that a hospice nurse would be going in doing something like that? But it's about that person-centered care, those goals of care, and it wasn't necessarily yes, she got a healthier diet as a result, but it was about looking at what were her needs and trying to address those. And I say from a standpoint of exercise and safe eating habits, it's going to be very different for every single patient and to think about how we might measure that is mind boggling to me.

Chris Comeaux: 40:04

Yeah, I think you're poking on what I was saying earlier, Annette, that the mass standardization approach to healthcare is antithetical. I always joke that Henry Ford said you can have a Model T in any color as long as it's black. Is that where we really? Because the baby boomers have not gone that way in the rest of, as they've aged, in the other parts of the economy. So, I think they're going to want it their way. Think of the McDonald's commercial. You want it your way and so I get what they're after.

Chris Comeaux: 40:34

But it's like it's missing the key point. I'm all about now trying to eat healthy and exercise, but I wonder if I'm at the end of my life. I know when I'm spent and I'm tired. Sometimes I just want to rest and do whatever it is I want to do, and at the end of people's lives it's almost like are we imputing our today to someone else in their life without fully understanding? Dying is different and I wonder I know Nurse Julie and Nurse Hadley have done a beautiful job finally educating the community via social media, but we've still got a long ways to go. Do people really still understand what death and dying is about?

Chris Comeaux: 41:11

And you read this I applaud the hey, we're trying to make America healthy again. Great, this is different and, at the end of the day, well then, what's the solution? What matters most to that person? If we can do that and guess what? That's actually what makes us the most brilliant model of healthcare ever devised, because we've always or we were supposed to always have been about that. Maybe we've lost our way in certain aspects of the hospice movement slash hospice field. But let's return. I love that quote, TS Elliott. You arrive where you first began, but you know the place for the first time. Maybe we need to kind of go back to what individualized patient care is supposed to be about, but that's hard to measure.

Judi Lund Person: 41:52

Yeah, it's very hard to measure and I don't want us to get to the place with this particular question where we say, well, the solution is to have a nutrition plan, dietician review. I don't want to get there at all, but I do want to keep on emphasizing that every patient is different and their needs will be different. I'll use my own mother as an example. So my mother, at the end of her life, failed a swallowing test and my sister is a dietician. So she's like oh, mom, try again. You know you can do it. Eat more, la, la, la. And so I ended up gathering some articles about patients at the end of life who really it's no longer helpful for them to eat. That's a part of this conversation too, and I think I think it is. I think you're exactly right. We have a long way to go in terms of education and really really important to put that in our comments.

Chris Comeaux: 42:55

Yeah, and when there lies the challenge right, we spend most of our life living, and when therein lies the challenge right, we spend most of our life living. We only spend a short part of our life dying, but the process is very antithetical compared to the rest of our lives and it feels like some of that's creeping into some of this. Again, I applaud the fact that they're trying to go. Well, how can we put better measures around this? But maybe let's just step back again and understand the essence of what this care is supposed to be about. This is what matters most to you and that's where I'm kind of hopeful about the HOPE tool, that there is some essence of well, what matters most to you and can we reach that? The challenge is okay. What did you say? And how do we deliver it? How do you put those two together and create a quantifiable measure? And where people can't game that system? That makes that difficult.

Annette Kiser: 43:41

It's hard.

Annette Kiser: 43:41

Well, and we spend a lot of time with quality measures in hospice being about process. The hospice item set is yes, it's. Did you ask the questions? But more importantly is did you check the boxes on the assessment form so that it then feeds out? And it's a matter of, with these questions of, is this what matters most? I don't think, if I went to most hospice patients and asked what matters most to you, that it's going to be exercise and nutrition. And are there other suggestions that we can make to CMS around quality measures? What would be meaningful to our patients and families and to those who are looking to choose a hospice? What matters to them? And yes, nutrition would be for some of those I live in the South and always have, and nutrition is big and it's something that you know families struggle with at the end of life, when patients will need. But we need to be thinking about what would be meaningful measures and how could we measure that, and I'm not sure how we would measure well-being and nutrition for our patients.

Chris Comeaux: 44:49

All right, ladies. Well, and there's a whole separate RFI, is there not?

Judi Lund Person: 44:54

Do we have to talk about that one?

Chris Comeaux: 44:56

Right, Well, and so maybe make sure I'm reading this right, because it took me a bit just to prepare for this show. I can't imagine you guys preparing to be able to answer the questions. But there was an RFI to advance digital quality measurement, DQM, in the HQRP, so the Hospice Quality Reporting Program. So, this is different than the first one we were talking about. Is that correct? Yes, this is different.

Judi Lund Person: 45:21

Unfortunately, it's different.

Annette Kiser: 45:23

But it's well and this gets into that. You used it earlier, Chris, when you said fire. So, this is that HL7, Fast Healthcare Interoperability Resources and I have to say that I enjoy IT to an extent and understanding what's what, and I spend time working with the EMRs and I've spent some time talking about interoperability and health exchanges, but fast health care interoperability resources was new to me. But I think what we want to do is not get hung up on that.

