Partnership for Quality Measurement
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CBE ID

3645

Title

Hospice Visits in the Last Days of Life

Project

Advanced Illness and Post-Acute Care

Endorsement Status

Endorsed with Conditions

E&M Committee Rationale/Justification

When the measure returns for maintenance (5 years), the measure developer should have:

- Explored the feasibility and utility of adding additional disciplines (e.g., chaplains) and patient preferences (e.g., visit refusal) to the measure;
- Conducted updated correlation analyses exploring included disciplines with patient/family satisfaction; and
- Explored, with the developer's technical expert panel (TEP), the timing and unpredictability of end-of-life events.

Is Under Review

No

Next Maintenance Cycle

Fall 2029

Previous Endorsement Cycle

Fall 2024

Initial Endorsement

Tue, 07/26/2022 - 09:23

Steward

Centers for Medicare & Medicaid Services

1.0 New or Maintenance

Maintenance

1.1 Measure Structure

Single Measure

1.3 Electronic Clinical Quality Measure (eCQM)

No

1.6 Measure Description

The proportion of hospice patients who received hospice visits from a Registered Nurse or Medical Social Worker (non-telephonically) associated with the measured hospice entity during at least two of the final three days of life.

1.7 Composite Measure

No

1.7 Measure Type

Process

1.8 Level of Analysis

Facility

1.9 Care Setting

Hospice

1.10 Measure Rationale

This process measure focuses on the provision of consistent professional staff visits during the last three days of life during this time of increased symptom burden. The disciplines included in this measure – registered nurse and medical social worker service visits – were selected not only because they are the focus of CMS's payment incentive policy for end-of-life visits (the "Service Intensity Add-On") but also empirical testing found these visits had the highest correlation with CAHPS Hospice scores (Abt, 2020). Additionally, CAHPS hospice ratings were found to be greatest when visits were provided on two of the last three days of life. Two days would seemingly be preferable to one day for providing more supportive services; as to why it would be preferrable to three days, families may prefer at least some privacy during an end-of-life vigil (and not requiring a visit every day of the last three days of life allows greater flexibility for hospice providers to achieve success at this measure).

Citation: Abt (2020). Hospice Visits When Death is Imminent: Measure Validity Testing Summary and Re-Specifications. Retrieved from: https://www.cms.gov/files/document/hqrphospice-visits-when-death-immine...

1.11 Measure Webpage

https://www.cms.gov/files/document/hospice-visits-last-days-life-hvldl-measure-...

1.13 Data Dictionary

Attached

1.14 Numerator

The numerator of this measure is the number of patients who received hospice visits from registered nurses or medical social workers associated with the measured hospice entity during at

least two of the final three days of life.

1.14a Numerator Details

The numerator of this measure is the number of patient stays for which the patient and/or caregiver received hospice visits from registered nurses or medical social workers during at least two of the final three days of the patient's life, as captured by Medicare hospice claims records. Registered nurse visits are identified by revenue code 055x (with the presence of HCPCS code G0299); Non-telephone visits by medical social workers are identified by revenue code 056x (other than 0569; HCPCP code G0155).

1.15 Denominator

The denominator for the measure includes all Medicare hospice patient stays captured by Medicare hospice claims records where the patient expired in hospice.

1.15a Denominator Details

The denominator for the measure includes all the hospice's patient stays where the patient expired in hospice (i.e., patients discharged to death) except for those meeting the exclusion criteria outlined below. Patients that expired in hospice care are indicated by reason for discharge code on the claim (PTNT_DSCHRG_STUS_CD equals [40, 41, or 42]). Hospice patient dates of death must occur during the reporting period (we report analyses at the hospice level using nationwide Medicare Part A hospice claims with dates of death in Calendar Years 2022 and 2023 (corresponding with the most recent available measure calculations, also used for the CMS Care Compare public reporting site's annual 2024 data update).

1.15b Denominator Exclusions

Hospice patient stays are excluded from the measure if the patient (1) received any continuous home care, respite care, or general inpatient care in the final three days of life or (2) if the patient was enrolled with the hospice fewer than three calendar days.

1.15c Denominator Exclusions Details

The exclusion criteria are:

1. Patient received any continuous home care, respite care or general inpatient care in the final three days of life (exclude if revenue codes = [0652, 0655, or 0656])
2. Patient was enrolled with the hospice fewer than three calendar days.

1.15d Age Group

Other

1.15e Age Range in Years

The target population is all patients admitted to Medicare-certified hospice programs, regardless

of patient age.

