



2021 Technical Expert Panel Meetings: Hospice Quality Reporting Program Summary Report

Prepared for:

Centers for Medicare & Medicaid Services

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Background

Introduction

The Centers for Medicare & Medicaid Services (CMS) is committed to the provision of high-quality care for Medicare beneficiaries enrolled in hospice. To this end, CMS continues to define, measure, and incentivize high-quality hospice care by prioritizing high-impact quality measures that align with the [Meaningful Measures Framework](#) (MMF) as part of its [Hospice Quality Reporting Program \(HQRP\)](#). CMS established the HQRP under [Section 1814\(i\)\(5\) of the Social Security Act](#) and requires all Medicare-certified providers to comply with specific reporting requirements.

Over the next several years, CMS anticipates expanding the HQRP to include additional quality measures consistent with the HQRP's goals. Abt Associates and its subcontractors, under contract with CMS, are developing a patient assessment instrument—the [Hospice Outcomes & Patient Evaluation tool \(HOPE\)](#)—that will support hospice quality measurement. HOPE will replace the current HQRP data collection instrument, the [Hospice Item Set \(HIS\)](#). The primary goals for HOPE are to reflect the care needs of people through the dying process, prioritize the safety and comfort of individuals enrolled in hospice nationwide, and promote person-centered care.

As part of its measure development process, CMS convenes groups of stakeholders and experts who contribute direction and thoughtful input during measure development and maintenance. To support these efforts, the Abt team solicited volunteers for a Technical Expert Panel (TEP) who were committed to improving the quality of care given to hospice patients.

TEP Responsibilities

CMS convened the HQRP TEP to provide thoughtful input during the quality measure conceptualization and development process. The HQRP TEP has committed to do the following:

- Serve the needs of the hospice population by seeking to improve the quality of care provided to hospice patients while also improving their quality of life.
- Ensure that quality measures developed, whether assessment instrument- or claims-based, are meaningful for the hospice beneficiaries and their families and caregivers, transparent to hospice providers, and useful to consumers.
- Be responsive to project timelines and provide timely responses to requests for input, insights, and feedback.
- Consider quality measures based on HOPE or claims data as a key focus area for their work.

CMS chartered the TEP for three years and tasked its members with providing input on measure concepts, candidate measures, measure specifications, measure testing, and measure implementation.

In 2021, the HQRP considered beginning with HOPE process measures rather than starting with the outcome measures, as process measures will help to acclimate providers as they transition from HIS to HOPE. Further, the initial intent was for the TEP to discuss measures in the context of HOPE testing results and to support measure implementation activities such as responding to questions from the National Quality Forum and public comments—neither of which have been completed as of the final 2021 TEP meeting. To maintain the valuable input of our TEP members as we continue to explore process measures and increase our understanding of how HOPE performs, we asked TEP members to extend their agreement through the fall of 2023.

TEP Composition

Consistent with the [Measures Management System Blueprint](#), Abt solicited nominations for and subsequently formed a TEP to provide input into the development of HOPE and related quality measures. TEP recruitment began in 2019 with a 30-day call for potential members to submit the accompanying nomination form. To solicit nominations from diverse group of hospice experts comprised of caregivers, family members, clinicians, quality improvement experts, methodologists, and other subject matter experts, as well as diversity in geographic and ownership perspectives, the CMS disseminated the call for TEP members through their webpage and national hospice provider associations. After the nomination period, Abt selected 12 nominees with diverse backgrounds and a range of perspectives and expertise. One nominee stepped down from the TEP before the first meeting, resulting in 11 HQRP TEP members.

The final TEP includes members from eight states representing all US regions, with three members representing rural areas. Members bring experience in hospice quality measurement, data collection, as well as a variety of clinical care experience in both for-profit and non-profit settings. **Table 1** presents the name and profile of these TEP members. For a detailed background of each TEP member, please see **Appendix A**.

Table 1. List of HQRP TEP Members

Name	Region	Urban/Rural	Size	Relevant Experience
Members from for-profit hospice organizations (n = 1)				
Ashley Arnold, BSN	Minnesota	Rural	Large	Hospice and palliative care nurse who trains and manages staff on data collection for clinical quality measures. Currently the Executive Director of Quality at St Croix Hospice.
Members from non-profit hospice organizations (n = 5)				
Bonnie Lauder, RN, PMHNP, MIS, CPHQ	New York	Urban	Large	Nurse with healthcare informatics expertise across settings. Currently Director of Quality at Visiting Nurse Services of New York.
William Matthews, RN	Florida	Urban	Large	Nurse who is responsible for cross-organizational collaboration to achieve quality improvement goals. Currently Quality Specialist at Tidewell Hospice, a part of Empath Health.
Jeff McNally, MD	Utah	Rural	Medium	Physician who focuses on standardizing workflows and identifying metrics for quality measures. Currently Hospice Medical Director for Intermountain Healthcare.
Bethany Myers, BSN, RN	Maryland	Urban	Large	Nurse who oversees data submission, audits data, and trains staff on quality reporting requirements. Currently Quality Assurance Nurse at Stella Maris Hospice.
Janell Solomon	Colorado	Rural	Large	IT professional with two decades of experience in hospice. Currently Director of Compliance at Sangre de Cristo Hospice and the EHR System Administrator for Sangre de Cristo Community Care.
Members from other organizations (n = 5)				
Connie Anderson, BSN, MBA	Washington	Urban	NA	Quality measurement development expert. Former Vice President of Clinical Operations at Northwest Kidney Centers.
Teresa Craig, BBA, CPA	Florida	Urban	NA	Former executive director of non-profit, for-profit, urban and rural hospices. Worked with hospice and home care programs, software, reporting tools, and technology. Currently retired but most

Name	Region	Urban/Rural	Size	Relevant Experience
				recently was the Director of Client Strategy at NetSmart in Kansas.
Kathleen Feeney, JD	Michigan	Urban	NA	Pediatric hospice caregiver with experience in quality improvement strategies to improve public service. Currently Chief Pro Tem for the Kent County Circuit Court.
Maureen Henry, PhD, JD	Utah	Urban	NA	Former research scientist at the National Committee for Quality Assurance and a Senior Manager at Customer Value Partners. Currently a Senior Program Officer at the National Academy of Medicine.
Sean Morrison, MD	New York	Urban	NA	Palliative care medicine physician and geriatrician, as well as a clinical and health services researcher. Currently Professor and Chair for the Brookdale Department of Geriatrics and Palliative Medicine at Mount Sinai. He is also the Director of the Hertzberg Palliative Care Institute and the National Palliative Care Research Center.

Prior TEP Meetings

The TEP has convened six times since November 2019. Table 2 briefly states the topics discussed at each meeting.

Table 2: TEP Meetings and Related Discussions

2019 ¹	
Fall	HOPE-based and claims-based outcomes measure concepts including pain, dyspnea, caregiver wellbeing, and patient preferences.
2020 ²	
Spring	Claims-based measure concepts of Hospice Care Index and Weekend Visits
Spring ³	HOPE-based outcome measure concepts addressing pain and the implications for HOPE items.
Fall	HOPE-based outcome measure concepts assessing pain and symptom management.
2021	
Summer	HOPE-based process measure concepts addressing pain and symptom management.
Fall	HOPE-based process measure concepts addressing pain and symptom management and measure concepts using other data sources.

¹ Refer to the [November 2019 Technical Expert Panel: Hospice Quality Report Program Summary Report](#) for additional details.

² Refer to the [2020 Technical Expert Panels: Hospice Quality Reporting Program Summary Report](#) for additional details.

³ This meeting was a workgroup with subset of TEP members

This report provides a summary of the TEP activities that occurred in 2021, and the recommendations from each.

2021 TEP Meetings

Abt convened two TEP meetings in 2021. The first focused on HOPE-based process measures intended to: 1) evaluate the rate at which hospices' use specific processes of care, 2) assist in reducing variation in care delivery, and 3) determine hospices' compliance with practices that are expected to improve outcomes. The second continued process measure discussions and explored potential areas for future quality measure development.