Annette Kiser: 45:57

I started reading those questions and it's like I don't know. I mean, I don't even understand some of those pieces. But it's more about how we can focus on how can technology give us better care, coordination, give us the information and CMS put this RFI around, our ability to do hope within the record and being able to submit that hope assessment using this technology. But it's more about again, those challenges we talked about with interoperability, and so a lot of this comes into play and maybe Judy has some thoughts on how we make this one a little different and don't say the same thing here that we said in the interoperability aspect.

Judi Lund Person: 46:42

Well, I think that is the challenge of this one, and I know, Annette, you and I both spent a lot of time trying to figure out. So, when I'm first reading I'm not a nurse, but I'm first reading this for the first time and I'm going okay fast. So, I'm thinking fast, like dementia scoring, and I'm like, oh no, that's not exactly what this is. So, what in the world are we talking about? So, I think language is the first challenge we have, and I immediately, in my own head, went to all right, who are the chief information officers that we know in hospices that are large enough to have one of those? Who can we talk to about this that knows more than we do? But I think, at the end of the day, my sense is just like you said, Annette.

Judi Lund Person: 47:37

My sense is that what CMS is thinking about is getting the HOPE data submission to be part of this interoperability. So, what does that mean? What does that mean exactly? And then, what are the barriers to that? And so, I go immediately then to our vendors. Are they ONC certified? So how many of our vendors have that certification, which is one of the pieces in play for this? So that's a piece of it for me.

Judi Lund Person: 48:15

Another thing I think we need to think about is what's required. What's required in terms of IT hardware? You know, never mind software for a moment, but what kind of hardware do you need? What kind of computers do you need? What kind of capabilities do you need to have on the side of, you know, tablets or whatever that would be able to submit this data? So my response on this particular RFI is and this is going to sound bad, but I think it's exactly right Please dumb it down for us, Please tell us what in the world you're talking about, and please don't use acronyms, Please don't use things where the average provider and I would say not just hospice provider, but the average provider has no idea what you're talking about. And so that, I think, is my first reaction. You know, if we are thinking about challenges for the submission, then what does that mean?

Judi Lund Person: 49:24

And I started thinking about do we submit all of this in the field? Do we submit this data while we're with the patient? Well, that opens the door to horrible connection issues. That opens the door to horrible connection issues. And so I wanted to go there as well and kind of think about okay, when do we submit, and what would this look like? And, you know, maybe one of our responses is also to say how many? Could we encourage some hospices that are early adopters, for instance in the IT space? Could we ask them to volunteer to be part of this pilot and then start to sort it out so that we can? The average hospice provider would know, kind of what the next steps are.

Chris Comeaux: 50:19

There's an article that I wish I could go back and find it, and so this analogy stuck in my brain. So for our listeners, maybe to help them with the concepts of HL7 and FHIR Fast Healthcare and Operability Resources, so the hospital's EMRs. So don't go back and quote me specifically, but let's say Epic versus Cerner. And so they were trying to position themselves and picture the electronic health records and the ancillary apps, if you will, around that that there's different train tracks, and so I'm kind of a history geek. During the Civil War they used to have to literally switch the trains because the train tracks were not all the same gauge, so you couldn't just go all over the country on the same train tracks because there were different gauges.

Chris Comeaux: 51:03

There's the analogy of the difference between kind of the healthcare technology standards, and so I can't remember if it was like Cerner and some others and then Epic and some others and they said, okay, we're going to create the same gauge train tracks so that way you can start to promote interoperability. And I think this kind of came out of some of the ONC initiatives, if you will, and that's where HL7 and FIRE was born out of. So at least you get conceptual like oh okay, so that's what they're trying to accomplish. Is so that way every person doesn't create their own gauge train tracks as a competitive strategy and then try to dominate the market as a strategy? Make sure all of that is standardized. So then, that way, people are building to that standard. Now you create more of a robust ecosystem of technology, solutions, et cetera.

Annette Kiser: 51:52

Well, and Judy mentioned that ONC certification and there are so many organizations that are struggling to find an ONC certified.

Jeff Haffner: 52:02

EMR.

Annette Kiser: 52:03

And we've even had EMRs say we're ONC certified but when you dig down, they're not ONC, they don't understand that. Or they are ONC certified because they have another platform, kind of behind the scenes, that they're using. And when we start thinking about some of these things for our hospice organizations and the terminology, it's difficult to think about how you then translate that. So I'm with you, Judy, and it's not a word I care to use all the time, but dummy down we needed to put the RFI to the EMR vendors for their aspect of a lot of things, put it to the you know chief information officers but then bring it into the hospice and really look at the aspects that apply specifically to what we're trying to do.

Judi Lund Person: 52:54

So, Chris, I want to go back to the same gauge railroad analogy. I love that analogy and I think one of the things that, as we are getting more sophisticated with EMR even that we are, and a lot of the vendors I've talked to over the last couple of years are people, vendors who say the biggest challenge is that the hospice who uses our EMR and customizes like times 100. And so once you customize, then we have a problem with standardization. So, if we said anything in this particular RFI, we should be like applauding CMS for saying we should be like applauding CMS for saying please standardize, and in this case it's standardized for the submission of hope. And you know, if standardization the same gauge railroad kind of approach is one of the outcomes of this, I think it's a really good thing. But at the same time it's like what are they talking about exactly? And I think that's really our biggest challenge.