1.16 Type of Score

Rate/proportion

1.17 Measure Score Interpretation

Better performance = Higher score

1.18 Calculation of Measure Score

1. The data used to calculate the measure are all Medicare Part A hospice fee-for-service claims within the relevant reporting period; this measure is calculated over two pooled years (we report analyses at the hospice level using nationwide Medicare Part A hospice fee-for-service claims with dates of discharge in Calendar Years 2022 and 2023, corresponding with information used for the Fall 2024 update to the Care Compare site).
2. Identify the denominator: all Medicare hospice patient stays with the patient discharged to death within the measurement period as identified by the claims discharge status code, PTNT_DSCHRG_STUS_CD equals [40, 41, or 42].
3. Remove any denominator exclusions:
    1. Patient received any continuous home care, respite care or general inpatient care in the final three days of life (exclude if revenue codes = [0652, 0655, or 0656])
    2. Patient was enrolled with the hospice fewer than three calendar days
4. Identify the numerator: patient stays among the denominator in which the patient and/or caregiver received visits from registered nurses or medical social workers during at least two of the final three days of life.
    1. Registered nurse visits are identified by revenue code 055x (with the presence of HCPCS code G0299).
    2. Non-telephone visits by medical social workers are identified by revenue code 056x (other than 0569; HCPCS code G0155).
5. Calculate the measure score as a proportion:
    1. For each hospice, divide the total number of cases in the numerator (Step 4) by the total number of cases in the denominator (Steps 2 and 3) and multiply by 100.
    2. Note: per CMS public reporting standards, the measure is suppressed for hospices with fewer than 20 cases in the denominator (see 1.26).
6. For this process measure there is no risk adjustment or stratification of measure scores.

1.19 Measure Stratification Details

The measure is not stratified.

1.20 Types of Data Sources

Claims Data

1.25 Data Source Details

Data are obtained from Medicare Part A Hospice Fee-For-Service Claims with dates of discharge in Calendar Years 2022 and 2023, corresponding with information used for the Fall 2024 update

to the Care Compare site; access was through the CMS Research Data Assistance Center (ResDAC) Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC).

1.26 Minimum Sample Size

To generate statistically meaningful results, the minimum CMS public reporting threshold is at least 20 denominator cases.

2.1 Attach Logic Model

2.1 Logic Model.pdf

2.2 Evidence of Measure Importance

Hospice Visits in the Last Days of Life is a measure of the proportion of hospice patients who received hospice visits from a Registered Nurse or Medical Social Worker (non-telephonically) during at least two of the final three days of the patient's life. Evidence available from clinical organizations and panels, as well as from individual studies, supports the measure's premise that clinician visits to patients at the end of life are associated with improved outcomes for both the patients and their caregivers.

The last week of life is typically the period in the terminal illness trajectory with the highest symptom burden. Highly specific physical signs associated with death are identifiable within 3 days of death (Hui et al., 2014; Ijaopo et al., 2023). Particularly during the last few days before death, patients experience many physical and emotional symptoms, necessitating close care and attention from the integrated hospice team and drawing increasingly on hospice team resources (de la Cruz et al., 2015; Dellon et al., 2010; Kehl et al., 2013). Hospice responsiveness during times of patient and caregiver need is an important aspect of care for hospice patients (Ellington et al., 2016). Although Medicare-certified hospices do not have any mandated minimum number of required visits for patients in routine home care (RHC), the most common level of hospice care, at the end of life, hospices should be equipped to meet the higher symptom and caregiving burdens of patients and their caregivers during this critical period (Teno et al., 2016). Clinician visits to patients at the end of life are associated with decreased risk of hospitalization and emergency room visits in the last two weeks of the patients' life, decreased likelihood of a hospital-related hospice disenrollment, and decreased odds of dying in the hospital (Seow et al., 2010; Phongtankuel et al., 2018; Almaawiy et al., 2014). In addition, clinician visits to patients at the end of life are associated with decreased distress for caregivers and higher satisfaction with home care (Pivodic et al., 2016).

Visits by staff who can assess symptoms and make changes to the plan of care as well as work with the patient and the primary caregiver to provide the appropriate palliation and emotional support (nurses, social workers, and physicians) are important to the quality of care hospices deliver, as noted by the National Quality Forum's preferred practices on the recognition and management of the actively dying patient (Teno et al., 2016). During the development of the Family Evaluation of Hospice Care survey, families voiced the importance of visits by these staff in the last days of life (Teno et al., 2016).

Several organizations and panels have identified care of the imminently dying patient as an important domain of palliative and hospice care and established guidelines and recommendations related to this high priority aspect of care. The National Quality Forum 2006 report “A Framework and Preferred Practices for Palliative and Hospice Care Quality” recommends that signs and symptoms of impending death are recognized, communicated, and educated, and care appropriate for the phase of illness is provided (National Quality Forum, 2006). The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care also acknowledge that “care of the patient at the end of life is time- and detail-intensive, requiring expert clinical, psychological, social, and spiritual attention to the process as it evolves” and recommends that hospices continually evaluate symptom management issues in anticipation of higher needs for staff support at this time (2018). Further, the American College of Physicians Clinical Practice Guidelines recommend that clinicians regularly assess pain, dyspnea, and depression for patients with serious illness at the end of life (Qaseem et al., 2008).