Summer 2021 TEP Meeting

On July 29, 2021, Abt Associates convened a two-hour virtual TEP meeting to discuss high-level HOPE-based measure concepts. CMS intends to calculate future measures using HOPE data. Abt presented the measures with the relevant draft HOPE items. Specifically, the Abt team sought input on the following eleven draft process measure concepts across five categories:

- Timely Reassessment of Symptoms Process Measures
 - Timely Reassessment of Pain Impact
 - Timely Reassessment of Pain Severity
 - Timely Reassessment of Non-Pain Symptom Impact

Symptom management, particularly for pain, is a central tenet of hospice care. These timely reassessment measures complement the previously discussed outcome measures. Since they are process measures, CMS may be able to incorporate them into the HQRP more quickly.

- Other Process Measures
 - Spirituality Assessment and Plan of Care
 - Psychosocial Assessment and Plan of Care
 - Transfer of Health Information
 - Medication Management
 - Wound Management Addressed in the Plan of Care

Practice guidelines¹ describe spiritual care as an integral part of hospice and palliative care, with Medicare's Hospice Conditions of Participation (COPs) specifying that hospices facilitate such care (42 CFR § 418). As such, we asked the TEP to explore measure concepts related to spiritual care. Note that spiritual care is distinct from religion and can be of value to hospice patients regardless of whether they hold religious beliefs.

As with spiritual care, psychosocial care is an integral part of hospice care. Here too, Medicare's Hospice Conditions of Participation (COPs) specify that hospices facilitate such care ([42 CFR. § 418](#)). Therefore, we asked the TEP to explore measure concepts related to psychosocial care.

The proposed Transfer of Health Information measures use [IMPACT Act Standardized Patient Assessment Data Elements](#). Measures that use these elements support quality measurement across post-acute care settings, including hospice. Cross-setting measures broadly support CMS' goals of improved coordination of care and patient outcomes.

Medication education and management is an expectation of clinicians in all settings in addition to being an expectation of the hospice CoPs for a comprehensive assessment ([§ 418.54](#)). The home health care setting currently uses a similar measure to address whether drug education for medications was provided to the patient and caregiver.

Wound care management is an important part of providing care to hospice beneficiaries. In July 2019, a US Department of Health and Human Services (HHS) Office of Inspector General (OIG) report entitled

¹ Refer to the [Hospice Quality Reporting Program Information Gathering Report](#).

[Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm](#) noted that hospice beneficiaries “had not received adequate services to care for wounds.” Further, some hospices do not consider wounds as related to the patient’s terminal diagnosis and therefore do not consistently include wound care in their plans of care. Inadequate wound care can result in unnecessary pain, trauma and hospitalization.

Fall 2021 TEP Meeting

Abt conducted a full-day webinar with the TEP on November 9, 2021, with ten TEP members participating. Dr. Sean Morrison was unable to attend the full day event but provided feedback during a separate call with the Abt team on November 3, 2021. As in prior years, we provided TEP members with an updated [HQRP Information Gathering Report](#). The Information Gathering Report summarizes available resources to inform HOPE development and related quality measures.

The purpose of the meeting was to solicit input from the TEP on specifications for the HOPE-based process measures supported at the July 2021 TEP meeting, the use of patient preference and tolerance data in quality measures, the potential development of quality measures from complaints surveys and deficiencies data, and other potential quality measure concepts. Specifically, the TEP:

- Continued discussion on the following HOPE-based process measures:
 - Timely Reassessment of Pain Impact
 - Timely Reassessment of Pain Severity
 - Medication Management

The TEP rated these measures as most important during the July 2021 meeting.

- Discussed the following additional HOPE-based measure concepts
 - Timely Reassessment of Symptom Impact

We proposed this measure as an alternative to the separate measures of pain impact, pain severity, and non-pain symptom impact presented in July 2021. This measure represents a single measure for all symptoms inclusive of pain impact and pain severity.

- Considered the implications of the following concepts on the timely reassessment of symptom measures
 - Missing Reassessments
 - Patient Preference and Desired Tolerance

The inability to complete certain patient reassessments as well as how to incorporate patient preferences are two concepts critical to best understanding how to implement symptom reassessment measures. In July 2021, the TEP raised specific concerns about patient preferences with respect to symptom reassessment measures, which they explored further in the November 2021 TEP.

- Explored directions for future quality measure development
 - Use of Survey and Deficiencies Data
 - Development of hybrid quality measures
 - Supporting consumers choosing a hospice

A July 2019 report by the Office of the Inspector General titled "[Hospice Deficiencies Pose Risks to Medicare Beneficiaries](#)" analyzed CMS's deficiency and complaint data between 2012 and 2016 and found deemed more than 300 hospices poor performers due to a serious deficiency or substantiated severe complaint. One of the report’s recommendations is to identify problems and strengthen oversight. To that

end, we reviewed the available hospice-level deficiencies data with the TEP and asked about its value and how meaningful it might be to consumers.

Hybrid quality measures combine data from multiple sources (e.g., Medicare Fee-For-Service claims, assessments, and/or publicly available data). Hybrid QMs expand the available information beyond that collected from a single data set, thereby increasing the range of potential quality constructs available.

Currently, [CMS Care Compare](#) provides information to help consumers choose a hospice. The TEP discussed what additional information may be valuable to consumers, in particular information that could be presented on CMS Care Compare, and how such information might inform future measure concepts.

Federal Stakeholder Debrief

Approximately one month after each TEP, Abt team members debrief with federal stakeholders. This includes a high-level review of measure development activities and a summary of the discussion and input provided during the TEP meetings. Federal stakeholders are given an opportunity for questions and reactions. In 2021 this meeting took place on December 6. Where applicable, we have included the reflections of federal stakeholders expressed during the debrief in our measure specific discussions. The remainder of this report presents the TEP's 2021 discussions in both July and November with respect to all the above topics and summarizes the key takeaways.

Timely Reassessment of Symptoms Measures

Symptom management, particularly for pain, is a central tenet of hospice care. Over the course of their two 2021 meetings, the TEP considered process measures that determine whether pain impact, pain severity, and the impact of other symptoms were reassessed timely. These timely reassessment measures are process measures that complement previously discussed outcome measures. The TEP additionally discussed topics that influence the timely reassessment measures: missing reassessments, a patient's desired tolerance, and patient preferences.

Timely Reassessment of Pain Impact

Background

The Timely Reassessment of Pain Impact measure captures the percentage of patients who have a pain impact reassessment within two days of when pain impact was determined to be moderate or severe upon the initial HOPE assessment. It corresponds with the Timely Reduction of Pain Impact outcome measure, which the TEP discussed in November 2020. We presented this measure to the TEP along with the corresponding draft HOPE items for assessing symptom impact, which includes pain. Exhibit 1 summarizes these items

Discussion

At the July 2021 meeting TEP members agreed that this measure was important with more than a third indicating they considered it a top choice for a HOPE process measure. Many members indicated their hospices employ existing metrics of timeliness of care regarding symptom management, and that pain control is a common concern. Several members expressed concern about instances where patient or caregivers do not want intervention or refuse a visit and asked that hospices not be penalized in these cases. TEP members also raised the consideration of patient preferences. For example, whether a patient who expresses a goal (desired tolerance) of "moderate" pain should receive repeated symptom reassessment visits they may not want.

The measure presented and discussed in July 2021 only included patients whose pain impact was initially assessed as moderate to severe in the denominator. Some stakeholders were concerned that focusing only on patients with moderate to severe symptom impact could result in a denominator that is too small to be publicly reported. As current data is insufficient to determine whether this is the case, the TEP discussed measure variations intended to increase the denominator of symptom impact measures, with the example of pain impact being the focus of the discussion.

In November 2021, Abt presented two versions of the Timely Reassessment of Pain Impact measure to the TEP. The first version aligned with the measure presented in July 2021. The second version of the measure looks at both timely assessment and timely reassessment of pain impact. Its denominator

Exhibit 1: Summary of HOPE items assessing symptom impact

Users will enter the code that best describes how the patient has been affected by each symptom (pain, shortness of breath, anxiety, nausea, vomiting, diarrhea, constipation, and agitation) over the past two days.

Coding:

- 1 Not at all
- 2 Slight
- 3 Moderate
- 4 Severe
- 9 Not Applicable

Users are also asked to indicate whether the patient has achieved symptom control at reassessment

Coding:

- 0. No
- 1. Yes
- 9. Not applicable

Users are advised to base their entries on their clinical assessment, including input from the patient and/or caregiver.