Chris Comeaux: 54:05

And just to our listeners, we're not talking out of both sides of our mouth. In fact, we teach this in our leadership immersion course. When I came into hospice, I grew up in business America and I had these amazing nurse mentors like Annette Kisers they're just a different name in my early part of my career in Pensacola and we used to have this ongoing debate standardization versus art and my nurse mentor was like you don't understand, Chris, hospice is art and I would go out and visits and I would see firsthand. I'm like, oh, she's right, but yet, wait a minute, what I've seen in the rest of business world should apply too. So how do you reconcile those two concepts? Well, there is a place for standardization, like what we're talking about right here. Make the technology, train tracks the same and if you have good standards, that should enable you to use system and process to customize by the bedside to what matters the most. So, then we could do the art where people look at it and go. It looks like magic what you guys do, and there's sometimes we feel like it's magic, but it's built upon systems and processes.

Chris Comeaux: 55:04

But the problem is it's all. It's been a patch quilt throughout most of our career. And Judi, you also poke on. You know the old Mary Labiak adage you've seen a hospice, you've seen a hospice and therein lies something you know. That's where I think CMS has been trying to kind of push against that to bring some standardization. But you have to be careful. We don't want to end up in Henry Ford world where you could have it in any color as long as it's black and then you end up with standardized for nutrition and all these sorts of things. That feels like the wisdom of kind of balancing within this RFI how we put that in words back to CMS. Maybe there's some cookie crumbs throughout this whole conversation where we could weave that together and paint that picture for them.

Judi Lund Person: 55:47

Yeah, I think you're exactly right, Chris.

Annette Kiser: 55:49

Well, and back to CMS. That's the whole point of these RFIs and so, again, we need you auspices to be sending information to your state associations, your national associations, to us, Judi and I are involved with National Association, and we'll be working on those comments. So, we need to hear from you. What are the stories, what are the challenges when we think about quality measures, what can we suggest? What do we want CMS to hear from us? And we've got about 21 days until those comments have to be at CMS, and so there's probably two weeks by the time this podcast drops actually.

Annette Kiser: 56:28

Well, this is true. Good point, Chris, good point.

Chris Comeaux: 56:31

So, Annette and Judi, I was gonna ask you for a final thought. So, Annette, my guess is that's anything else you want to add to your final thoughts before we go to Judi.

Annette Kiser: 56:37

That's it.

Chris Comeaux: 56:38

Okay, Judi.

Judi Lund Person: 56:44

So, you know, let's start focusing on June, the 10th, and let's make sure that we have robust comments for each of these areas, along with examples and I am really big on it's not anecdotal so much as experience of individual hospices around, whatever the issue is, and I think that's going to be really critical in these. Now, the piece I think I want to add to that and not time to talk about it today but the enormous focus from HHS and CMS on deregulation, and so that's a topic for another time. But this set of RFIs certainly are one piece of that. But I think what we're seeing in the administration as a whole is how are we going to do less regulation? And I know there are many listeners who are going. I have 102 ideas on how we can do this. So, another discussion certainly, but that is if we're looking at the landscape in totality. That is going to be one of our biggest, biggest areas for comment.

Chris Comeaux: 57:58

That's well said, ladies. In fact, I was thinking maybe August-ish, we should come back together and do another show, because I think August into September number one, we'll have the final wage index, but two, we may start to see then, as the new administration and CMS is kind of getting their traction, what are we going to see. So, if you guys that sounds good to you, then maybe we can kind of plan on that. Sure, sure, absolutely awesome. Well, I appreciate both of you. Thank you, I was just reflecting.

Chris Comeaux: 58:27

You know so many of the early years, Judi and Annette. You know hospice became what it is today because of like this transdisciplinary approach of just different people and different experts. Technology is a member of the team that we're going to have to up our game. There's no question with how quickly artificial intelligence is moving, we've got to, and I wasn't trained as a technology person. I know enough to be dangerous, and so getting those people at the table so we don't let the tail wag the dog, but we apply technology as an accelerator feels like one of the key points to potentially our success and kind of threading this line between mass standardization and mass customization. How do we use the technology to enable us to do that and not where. Then all of a sudden we're just checking a bunch of boxes and all of a sudden we're like we really lost what we were. That feels like what maybe is at risk with all of this. Yeah right absolutely all right.

Chris Comeaux: 59:17

Well, appreciate you both to our listeners. We appreciate you. Thanks for listening. Subscribe. Hit the subscribe button, pay it forward to your friends, your coworkers. We do this show in service to you and bring incredible people like Judi and Annette so you can know what's going on. And, as we always do on TCNtalks, we always want to leave you with a quote, something just to think more about the show today. This is from Simon Sinek. "Leadership is not about being in charge. It's about taking charge of those in your charge. Thanks for listening to TCNtalks.