Further, there is evidence of disparity in hospice staff visits at end of life. Patient characteristics associated with greater increases in visit frequency at end of life include being younger, male, white, having a spouse caregiver, and shorter hospice length of stay (Ellington et al., 2016). Another study found that hospice staff visits in the last two days of life were less likely for Medicare beneficiaries who were black, dying on a Sunday, or receiving care in a nursing home (Teno et al., 2016). Thus, measuring these visits may also reduce disparities in care.

Finally, research has shown that hospice visits by professional staff in the last days of life are correlated with higher care quality reported by caregivers. Christian et al. (2020) found that receiving visits from a registered nurse or social worker during at least two of the last three days of life was positively correlated with CAHPS Hospice outcomes, while Anhang Price et al. (2020) found that providing professional staff visits in the last two days of life to 71.1% or more of patients was associated with hospices ranking in the top quartile of both CAHPS and Hospice Item Set (HIS) performance.

Citations:

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2.4 Performance Gap

We completed analyses at the hospice level using nationwide Medicare Part A hospice fee-for-service claims with dates of death in Calendar Years 2022 and 2023 (corresponding to information used for the Fall 2024 update to the Care Compare site). The performance scores below represent fee-for-service claims data from 1,689,061 hospice patients receiving service from 4,455 hospice entities (with measure denominators of 20+, the steward's minimum standard for public reporting). Performance scores are listed below, calculated at the hospice-level. The nationwide average is 54.3% (standard deviation is 22.1%; interquartile range 40.7% – 58.8%). Scores in the 1st decile averaged 10.0% and in the 10th decile averaged 84.2%.

Table 1. Performance Scores by Decile

Performance Gap

	Overall	Minimum	Decile_1	Decile_2	Decile_3	Decile_4	Decile_5	Decile_6	Decile_7	Decile_8	Decile_9	Decile_10	Maximum
Mean Performance Score	54.3	0.0	10.0	27.6	40.3	48.7	55.7	61.4	66.4	71.2	76.6	84.2	100.0
N of Entities	4,455	39	445	443	441	450	444	444	451	446	444	447	1
N of Persons / Encounters / Episodes	1,689,061	1,605	50,618	109,346	152,697	228,866	206,358	204,647	207,094	192,588	181,702	155,145	84

2.6 Meaningfulness to Target Population

In interviews with former hospice caregivers in September 2024, we asked about the value and importance of a measure to assess hospice visits from registered nurses and social workers in the last three days of the patient's life. Several caregivers reported that this information was "very important" for choosing a hospice because caregivers may not know what to expect at the very end of life and therefore may need support and guidance from hospice staff. One caregiver commented that a low score on the measure would be a red flag that a hospice was not providing high quality care because support in the last few days of life was assumed to be the standard of care.

3.1 Contributions Towards Closing Care Gaps

We calculated measure performance scores across the characteristics of the eligible population listed in section 4.1.4: age, gender, race/ethnicity, diagnosis, and rurality. We did not find any meaningful differences in measure scores with respect to age, gender, or diagnosis. We do note two areas with disparities: non-white beneficiaries less often receive hospice visits in the last days of life (white 60.0% vs. black 52.3%, Asian 45.1%, Hispanic 48.8%). This finding should be further monitored to ensure that beneficiaries receive adequate care at the end of life.

Additionally, there is a slight disparity in rurality: rural patients are more likely to receive visits at the end of life. CMS had received concerns from rural providers who thought they would have unfairly lower measure scores given access issues in rural settings. The evidence seems to suggest the opposite, that hospices serving rural patients do a better job of providing visits at the end of life.

% Meeting Performance Criteria for Hospice Visits in the Last Days of Life

Beneficiary Age

Under 65

58.8%

65-69

59.2%

70-74

59.7%

75-79

59.7%

80-84

59.6%

85-89

59.0%

90-94

58.2%

95+

56.7%

Gender

Male

58.8%

Female

58.9%

Race/Ethnicity

White

60.0%

Black

52.3%

Asian

45.1%

Hispanic

48.8%

Other/Unknown

53.2%

Primary Diagnosis

Dementia/Alzheimer'/Parkinson's

57.6%

Cerebrovascular Accident

57.4%

Cancer

60.0%

Chronic Kidney Disease

59.3%

Heart Disease

59.1%

Lung Disease

57.9%

None of the Above

59.8%

Urban/Rural Location of Service

Urban

57.8%

Rural

63.3%

4.1 Feasibility Assessment

The Hospice Visits in the Last Days of Life (HVLDL) measure is constructed entirely from hospice claims records from the Medicare Hospice Benefit, which are already collected by CMS for payment and quality purposes. Claims data are considered accurate and reliable for measure development, as they are used for payment and subject to audit. Claims data are used to calculate quality measures that are implemented and publicly reported in other CMS quality reporting programs (QRPs), including the post-acute care QRPs. The data needed to calculate this measure are readily available and require no additional data submission beyond what is already collected on claims in the normal course of business. This measure poses no additional data collection burden to hospice providers and no burden to hospice patients or their caregivers.