For the most current information on HOPE development, visit

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE>

includes all patients who are eligible for a pain assessment. The numerator would include patients who received a timely initial assessment, as well as patients who received a timely reassessment when their initial assessment indicated their pain impact as moderate or severe. See **Exhibit 2** for the details on each measure presented to the TEP in 2021.

Exhibit 2: Two versions of the Timely Reassessment of Pain Impact Measure

<i>Version 1, presented at July 2021 Meeting</i>		<i>Version 2, presented at November 2021 Meeting.</i>	
<u>Timely Reassessment of Pain Impact</u>		<u>Timely Assessment and Reassessment of Pain Impact</u>	
Numerator:	Patients who receive a pain impact reassessment within 2 days of the initial assessment	Numerator:	Patients who received an initial pain impact assessment within the assessment timeframe AND patients who receive a pain impact reassessment within 2 days of the initial assessment when pain impact was moderate or severe
Denominator:	Patients with pain impact initially assessed as moderate or severe	Denominator:	Patients eligible for an initial pain impact assessment

The TEP predominantly supported the first version: “Timely Reassessment of Pain Impact.” The TEP found the second version complicated. They thought it would be difficult to explain to hospice staff and confusing for patients and consumers. Members also cited concerns about the administrative burden of the measure and its potential incompatibility with electronic health records.

Key Takeaways

The TEP considers Timely Reassessment of Pain Impact an important measure and prioritizes it highly when considering future HOPE process measures. They preferred the simpler version of the measure that focused on timely reassessment of pain impact among patients with moderate to severe pain impact at the initial assessment. They found the combined measure confusing, believed it would be less meaningful to consumers, and thought it diluted the original intent of the measure—to address moderate to severe pain impact in a timely manner.

Timely Reassessment of Pain Severity

Background

This measure captures the percentage of patients who have a pain severity reassessment within two days when pain severity was initially assessed as moderate or severe. It corresponds with the Timely Reduction of Pain Severity outcome measure, which the TEP discussed at the full-day TEP meeting in November 2020. Note that because this measure focuses on patients with moderate to severe pain severity, it has the same risk of a small denominator as the Timely Reassessment of Pain Impact Measure. The draft HOPE items that capture pain severity are summarized in Exhibit 3.

Discussion

At the July 2021 meeting, TEP members agreed that this measure was important with more than a third considering it a top choice for a HOPE process measure. They agreed that the measure is appropriate for the hospice setting and aligns well with HQRP's quality measurement goals. While the panel largely expressed positive feedback for this measure, one member raised a concern about patient preferences, noting that the measure should not incentivize hospice staff to spend time with patients who prefer not to be visited at the expense of tending to those in pain crises.

Key Takeaways

The TEP considers Timely Reassessment of Pain Severity an important measure and prioritizes it highly when considering future HOPE process measures. However, care should be taken to be respectful of patient preferences, and the measure may be at risk of having a denominator too small to publicly report.

Exhibit 3: Summary of HOPE items assessing pain severity

Users will enter the code that indicated whether a patient was screened for pain (and if yes, the date of the first screening), the patient's pain severity, and the type of standardized pain tool used.

Coding for pain screening:	Coding for pain severity:	Coding for standardized pain tool used:
00. No	00. None	01. Numeric
01. Yes	01. Mild	02. Verbal Descriptor
	02. Moderate	03. Patient Visual
	03. Severe	04. Staff Observation
	09. Not Assessed	09. No standardized tool used

Users are advised to base the entry on their clinical assessment, including input from the patient and/or caregiver.

For the most current information on HOPE development, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE>

Timely Reassessment of Non-Pain Symptom Impact and Timely Reassessment of Symptom Impact

Background

The TEP discussed the Timely Reassessment of Non-Pain Symptom Impact measure in July 2021. This measure captures the percentage of patients who have a (non-pain) symptom impact reassessment within two days when symptom impact was initially assessed as moderate or severe. It corresponds with the Timely Reduction of Symptom Impact outcome measure the TEP discussed at their full-day meeting in November 2020 and would rely on the same HOPE data (see Exhibit 1). Here too, because the measure focuses on those with moderate to severe symptom impact, the measure's denominator may be too small to publicly report.

To address this concern across all the symptom reassessment measures, Abt presented The Timely Reassessment of Symptom Impact measure for discussion at the November 2021 TEP. This would capture reassessment for pain severity, and for the impact of pain, shortness of breath, anxiety, nausea, vomiting, diarrhea, and constipation in a single measure.

Discussion

As with the other symptom reassessment measures discussed in July 2021, most TEP members agreed that a measure of non-pain symptom impact was important, some indicating they considered this a top choice for a HOPE process measure. The TEP considered symptom reassessment measures collectively as the most critical and beneficial for hospice quality reporting.

TEP members had differing opinions regarding the combined timely reassessment of pain severity and symptom impact process measure relative to having separate measures for pain severity and pain impact. Some members noted that often these symptoms are interconnected. For example, anxiety often

accompanies shortness of breath and pain. Conversely, TEP members in support of *individual* symptom measures noted the distinction between symptoms. Other TEP members highlighted the ways in which pain differed from other symptoms in terms of time to resolve symptoms, required resources, and state regulations. For example, severe vomiting should improve immediately, whereas anxiety may take much longer to improve because it can take time to identify its cause. With respect to resources, different resources are better suited to treating different symptoms—a nurse and physician would be treating pain, while a social worker can help address anxiety. During the federal debrief, stakeholders also expressed concerns about combining symptoms, believing it may diminish the attention pain receives.

Some TEP members noted despite some of the challenges associated with a combined measure, consumers may benefit from one straightforward, easily read measure that includes all major symptoms. As one TEP member explained, “When I’m choosing a hospice, I want to know that the hospice can treat and reassess the whole package of symptoms.” Meanwhile, providers may benefit from receiving a more granular breakdown to aid quality improvement: “If I’m not scoring well on measures, I want to know which aspect in particular I need to work on.”

Key Takeaways

The TEP considers symptom reassessment measures critical for hospice quality reporting, but there was disagreement as to whether pain should be measured separately from other symptoms. While a combined measure better reflects the entirety of the patient experience and may be easier for consumers to understand and interpret, not all symptoms require the same level of intervention or respond to interventions within the same period.

Patient Preference and Desired Tolerance

Background

The TEP consistently agrees that because hospice focuses on the specific needs and desires of individual patients, their preferences need to be considered when determining whether a hospice is providing quality care. As noted earlier, when discussing both timely reassessment of symptom impact and pain severity the TEP expressed needing to consider patients’ preferences. They mentioned wanting to be sure the hospice is focusing its resources on resolving pain crises rather than, for example, reassessing patients who are comfortable where they are and would prefer to spend that time with family. During the November 2021 TEP, they specifically discussed the role of desired tolerance with respect to the measures of symptom impact (including pain) and pain severity and the role of patient preferences with respect to these same measures. The potential HOPE items that would support inclusion of desired tolerance and patient preference are shown in Exhibit 4.

Discussion

Desired Tolerance

Members expressed concerns over both the hospice provider's and the patient's ability to rate desired tolerance. Members mentioned that understanding desires and preferences for nonverbal or pediatric patients would be challenging. Abt explained that the relevant proposed HOPE items (see Exhibit 4) would be captured based on the clinician's assessment, including conversations with patients, caregivers, and facility staff providing care, as applicable.

In terms of desired tolerance, the TEP members noted that patients themselves may change their desired tolerance for pain or other symptoms once they understand the type of relief hospice may be able to offer them. Education is a critical component to patients effectively rating their desired tolerance and hospices should provide the necessary education before having the patient to choose whether they would like intervention. Patients may be able to achieve a level of comfort they did not know was possible. Another described caring for a dying relative who tried to tolerate a high level of pain, until education about pain medication helped her discover a new level of comfort. Ascertaining patient preferences requires an ongoing dialogue about pain, its management, potential side effects, and the effect of treatments.

The TEP raised concerns with the use of the word "tolerance" in this context, as there may be too much variation in what that means to patients. For example, some patients may consider a low pain tolerance a "character flaw," which in turn may influence how they respond to being asked what level of pain they feel is acceptable to them. TEP members believed that a patient's desired pain tolerance is less important than their desired pain goal and pain's impact on goals of care (i.e., does pain prevent patients from accomplishing what they want to). The TEP had no additional thoughts on desired tolerance and pain severity.

