AXXESS Hospice

HOSPICE QUALITY REPORTING

Understanding Quality Measures for Success

Introduction

The Hospice Quality Reporting Program (HQRP) was created to evaluate a hospice provider's response to the patient, family and caregivers' needs and to ensure hospices have a solid foundation for providing quality care. The Centers for Medicare and Medicaid Services (CMS) determines the measures that will be utilized in the HQRP. Currently, the HQRP consists of four different quality measures:

1. Hospice Care Index (HCI)

2. Hospice Visits in the Last Days of Life (HVLDL)

3. Comprehensive Assessment at Admission: Hospice Outcomes and Patient Evaluation (HOPE)

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS star ratings, HCI scores and HVLDL are reported publicly on the CMS Care Compare website, and hospices that do not submit their quality data will get a deduction in their Medicare reimbursement. Hospices face a 4% reduction in reimbursement for failure to meet requirements for HOPE and CAHPS data submission. Therefore, it is critical for hospice providers to understand, monitor and submit their quality data.

This eBook will provide an overview of each of the four quality measures to help hospice providers understand how each measure is evaluated.

Hospice Care Index (HCI)

CMS introduced the Hospice Care Index as part of the 2022 Hospice Final Rule, which is designed to identify current hospice aggregate performance trends relative to other hospices. The Hospice Care Index measures the hospice organization's ability to address patient needs and care outcomes throughout a patient's stay in hospice. Collectively, the index measures represent different aspects of hospice service and characterize hospices comprehensively, rather than on a single care dimension.

HCI is a single measure comprised of 10 indicators calculated from Medicare claims data. Each of the 10 index measures is worth one point and will be calculated to inform a total Hospice Index Score for the provider. Hospices with fewer than 20 discharges in the two pooled years of data are not assigned a score per CMS quality reporting program as there is not sufficient data to reliably calculate scores.

Hospice Care Index Measures:

- Continuous home care or general inpatient care level provided
- Gaps in skilled nurse visits of more than eight consecutive days in each 30-day care period
- Early live discharges during the first seven days of hospice care
- Late live discharges after 180 days of hospice care
- Hospital admission within two days of live discharge with hospice readmission within two days of hospital discharge
- Live discharge from hospice followed by hospital admission when death occurs within two days of hospital admission
- Per beneficiary spending
- Skilled nursing care minutes per routine home care day
- Skilled nursing visits on the weekend
- Visits in the last days of life

Hospice Visits in the Last Days of Life

Hospice Visits in the Last Days of Life is constructed from the Medicare hospice claim records. It assesses the number of visits made by a registered nurse or medical social worker on at least two of the last three days of life. The goal of the measure is to improve the quality of care provided in the last days of life when patients experience the most pain and symptoms. During this time, patients experience many physical and emotional symptoms, that necessitate close monitoring by the hospice team. Hospices are not given a minimum visit mandate at the end of life, but all hospices should be equipped to meet the higher symptom and caregiving burden of patients and their caregivers during the final days of life.

Hospice patients must receive hospice services for at least three days to be included in the measure, with the 3 days defined as:
Day 1, the day of death;
Day 2, the day prior to death; and
Day 3, the day two days prior to death

Patients who do not die on hospice or receive continuous home care, general inpatient care or respite care in the last three days of life are not included in the calculation. Visits that occur after a patient's death are also excluded from the measure.

Comprehensive Assessment at Admission: HOPE

The Comprehensive Assessment at Admission (CBE #3235) is publicly reported on the CMS Care Compare website. As a composite score, hospice providers will only get credit if each care process is performed at the time of admission. Patients must be 18 years old to be included in the calculation of the score; the threshold for reporting this measure is 20 admissions during a reporting period.

The following chart shows the care processes and their associated timeframes.

HOPE ID	Care Process Included in the HOPE Comprehensive Assessment at Admission	
F2000A F2000B	Patient/responsible party asked about CPR preference	Seven days prior to admission or within five days of admission
F2100A F2100B	Patient/responsible party asked about preferences regarding life sustaining treatments other than C	Seven days prior to admission or within five days of admission
F2200A F2200B	Patient/responsible party asked about existential concerns	Seven days prior to admission or within five days of admission
J0900B J0900D	Patient screened for pain AND Report that they do not have pain OR Report mild, moderate, or severe pain AND A standardized pain tool is used	Within two days from the date of admission
J0900C	For patients reporting mild, moderate or severe pain; comprehensive pain assessment that includes at least five of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain and the effect on function or quality of life.	Within one day of the pain screening
J2030B	Patient screened for shortness of breath	Within two days of admission
J2030C J2040A	Patient screened positive for shortness of breath AND Did not decline treatment for shortness of breath	Within one day of the screening for shortness of breath OR Treatment of shortness of breath occurred prior to the screening
N0500A N0520A N0520B	Patient has scheduled opioid initiated or continued or has a bowel regimen started OR There is documentation of why a bowel regimen was not started OR The patient did not have a bowel regimen scheduled or continued	Within one day of the scheduled opioid being scheduled or continued

Process Measures Calculated from Hospice Outcomes and Patient Evaluation

Two new quality measures will be calculated from data collected through the HOPE tool. Both measures track the percentage of hospice patient assessments that have a symptom follow-up within two (2) calendar days when the symptom impact was initially assessed as moderate or severe, specifically:

- Timely Follow-up for Pain Impact measures the percentage of hospice patient assessments that have a symptom follow-up visit within two calendar days after pain impact was initially assessed as moderate or severe; and
- Timely Follow-up for Non-Pain Symptom Impact measures the percentage of hospice patient assessments that have a symptom follow-up visit within two calendar days after non-pain symptom impact was initially assessed as moderate or severe.