Patient Preferences

As with the desired tolerance item, patients may change their preferences once they have received some education. One TEP member noted that patients may be concerned about side effects based on a prior experience or "something they've heard about."

The TEP had concerns about the burden of repeated re-assessments. Some TEP members expressed concern about providing reassessments when patients may not want or need them. Some members thought there should be a pathway in the timely reassessment of pain impact process measure that allows hospices to skip the reassessment depending on patient preferences, noting that the cycle of two-day reassessments may become tiresome for a patient. However, other TEP members preferred maintaining the reassessment within the 48-hour requirement, at least initially, noting that "people change their

Exhibit 4: Summary of HOPE items assessing patient desired tolerance and patient preference

For desired tolerance, users will enter the code that best describes the patient's desired tolerance for each symptom (pain, shortness of breath, anxiety, nausea, vomiting, diarrhea, constipation, and agitation) at the time of the assessment

Coding for patient's desired tolerance:

01. None
02. Slight
03. Moderate
04. Severe
09. Not Applicable

For patient preference, users will enter the code that indicates whether the patient prioritizes a reduction in symptoms, even with potential treatment side-effects or inconvenience.

Coding for patient preferences:

00. No
01. Yes
09. Not Applicable

For both items users are advised to base the entry on their clinical assessment, including input from the patient and/or caregiver.

For the most current information on HOPE development, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE>

minds—especially if they’ve been living with pain for two days” and that “it’s always good to do the reassessments and make sure we are meeting the patient’s goals of care.” Federal stakeholders expressed concern that hospices may not follow up with a patient for whom the hospice indicated a preference not to prioritize a reduction in symptoms.

Some members supported a hybrid of a 2-day reassessment and consideration of preferences. If there is no change in medication, the patient is educated, and the patient’s preference is not aligned with recurring visits, reassessing every two days may not be necessary. One member suggested considering patient preferences after the first reassessment, so there is not a recurring reassessment every two days if the patient does not want it. Another member suggested maintaining a two-day reassessment for the process measure (i.e., the patient’s pain impact would need to be reassessed within 48 hours) and incorporating patient preferences in the outcome measure (i.e., the pain’s impact may not change or need to change within two days depending on patient preference for treatment, the hospice’s recommendations, or the plan of care).

Key Takeaways

Patient preferences for symptom management, with or without inclusion of the patient’s desired tolerance level for symptoms, are important. The TEP did not consider desired tolerance taken alone in conjunction with the proposed measures as valuable. Determining a patient’s desired tolerance level for pain or symptoms may be challenging, perhaps superseded by the patient’s preference, and less informative than determining how a symptom is impacting a patient’s ability to meet their goals. The TEP provided some suggestions for balancing preferences with measure requirements, such as doing a first two-day reassessment, but timing future reassessments based on the patient’s preferences.

Missing Reassessments

Background

Abt acknowledged that there are many instances when a symptom reassessment may not occur. Examples include patient death, patient revocation of hospice, hospice discharge of patient, and failure of hospice to schedule or complete the reassessment within the allotted timeframe. Abt asked the TEP to discuss under what circumstances patients who did not receive a reassessment in accordance with the measure should be excluded from measure calculations.

Discussion

The TEP largely supported exclusions for patient death, revocation, and discharge. Several members supported exclusions for any length of stay less than two days, with one member noting that there are exclusions in other quality measures for short lengths of stay. This is particularly relevant in the hospice setting where patients may die within 48 hours, leaving no time for reassessment. For patients who revoke their hospice benefit, several TEP members believed it does not reflect hospice quality and those patients should be excluded from measure calculations. One member noted that revocation is a patient’s choice and often stems from patients and caregivers struggling with the active dying process. However, one TEP member dissented, noting that sometimes patients revoke hospice if they are not getting the services they want. He expressed further concern over excluding patients discharged before the two days. He felt excluding discharged patients may incentivize hospices, particularly private hospices, to discharge patients before a reassessment and noted that “it’s not good medical practice to discharge patients before they are reassessed.”

Regarding failure of hospice to schedule or complete the reassessment within the allotted timeframe, the TEP noted that external factors (e.g., a patient refusing reassessment or an unreachable patient) can cause missing reassessments. Several TEP members proposed that including such patients in measures may misrepresent hospice efforts given these circumstances are outside of the hospice’s control. One member suggested adding response item that allows hospices to indicate that they attempted to reach a patient or caregiver, even if that patient or caregiver was ultimately unreachable.

However, another TEP member posited that the two-day timeframe is long enough for a hospice to respond to moderate or severe pain. In her experience, “in most cases, the family is the one calling the hospice,” and “it’s unacceptable” if a hospice does not reassess high pain within two days. Another member put it: “If we’re talking about significant symptoms, it’s up to the hospice to figure out how to make that reassessment happen – even if it’s challenging.” Other TEP members agreed that failure of hospice to schedule or complete the reassessment within the allotted timeframe should not be an exclusion. One member noted that missing assessments for any reason should be rare, and therefore should not meaningfully influence the overall quality measure for a given hospice that is otherwise providing good care.

Key Takeaways

The TEP agreed that patients with a length of stay of less than two days should be excluded from measures that require a reassessment in two days. However, hospice providers should do everything possible to complete a reassessment for patients with adequate lengths of stay, even while acknowledging that sometimes this may not be possible due to circumstances outside of the hospice’s control.

Other Process Measures

The TEP discussed several other process measures concepts: spiritual care, psychosocial care, transfer of health information, medication management, and wound management. Most of the measures discussed reflect hospice CoPs. The transfer of health information and medication management measures have the potential for cross-setting applications, while the wound management measure may address potential harms.

Spiritual Care Assessment and Plan of Care

Background

In July 2021, the TEP discussed two spiritual care measures: 1) the percentage of patients who have all components of a spiritual care assessment completed within the hospice admission timeframe, and 2) the percentage of patients who have spiritual needs identified and who have a plan of care addressing those needs within the hospice admission timeframe. The first is relevant for all patients, while the second focuses on patients who have identified spiritual needs. These measures were presented along with the proposed HOPE data elements that would support them (see Exhibit 5).

Discussion

With respect to a spiritual care assessment process measure, several TEP members expressed concern about its purpose given of the limited evidence linking spiritual care to improved patient outcomes. While one TEP member reported that their hospice has seen increases in quality of life for patients who do accept spiritual care visits, generally, it is difficult to determine if it affects their quality of care. Another complexity is religious beliefs in certain geographic areas, with one TEP member noting “I live in a state with a deep religious divide.”

Some TEP members did not consider completing the full HOPE assessment (see Exhibit X) as worth the requisite time and resources given the lack of evidence supporting improved outcomes. Particularly since assessing the spiritual needs of the patient and family and

Exhibit 5: Summary of HOPE items for spiritual care assessment and plan of care.

To assess spiritual care needs the user will enter a code that for two questions, one indicating whether a patient is able to respond and the other whether they are willing to participate in a spiritual assessment.

Coding for patient response:

- 00. No, the patient is not able to respond/willing to participate
- 01. Yes, the patient is able to respond/willing to participate
- 05. Not assessed

Users also code the extent to which a patient is experiencing each of the following peace in the face of illness, meaning and joy in their life, spiritual or religious struggles, and comfort and strength from spirituality or religion. Users also code caregiver experience of spiritual struggles and receipt of comfort and strength from spirituality or religion.

Coding for spiritual care assessment:

- 00. Not at all
- 01. Occasionally
- 02. Sometimes
- 03. Most of the time
- 04. All of the time
- 05. Not assessed.

Users then code whether the patient or caregiver has spiritual needs using the following:

- 00. No, spiritual or religious needs not identified
- 01. Yes, spiritual or religious needs identified

When spiritual care needs are identified, the user codes whether a spiritual plan of care was established using the following:

- 00. No, plan of care addressing spiritual or religious needs not established
- 01. Yes, plan of care addressing spiritual or religious needs established

For the most current information on HOPE development, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE>

making services such as spiritual counseling available is already a requirement across hospices

The TEP considered Spiritual Plan of Care a “check-the-box” item that could be easily “skewed by clinicians,” rather than a true measure of quality.

Key Takeaways

The TEP did not consider either spiritual care process measures to be a priority in the hospice settings, as they would not meaningfully measure quality of patient care.

Psychosocial Assessment and Plan of Care

Background

In July 2021, the TEP discussed two psychosocial care measures: 1) the percentage of patients who have all components of a psychosocial assessment completed within the hospice admission timeframe, and 2) the percentage of patients who have psychosocial needs identified and who have a plan of care addressing those needs within the hospice admission timeframe. Abt presented these measures along with the proposed HOPE data elements that would support them (see Exhibit 6).

Exhibit 6: Summary of HOPE items for psychosocial assessment and plan of care.

Users will first enter a code to indicate whether a psychosocial assessment was completed using the following:

- 00. No, psychosocial assessment not completed
- 01. Yes, psychosocial assessment completed
- 05. Not assessed

Users also code the extent to which a patient’s care and safety needs are being met, whether the patient or caregiver needs with respect to financial resources, social support, and coping related to anticipatory grief are being met, and whether the patient and caregiver are experiencing care congruent with their cultural beliefs using the following:

- 00. Not at all
- 01. Occasionally
- 02. Sometimes
- 03. Most of the time
- 04. All of the time
- 05. Not assessed.

Users also code whether the patient and caregiver are aware of the patient’s prognosis using the following:

- 00. No
- 01. Yes
- 05. Not Assessed

Users then code whether the patient or caregiver has psychosocial needs using the following:

- 00. No, psychosocial needs not identified
- 01. Yes, psychosocial needs identified
- 09. Not applicable (for caregivers when no caregiver is available)

When psychosocial needs are identified, the user codes whether a spiritual plan of care was established using the following:

- 00. No, plan of care addressing psychosocial needs not established
- 01. Yes, plan of care addressing psychosocial needs established

For the most current information on HOPE development, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE>

Discussion

TEP members noted that psychosocial assessments are important from a consumer perspective. However, because hospices already conduct psychosocial assessments to satisfy their CoPs, a quality measure

would be redundant. Though each TEP member indicated that their hospice conducts psychosocial assessments, there is no standardized assessment and assessments used by hospices can vary. This feedback was mirrored when discussing a psychosocial plan of care. One member had noticed a correlation between provision of psychosocial care and hospitalization. This suggests that the measure may be more useful as a long-term component of an outcome measure related to hospitalizations instead of a process measure.

Key Takeaways

The TEP did not consider either psychosocial care process measure to be a priority in the hospice settings, as they would simply reflect whether a hospice complies with existing Conditions of Participation. However, there may be value in considering psychosocial care in other measure structures.

Transfer of Health Information

Background

In July 2021, the TEP discussed two transfer of health information measures: 1) the percentage of patients who have their medication list provided to the patient, family, and/or caregiver at discharge, and 2) the percentage of patients who have their medication list provided to the subsequent provider at discharge. See Exhibit 7 for a summary of the proposed HOPE items that would support this measure.

Discussion

TEP members agreed that because hospices discharge so few patients, the denominator for either measure would likely be small. The small number of relevant patients would diminish the overall importance of the measures and may skew the results. Further, several members believed that hospices will simply make sure each patient or caregiver receives medication information, ensuring the measure has a high performance rate. TEP members suggested that capturing whether the medication information provided to the patient or caregiver was accurate and helpful would be more valuable. They further noted that ensuring patients or caregivers have a current medication list is more important while the patient is enrolled in hospice, rather than when they are discharged.

Exhibit 7: Summary of HOPE items supporting transfer of health information

Users will indicate whether the patient's current reconciled medication was transmitted to the subsequent provider, patient, family, and/or caregiver and how that information was provided.

Coding for provision of medication list:	Coding for transmission route of medication list:
0. No	A. Electronic Health Record
1. Yes	B. Health Information Exchanged Organization
	C. Verbal (e.g., in-person, telephone, conference)
	D. Paper-based (e.g., fax, copies, printouts)
	E. Other methods (e.g., testing, email, CDs)

For the most current information on HOPE development, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE>

Key Takeaways

The TEP did not consider the process measures for transfer of health information to be a meaningful quality indicator, as it reflects only whether the hospice provided the information and does not assess the helpfulness of that information to the patient or caregiver. Further, such a measure would reflect a small number of hospice patients.

Medication management

Background

This measure captures the percentage of patients, families, or caregivers who need assistance in medication management and received medication teaching from the hospice. The measure presented in July 2021 included all patients regardless of setting. In November 2021, the TEP discussed a version of the measure that excludes patients residing in inpatient facilities. A summary of the draft HOPE items supporting this measure are presented in Exhibit 8.

Discussion

Overall, the TEP agreed that this is an important process measure, particularly the hospice setting “when so much [responsibility around medication management] is on the family.” In July 2021, the TEP agreed that the measure should apply to patients in multiple settings, as patients in settings such as assisted living

facilities could benefit from it. In November 2021, the TEP discussed whether to exclude patients residing in inpatient facilities due to the presence of licensed staff to administer medications (i.e., skilled nursing facilities, nursing homes, inpatient hospice, or hospitals). Several members agreed to this exclusion and continued to support the inclusion of patients living in congregate homes (i.e., assisted living or residential care homes) in a process measure. However, one TEP member raised concerns about congregate home settings’ inclusion in a potential medication management outcome measure, as hospices cannot necessarily control (and thus, should not be held accountable for) the policies, procedures, and outcomes of assisted living facilities.

During the July 2021 meeting, a few TEP members suggested improvements to the measures. Another member suggested pairing the measure with a CAHPS-based patient experience measure to capture whether that the training around medication management was effective. Another member noted that a medication management process measure might improve CAHPS scores. CAHPS includes a medication management component and having a process measure could serve as an additional cue to discuss medication management which may be

helpful to clinicians. In November 2021, another member suggested measuring medication management training not only upon admission but any time the living arrangements change, such as to an inpatient unit.

Key Takeaways

The TEP agreed medication management was an important process measure but had concerns about being responsible for outcomes in facilities where the hospice does not have control over policies or procedures,

Exhibit 8: Summary of HOPE items supporting medication management

Users will code a patient, family, or caregiver’s current ability to prepare and take medications safely and reliably.

Coding for medication management ability:

0. Independent
1. Needs assistance
2. Dependent
9. Not applicable (for patients not taking any medications)

Users also indicate with a checkbox whether the patient and/or caregiver needs medication management education/training to meet the patient’s needs and whether such training was initiated at the time of the assessment or was ongoing from a prior visit.

Users also code the patient’s living arrangements.

Coding for living arrangements:

01. Person lives alone
02. Person lives with others in the home
03. Person lives in congregate home
04. Person is in an inpatient facility
05. Person does not have a permanent home or is homeless

For the most current information on HOPE development, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE>

such as an assisted living facility. They supported excluding patients in inpatient facilities from the measure, but felt the measure remained important in all other settings.

Wound Management

Background

As previously mentioned, and OIG report entitled [Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm](#) indicated that wound care in the hospice setting may be inadequate and hospices may not be consistently including wound care in their plans of care. The presented measure captures the percentage of patients with wounds who have wound care interventions on their plan of care. A summary of potential HOPE items that would support this measure are presented in Exhibit 9.

Discussion

Several TEP members predicted that there would little variability between hospices on this process measure and it would be quickly “topped out.” As one member noted, in most hospices “if there is documentation of a wound, there should also be documentation that there was a plan of care to tend to the wound.” Members acknowledged that hospices do see many wounds, and in some cases, patients can enter hospice with significant wounds that have not been properly cared for in other settings. The goal of hospice is not necessarily to heal the wound but to make and keep patients comfortable. Members noted that in many cases an EMR suggests appropriate interventions the hospice should add to the care plan based on the wound type.

Key Takeaways

The TEP agreed that a process measure focused on whether patients with wounds have wound care interventions on their care plan would not be meaningful as most hospices already have standard processes in place to capture wound care interventions in the plan of care. Further, they believe a wound care process measure would have little variability between hospices, limiting its usefulness to consumers.

Exhibit 9: Summary of HOPE items for wound plan of care.