Hospice clinicians will collect data for these measures using HOPE. The symptom impact assessments are conducted at fixed timepoints during a hospice election:

- At admission (ADM) and
- Two HOPE Update Visits (HUVs) occurring between days 6-15 and 16-30 of the hospice stay.

During admission or the HUV, data collected for the Symptom Impact item (J2051) may trigger the need for the Symptom Follow-up Visit (SFV). The SFV is an in-person visit expected within two calendar days as a follow-up for any moderate or severe pain or non-pain symptom impact identified during an admission or HUV. For these measures, the measurement period starts on the date of the symptom impact screening (J2050B) where the impact is rated as moderate or severe and continues for two more calendar days.

Depending upon responses to the Symptom Impact item (J2051) at admission and the two HUVs (each at specified timeframes), up to three SFVs may be required over the course of the hospice stay.

If there is evidence of ongoing moderate or severe symptom impact during an SFV, no additional SFV is required for HOPE. However, the hospice staff are expected to continue following up with the patient based on their clinical and symptom management needs.

Patients can be excluded from this measure if the patient was discharged for any reason before the SFV could be completed or if they did not have pain or non-pain symptom assessed as moderate or severe.

Customer Assessment of Healthcare Providers and Systems

CAHPS survey scores are posted on the Care Compare website allowing consumers with a quick way to assess a hospice agency's quality measure scores and star rating. The star ratings range from one to five stars, with one being the lowest rating. The goal of the star rating system is to provide consumers with an easy-to-understand method to summarize CAHPS scores and make the comparison between hospices easier. CAHPS survey results include 8 quarters of survey results are updated on the Care Compare website every other quarter.

The CAHPS survey is administered to the primary informal caregiver about the hospice care received by the decedent. The hospice is responsible for identifying the primary informal caregiver that may be eligible to receive the CAHPS Hospice Survey. Surveys are administered via a phone call, paper survey or email. Ensuring accurate contact information for the correct caregiver including address and phone number can ensure the survey is received by the caregiver. Hospice agencies may let caregivers know they may receive a survey and encourage them to complete it, but they must inform all caregivers. Hospices may also communicate the name of the survey vendor that will be administering the survey to caregivers. The CAHPS Hospice Survey is initiated two months following the month of patient death. For example, if a patient dies in January, the survey vendor must start surveying the patient's primary caregiver starting April 1.

Survey responses will be converted to top-box scores, which are scores that reflect the proportion of respondents who gave the most favorable response. Each top-box score will be adjusted for survey mode and case mix prior to being converted into a star rating.

An overall summary score, the Family Caregiver Survey Rating, will be published for organizations that complete 75 or more surveys during a reporting period. Hospices that have fewer than 50 survey eligible decendents/caregivers can request an exemption from participation in the CAHPS Hospice Survey. The Family Caregiver Survey Rating is a summary star that reflects the average star rating the hospice based on the top-box score for each measure included in the survey. "Rating of this Hospice" and "Willingness to Recommend Hospice" are global measures that do not point directly to the care provided, so these measures are valued at 0.5 in calculating the Family Caregiver Rating. The six remaining measures are each valued at 1.0.

Measure	Scoring Weight
Communication with family	1
Getting timely help	1
Treating patient with respect	1
Emotional and spiritual support	1
Help for pain and symptoms	1
Training family to care for patient	1
Rating of this hospice	1/2
Willing to recommend this hospice	1/2

The overall CAHPS star rating calculation will be the average of the star ratings across the eight measures. Scoring weights will be rounded to the whole number.

Conclusion

Quality of care touches every aspect of hospice; therefore, quality improvement should be the hub of every hospice organization. It's important for hospices to have regular meetings to review their quality data and compare it to the HQRP regulatory requirements, benchmarks and organizational goals. Hospice providers that commit to this data analysis will find quality becoming an integral part of the organization.

For additional information or questions, or to learn more about hospice technology solutions that can help your team develop a strong quality improvement program, please connect with Axxess.

About the Authors

Wendy Amerson is the Director of Hospice Sales for Axxess. She leverages her many years of expertise in the hospice industry to help ensure the software solution is easy to use and allows agencies to be clinically, administratively and financially compliant. Prior to serving in the Director of Hospice Sales role, she was a Product Manager focusing on creating software that was efficient and educated new team members on the benefits of the solution. Previously, she served as the Regional Director at AngMar Medical Holdings, where she was responsible for monitoring and measuring all hospice metrics. She enjoys spending time with her family, being outdoors and traveling.

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