Users will first enter a code to indicate whether a patient has any skin condition using the following:

0. No skin condition
1. Yes

Users then indicate the types of skins condition present during the assessment:

- B. Pressure Ulcers (Stage 1, 2, 3, or 4)
- C. Surgical wounds
- D. Other Ulcers (Kennedy, stasis, diabetic, or other)
- E. Other skin conditions (rash, tear, other)

Users also indicate wound characteristics:

- A. Wound discharge
- B. Signs and Symptoms of infection
- C. Pain (e.g., with wound assessment or treatment)
- D. Odor
- E. None of the above

Users then indicate types of wound interventions:

- A. Medicate prior to wound care
- B. Dressing change
- C. Debridement
- D. Topical medication
- E. Negative pressure wound therapy
- F. Other
- G. None of the above

For the most current information on HOPE development, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE>

Future Quality Measure Development

In consideration of continued expansion of the HQRP, we asked the TEP to consider the value of data other than HOPE. Specifically, we presented the TEP with survey and deficiencies data, hybrid measures that combine HOPE data and data from other sources, and information that could support consumers as they choose a hospice provider. We asked the TEP about the value of the data, whether the information it provides is meaningful, and whether it could support potential quality measures. These discussions were exploratory in nature and did not include specific data items or measure specifications.

Use of Survey & Deficiencies Data

Background

Surveyors from either State Survey Agencies or Accrediting Organizations conduct onsite reviews of hospices to promote compliance and quality of care at least once every three years. During these visits surveyors review clinical records, investigate complaints, and visit patients to understand how the hospice works. If the hospice fails to meet a Medicare program requirement, surveyors cite it with a deficiency. As a result of the [Consolidated Appropriations Act of 2021](#), survey data, including deficiencies, will be publicly reported as of October 2022. We reviewed the available hospice-level deficiencies data and with the TEP and asked about its value and how meaningful it might be to consumers.

As mentioned previously, a July 2019 report by the Office of the Inspector General titled "[Hospice Deficiencies Pose Risks to Medicare Beneficiaries](#)" analyzed CMS's deficiency and complaint data between 2012 and 2016. They found that overall, more than 300 hospices were poor performers due to a serious deficiency or substantiated severe complaint. One of the recommendations stemming from that report was to use the deficiency data to identify problems and strengthen oversight. To that end, we also asked the TEP about using the data's potential in quality measure development.

Discussion

The TEP raised several concerns about variation in deficiencies data. Members note variation between regions, as location affects the how surveyors are trained, how surveys are handled, and ultimately, survey results. TEP members suggested that survey results could vary based on whether a public or private surveyor conducted it. Further, the TEP described how the methodology of a large private surveyor has recently shifted from citing trends to a "see one, cite one" approach. With some surveyors using a "see one, cite one" methodology and other agencies continue to judge trends the data may be less valuable for public reporting as it is less comparable.

As to the overall value of deficiencies data, several TEP member shared experiences of surveyors unfamiliar with hospice and poorly versed in hospice CoPs. They suggested some surveyors' lack of familiarity with hospice decreases the value of deficiencies in measuring hospice quality. TEP members also raised additional concerns about the "see one, cite one" approach, leading to increased citations of rare events instead of trends in hospice quality.

TEP members recognized that deficiencies and the surveyor's methods for reviewing compliance can be nuanced and difficult to understand. They agreed that consumers may have trouble interpreting deficiencies data. One TEP member commented that consumers may not understand the levels of severity, so unfiltered public reporting may lead to misinterpretations about the severity of deficiencies. Another agreed that consumers may focus on deficiencies instead of quality measures, which are more relevant to quality care.

However, the discussion also raised some benefits of providing deficiencies data to consumers. One TEP member indicated that, in their experience, consumers look to websites including Yelp and Care.com, which primarily provide individuals' complaints. If the aforementioned issues were resolved, publicly reporting deficiencies data could provide consumers an alternative source of digestible, accessible,

uniform information on quality of care. Another TEP member observed that this is the first measure discussed where the person reporting the data is not directly affected by the results. They felt it is important to include measures with neutral reporters.

The TEP acknowledged that deficiencies data will likely be publicly reported. Several members agreed that filtering deficiencies (e.g., reporting only conditional level deficiencies instead of the total number of deficiencies) would ameliorate some of the variation and make the data more reflective of quality and more digestible to consumers.

Key Takeaways

Overall, TEP members expressed reservations about the usefulness of data from deficiencies and complaints surveys in measuring hospice quality. The TEP's main reservations were inconsistencies in deficiency citations over time, between regions, and between surveyors. There was also discussion about consumers' ability to interpret these data in context. The TEP largely agreed that meaningful distinctions between hospices would not be obvious to most consumers. However, members also suggested deficiencies data could provide uniform, accessible information to consumers if consolidated appropriately.

Hybrid Quality Measures

Background

Hybrid measures expand the available data and thereby expand potential question measure concepts. The primary drawbacks to hybrid measures are the logistics and limitations of combining data sources as different data sources may have differing time frames and/or aggregation levels (i.e., patient- vs. provider-level data). After presenting an overview of hybrid quality measures we proposed three example potential concepts for the TEP to consider:

- Hospitalization of beneficiaries with a Do-Not-Hospitalize order (hybrid of Acute Inpatient Medicare Fee-for-service claims and HOPE data)
- Percentage of days spent at home among beneficiaries with a Do-Not-Hospitalize order (hybrid of Medicare Hospice claims and HOPE data)
- Failure to clarify preferences of beneficiaries who revoke hospice and who are hospitalized or die shortly post-discharge (hybrid of Acute Inpatient & Hospice Medicare Fee-for-service claims, Medicare enrollment information, and HOPE data,)

The first two measures' rationale is based on the strong emphasis the Medicare Hospice Benefit has placed on providing care in the home since its inception in 1983 ([46 FR 38146](#)). The third measure acknowledges that beneficiaries may revoke their hospice benefit at any time and pursue curative treatment. In those cases, hospices should clearly document the patient's preferences and provide that information as part of the transfer documentation. This third concept reflects both good care processes measure (documentation of patient preference and transfer of that documentation) and avoidance of a poor outcome measure (hospitalization or death shortly after hospice discharge).

Discussion

The TEP was generally supportive of hybrid measure development for the HQRP, and the example concepts proposed. Several members described how their hospices are already analyzing available data to determine whether patient preferences for hospitalization and resuscitation are being honored. Many believed the additional non-claims-based data could provide additional valuable insights into the quality of hospice care provided. For example, additional data sources could help hospices understand differences in patient populations and whether patient preferences and goals are being honored. TEP members described several applications for measures such as the one Abt proposed: examining the

correlation between different patient preferences and outcomes, monitoring whether hospices are encouraging complicated patients to revoke their benefit, and using the data to educate families and caregivers on a patient’s end-of-life wishes. However, one TEP member noted that there is a wealth of information in claims data, and CMS still might be able to draw future measure concepts from claims data alone. Another warned that patient preferences can change quickly, and preferences documented early in hospice care may change when a patient is in crisis.

TEP members asked for clarification on the timeframe for these potential measures. One member suggested the measures incorporate targets and benchmarks for revocation to capture trends. Another agreed with the use of benchmarks but recommended using only claims data to assess revocations. The discussion also included how to address gaps between hospice revocation and seeking of treatment such as hospitalization. One suggestion was to categorize discharged patients according to whether their preferences were known and correctly addressed by the hospice.

Key Takeaways

The TEP supported use of hybrid measures generally, and further supported hybrid measures that address a patient’s end-of-life preferences, including a patient’s ability to remain at home. However, the TEP requested additional clarification on the details on how such a measure would be defined, calculated, and implemented.

Supporting Consumers with Hospice Selection

Background

Currently, CMS Care Compare provides information to help consumers choose a hospice. The TEP discussed what additional information may be valuable to consumers, and how such information might inform future measure concepts. The week prior to the November 2021 TEP meeting, Abt provided members a list of questions that may be helpful to patients and families when selection a hospice and asked members to indicate whether they believed the questions would be important for the selection process.

To create this list, Abt conducted environmental scan and compiled questions from several sources: American Hospice Foundation, National Association for Home Care and Hospice, National Hospice and Palliative Care Organization, Hospice Foundation of America, Harvard Health Publishing, and CMS Care Compare. Forty-two questions or question groups were sorted into seven categories: administrative (five questions), services provided (fourteen questions), care plan (five questions), support and other levels of care (five questions), team members (eight questions), quality monitoring and improvement (four questions), and resources (one question). Abt shared the polling the results to the group. The questions, their category, and amount of TEP support for them is presented in Table 3

Table 3. TEP Support for Questions for Patients and Consumers Choosing a Hospice

Question or Question Group	Category
80% or more of TEP members agree these questions are important (n=18 questions)	
How long does it typically take the hospice to enroll someone once the request for services is made? How quickly can the intake/admissions staff come to begin the admissions process?	Administrative
Is the hospice accredited, and if required, state-licensed?	Administrative
How does the hospice handle payment and billing? What kind of out-of-pocket expenses should the family anticipate?	Administrative
How rapid is crisis response? If the family needs someone to come to the home at 3:00 AM on a Saturday, where would that person come from? What is their average response time? Who is available to make the home visit (nurses, doctors, social workers, chaplains)?	Services

Table 3. TEP Support for Questions for Patients and Consumers Choosing a Hospice

Question or Question Group	Category
Is someone available at nights or on weekends? What is the typical response time if we need to reach someone at the hospice aster normal business hours, or on weekends for holidays? How are services provided after hours?	Services
What services are provided? Are there any services, medication or equipment that the hospice doesn't provide?	Services
How often will a hospice team member visit?	Services
How will pain and other symptoms be managed? How quickly can we expect pain or other symptoms to be managed? How will the hospice respond if medications do not seem to be sufficiently addressing pain or symptoms?	Services
How will the hospice team prepare the patient and family for what to expect?	Services
Will the hospice provide training to family caregivers?	Services
What is the expectation about the family's role in caregiving?	Services
How will the hospice team keep the patient and family informed about the patient's condition?	Care plan
Does this provider include the patient and his or her family in developing the plan of care? Are they involved in making care plan changes?	Care plan
What kind of support is available to the family/caregiver? Can the hospice provide respite care to give family caregivers a break and how does the hospice arrange that?	Support and other levels of care
When the hospice orders medication, where can it be picked up, or is it delivered by the hospice?	Support and other levels of care
Who will be on the hospice care team, and how are they trained, screened, and managed?	Team members
How are patient/family concerns handled? Is there a clear process for sharing concerns with appropriate hospice staff and making sure they are addressed, including a process for escalation if the concerns is not adequately addressed at lower levels?	Quality monitoring and improvement
Who can the patient and his or her family members call with questions or complaints? How does the agency follow-up on and resolve problems?	Quality monitoring and improvement
60 – 79% of TEP members agree these questions are important (n=11 questions)	
Does the hospice offer extra services beyond those required?	Services
What kind of bereavement services/support does the hospice provide?	Services
Can the hospice meet your specific needs? Is there anything currently being done for the patient that a hospice under consideration would not be able to do?	Services
Does the hospice prepare families for the death of a patient if there is not a member for the hospice team on site?	Services
Is the patient's course of treatment documented, detailing the specific tasks to be carried out by each professional caregiver? Does the patient and his or her family receive a copy of this plan, and do the caregivers update it as changes occur? Does this provider take time to educate family members on the care being administered to the patient?	Care Plan
Can the patient take their current medications?	Support and other levels of care
What procedures does this provider have in place to handle emergencies?	Support and other levels of care

Table 3. TEP Support for Questions for Patients and Consumers Choosing a Hospice

Question or Question Group	Category
Do members of the team providing care have additional and certifications for the hospice and palliative care skills?	Team members
Will the patient have the same hospice nurse?	Team members
How does the hospice measure and track quality? Does the hospice conduct a family evaluation survey?	Quality monitoring and improvement
Does this provider supply literature explaining its services, eligibility requirements, fees, and funding sources (e.g., a Patient Bill of Rights)?	Resources
40 - 59% of TEP members agree these questions are important (n=12 questions)	
Is the hospice a We Honor Veterans partner	Administrative
Has the hospice been surveyed by a state or federal oversight agency in the last five years?	Administrative
How does the hospice work to keep the patient comfortable?	Services
How quickly will a plan of care be developed for the individual by the hospice?	Care plan
Are nurses or therapists required to evaluate the patient's home care needs? If so, what does this entail? Do they consult the patient's physicians and family members?	Care plan
With which nursing homes or long-term care facilities does the hospice work?	Support and other levels of care
Can the patient still see their regular doctor while on hospice? If yes, how will the hospice team coordinate care with the doctor?	Team members
What does the hospice volunteer do? What services do they offer and if requested, how quickly will a volunteer be available? How can we request help from a volunteer?	Team members
Are clinical staff (physicians, advanced practice nurses, nurses, nursing assistants, social workers, or chaplains) certified or credentialed in hospice and palliative care?	Team members
How many patients at any one time are assigned to each hospice staff member who will be caring for the patient?	Team members
What is the role of doctors, nurses, and other health professionals?	Team members
Does this provider assign supervisors to oversee the quality-of-care patients are receiving in their homes? If so, how often do these individuals make visits?	Quality monitoring and improvement
20 - 39% of TEP members agree these questions are important (n = 1)	
How does the hospice ensure patients' confidentiality?	Services

NOTE: No questions had the support of 20% or less of the TEP members. One TEP member was unable to complete the polling exercise.

As part of the pre-meeting exercise, members also provided additional questions that would recommend a patient or caregiver as a potential hospice provider. Their responses included:

- What were the results of your most recent survey?
- What is the daily census of your hospice?
- What is the hospice ownership (e.g., non-profit, national for-profit chain, local for-profit, private equity)?
- Do they specialize in pediatric hospice? Or how many pediatric hospice patients do they treat per year?

- What makes them different from other hospice programs? What responsibility does each of the team members have in the care of the patient (e.g., chaplain, social worker, dietitian)?

Discussion

Many TEP members agreed that much of the presented information is important for patients and caregivers choosing a hospice, but not all the information could be measured. Several TEP members agreed that the amount of information that received TEP support on the poll would be overwhelming to consumers. One member added that consumers are often in an emotional or anxious state when choosing a hospice, further complicating their ability understand information presented to them. She suggested the fewer questions that focus on direct care and support for caregivers would better serve consumers. The discussion yielded two factors for additional consideration: (1) which information is important for Care Compare or similar websites, and (2) which information is measurable and can be reported?

The TEP noted that what can be conveyed through the questions and what matters to individual consumers can vary. For example, one member described that though they service few pediatric patients, they do have a pediatric specialist. In this case, providing information on the number of pediatric patients they served does not reflect the ability to treat pediatric patients. Another provided an example of how medication management was important to her selecting a hospice medication management because of her personal experience struggling to find a stable drug regimen for her family member. This type of information may not as highly prioritized by other consumers with different experiences. Another member noted finding value in being able to provide an “exit interview” after a family member’s hospice stay, and understanding how patients, families, and caregivers can communicate with the hospice could be valuable to consumers.

The TEP highlighted the following questions as important information to provide to consumers:

- How do hospices manage cases across nursing shifts (i.e., is there the “same case manager, different nursing shifts?)
- How do hospice team members communicate with each other about the patient and ensure continuity of care?
- What should consumers expect when a patient is admitted? What is the role of the caregiver?
- What services can a consumer expect to be covered under the Medicare hospice benefit?
- How are medications managed (e.g., how quickly would a medication be discontinued)?
- What more specialized services are available (e.g., occupational therapy for patients having difficulty swallowing)? Does the hospice have partnerships with or recommendations for services that hospice does not provide?

When asked specifically about what could be of value on CMS Care Compare, one member proposed timeliness of admission. All TEP members considered this information in the pre-TEP survey, and it can be discretely reported on CMS Care Compare and potentially be developed into a quality measure.

Key Takeaways

The TEP considered almost all the questions discussed as important to consumers choosing a hospice but recommended that care should be taken to not overwhelm consumers. Selecting a few measures of high importance would be preferable to more measures. They also questioned whether many of the questions could feasibly be measured. They further emphasized that what consumers consider important will

depend on their individual experience and their specific concerns. In other words, what one consumer considers important may be different than what another consumer considers important.

Conclusions

Timely Reassessment of Symptoms Measures

The TEP continues to consider timely reassessment of symptoms important and to prioritize them highly when considering future HOPE process measures. They preferred simpler measures where possible. However, when considering combining symptoms into a single symptom reassessment measure, they acknowledged that not all symptoms require the same level of intervention or respond to interventions within the same period. Considering patient preferences in symptom reassessment measures remain important. However, the TEP did not consider a patient's desired tolerance alone important. The TEP provided some suggestions for balancing preferences with measure requirements, such as doing a first two-day reassessment, but timing future reassessments based on the patient's preferences. With respect to capturing missing reassessments in a measure, patients with a length of stay of less than two days should be excluded from relevant measures but hospice providers should do everything possible to complete a reassessment for patients with adequate lengths of stay.

Other Process Measures

The TEP did not consider most of the other process measures presented as a priority in the hospice setting or a meaningful indicator quality. The TEP believed spiritual, psychosocial and wound care measures to be "check the box" measures that would have little variability and therefore little meaning. Transfer of health information does not reflect whether information provided to the patient or caregiver is helpful, and it would reflect only the small number of patients who transfer to another provider of care. The exception is medication management, which the TEP agreed was an important process measure. They supported excluding patients in inpatient facilities from the medication management measure.

Future quality measure development

Overall, TEP members expressed reservations about the usefulness of data from deficiencies and complaints surveys in measuring hospice quality. They expressed concerns about inconsistencies in deficiency citations over time, between regions, and between surveyors, in addition to consumers' ability to meaningfully interpret the data. The TEP widely supported hybrid measures that combine HOPE data with other data sources, as well as the specific concepts proposed that addressed a patient's end-of-life preferences, including a patient's ability to remain at home. With respect to information that might help consumers choose a hospice, the TEP considered much of the information discussed important but cautioned that it would be easy to overwhelm consumers. They also noted the individual nature of what a consumer would consider important, and many of the questions likely cannot be easily measured.

Next Steps

In 2022 Abt intends to host two additional TEP meetings. These meetings may be used to review additional data collected from HOPE testing and its impact on prior measure discussions and discuss what risk factors would be important to consider in quality measure calculations. Additionally, we can continue discussions on how to support consumers in choosing a hospice and how to structure a hybrid measure that reflects patient hospitalization preferences. For the former, we would focus on one to three of the questions indicated as most important by the TEP, and for the latter, we can potentially provide analysis on the rates of hospitalization and for do-not-hospitalize patients and related HOPE data, if available.

Appendix A: TEP Member Background Statements

Connie Anderson is the former Vice President of Clinical Operations at Northwest Kidney Centers, where she spent forty-four years working extensively in quality measure development. Ms. Anderson is currently the Co-Chair of the End Stage Renal Disease Standing Committee for quality measures and has been actively involved with the National Quality Forum (NQF) for fifteen years. She is also an international resource for those interested in home hemodialysis and is known for her humane care of renal disease patients. Ms. Anderson received her BSN from University of Washington and currently lives in Kirkland, WA.

Ashley Arnold is the Executive Director of Quality at St. Croix Hospice, which is a large, for-profit facility located in Oakdale, Minnesota. As a certified hospice and palliative care nurse, Ms. Arnold has a combination of clinical and managerial experience. At St. Croix Hospice, she has delivered hospice care directly, while also training and managing field staff on data collection for quality measurement. Ms. Arnold received her BSN from Saint Catherine University and currently lives in Saint Michael, Minnesota.

Teresa Craig is the former Director of Client Strategy at NetSmart, an electronic health record (EHR) vendor for post-acute care communities. Ms. Craig retired from this position in 2020, after twenty-six years of experience working with hospice and home care programs, software, and technology. She has served as Executive Director, CIO, CFO, and Vice President for both non-profit and for-profit hospice providers across multiple states and in both urban and rural locations. She has also served on the Quality Council for these hospice providers, while overseeing the development of home care software and reporting tools. Ms. Craig received her BBA from Wichita State University and currently lives in Tampa, Florida.

Kathleen Feeney is the Chief Judge Pro Tem of the Kent County Circuit Court in Grand Rapids, Michigan, where she routinely employs quality improvement strategies in evaluating and improving public service. Ms. Feeney serves on numerous statewide workgroups to improve child protection proceedings and the provision of care to medically fragile children. Following the death of her one-year-old daughter in 2000, Ms. Feeney and her husband joined the Family Center Care Advisory Council at the Helen DeVos Children's Hospital to support clinicians in making hospice care more patient-centered. Ms. Feeney received her JD from The University of Illinois and currently lives in Grand Rapids, Michigan.

Maureen Henry is a Senior Program Officer at the National Academy of Medicine and a Senior Manager at Customer Value Partners, a management consulting company. In her previous role as Research Scientist at the National Committee for Quality Assurance (NCQA), Ms. Henry led a learning collaborative of palliative care organizations to use quality improvement techniques to evaluate patient-defined measures in serious illness care, as well as a project to develop care coordination measures for the Medicare Advantage Program. Ms. Henry has also served as the President of the Utah Hospice and Palliative Care Organization, the Executive Director of the Utah Commission on Aging, and the Director of Utah's Aging and Disability Resource Connection (ADRC). Ms. Henry received her PhD from the University of Utah, her JD from The University of California at Berkeley, and her BA from the University of Delaware. She currently lives in Sandy, Utah.

Bonnie Lauder is the Director of Quality at the Visiting Nurse Service of New York's Hospice and Palliative Program and a registered nurse. Ms. Lauder has twenty-five years of experience in the field of healthcare informatics and quality, with a focus on interpretation and implementation of regulatory standards and measures. Since 2005, she has successfully designed and implemented core clinical and management delivery systems across hospital, home care, and hospice continuums using the Institute for Healthcare Improvement's (IHI) Collaborative Model for Achieving Breakthrough Improvement. Ms. Lauder is also a published author on topics related to evidence-based care implemented at the interdisciplinary care team level. She received her BSN from the State University of New York at Downstate and her Master's in Information Systems from Pace University. Ms. Lauder currently lives in New York, NY.

William Matthews is a Quality Specialist Nurse for Tidewell Hospice, a large non-profit facility in southeast Florida. He is regularly involved in the process of abstracting, submitting, and analyzing the Hospice Item Set (HIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) data that is currently required by the Hospice Quality Reporting Program (HQRP), and is familiar with providing the bedside care that quality measures assess. He also collaborates with clinical management, the education department, and the IT department to ensure a comprehensive approach to achieving quality improvement goals. Mr. Matthews received his RN from Manatee Community College and his BA from the University of South Florida. He currently lives in Sarasota, FL.

Jeff McNally is the Senior Medical Director of Homecare/Hospice/Palliative Care/Post-Acute Care at Intermountain Healthcare, a Utah-based, not-for-profit system of hospitals and other health service entities. After twenty-three years of providing emergency medicine care, Dr. McNally transitioned to hospice care. Currently, he works on standardizing workflows and determining metrics to accurately measure the quality and experience of care. Dr. McNally received his MD from the University of Washington and his BA from Stanford University. He currently lives in Salt Lake City, UT.

Sean Morrison is a practicing palliative medicine physician and geriatrician, clinical and health services researcher, as well as the recently appointed Chair of the Brookdale Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai. Dr. Morrison has published over 200 research articles, most of which focus on improving the management of pain in older adults and on developing and evaluating models of palliative care delivery in hospitals and the community. Dr. Morrison received his BA from Brown University and his MD from the University of Chicago. He currently lives in New York, NY.

Bethany Myers is a Quality Assurance Nurse at Stella Maris Hospice, a large facility in Timonium, Maryland. In her current role as a practicing clinician, Ms. Myers transmits completed HIS to CMS for hospice homecare and inpatient units, while reviewing CASPER report for errors or warnings, compiles quality assurance data, audits admission charts, and educates staff about reporting and patient care issues. She also monitors hospice quality data and synthesizes results for other nurses. Ms. Myers received her BSN from Messiah College and currently lives in Timonium, MD.

Janell Solomon is the Director of Compliance at Sangre de Cristo Hospice, a large non-profit facility in rural Colorado. In her current role, Ms. Solomon performs audits of quality measurement documentation and trains staff on how to improve documentation of responses for HIS elements. She ensures the integration of other necessary elements such as payroll, pharmacy, and clinical supply

needs. Ms. Solomon was a participant in the Centers for Medicare Services (CMS) HEART Pilot A Test, while also leading numerous beta tests in coordination with Sangre de Cristo's electronic health record (EHR) vendor to improve the efficiency and capability of new software. She currently resides in Pueblo, CO.