4.3 Feasibility Informed Final Measure

No adjustments to the measure were necessary, as the HVLDL measure is entirely claims-based. Claims-based data are readily accessible and avoid provider, patient, and caregiver burden, and are therefore an excellent source of information for consumers.

4.4 Proprietary Information

Not a proprietary measure and no proprietary components

5.1.1 Data Used for Testing

The dataset used for testing is nationwide Medicare Part A hospice fee-for-service claims with dates of discharge in Calendar Years (CY) 2022-2023 (January 1, 2022 through December 31, 2023; the data also includes the last couple days of December, 2021 to assess whether visits occurred in the last days of life for deaths on January 1, 2022).

5.1.2 Differences in Data

None.

5.1.3 Characteristics of Measured Entities

Data for these analyses corresponds to 4,455 Medicare-certified hospices providing service during Calendar Years 2022-2023. These hospices were identified using 100% Medicare Part A hospice fee-for-service claims during this period. These providers correspond to the nationwide set of hospices; no sampling was used. Characteristics of these providers are reported in the table below.

During the reporting period, 4,455 hospices met the reporting standards for the CMS public reporting (1,353 additional hospices had eligible denominator stays, but fewer than the 20 total required). The majority of hospices were freestanding (84.1%), for-profit (67.9%), and in urban areas (81.2%). The number of eligible stays per hospice (for those meeting reporting requirements) ranged from 20 to 14,123. The mean hospice size was 379 eligible stays, and the median size was 196 eligible stays.

Hospices (% Hospices*)

Decade of Medicare Certification

1980s

504 (11.3%)

1990s

847 (19.0%)

2000s

1,002 (22.5%)

2010s

1,505 (33.8%)

2020s

535 (12.0%)

Missing

62 (1.4%)

Facility Type

Facility-Based

614 (13.8%)

Freestanding

3,745 (84.1%)

Missing

96 (2.2%)

Profit Status

Government-owned

486 (10.9%)

Non-profit

847 (19.0%)

For-profit

3,026 (67.9%)

Missing

96 (2.2%)

Census Region

Northeast

419 (9.4%)

Midwest

982 (22.0%)

South

1,544 (34.7%)

West

971 (21.8%)

Outlying territories

539 (12.1%)

Urban/Rural

Urban

3,619 (81.2%)

Rural

772 (17.3%)

Missing

64 (1.4%)

* Percentages may not sum to 100 due to rounding.

5.1.4 Characteristics of Units of the Eligible Population

Analyses were based upon those hospice elections ending in the patient's death during the reporting period (calendar years 2022-2023). A total of 1,689,061 elections eligible for the denominator were identified. Because episodes are centered around a patient’s death, a single episode is equivalent to a single beneficiary. Characteristics of those eligible episodes/beneficiaries are reported in the table below (characteristics are missing for 3,331 beneficiaries, or 0.2% of the sample, who are omitted from below). Most beneficiaries were aged 65 and older (96.7%), 57.6% were female, and 86.9% were white. The most common primary diagnoses were cancer (27.6%) and dementia/Alzheimer’s/Parkinson’s (23.8%). Most beneficiaries lived in urban areas (81.6%).

Beneficiaries (% Beneficiaries)

Beneficiary Age

Under 65

55,020 (3.3%)

65-69

106,721 (6.3%)

70-74

167,644 (9.9%)

75-79

230,961 (13.7%)

80-84

289,426 (17.2%)

85-89

323,635 (19.2%)

90-94

300,926 (17.9%)

95+

211,397 (12.5%)

Gender

Male

715,211 (42.4%)

Female

970,519 (57.6%)

Race/Ethnicity

White

1,465,152 (86.9%)

Black

127,532 (7.6%)

Asian

23,195 (1.4%)

Hispanic

27,910 (1.7%)

Other/Unknown

41,941 (2.5%)

Primary Diagnosis

Dementia/Alzheimer's/Parkinson's

400,428 (23.8%)

Cerebrovascular Accident

159,891 (9.5%)

Cancer

465,822 (27.6%)

Chronic Kidney Disease

36,108 (2.1%)

Heart Disease

299,001 (17.7%)

Lung Disease

133,713 (7.9%)

None of the Above

190,767 (11.3%)

Urban/Rural Location of Service

Urban

1,375,926 (81.6%)

Rural

309,804 (18.4%)

* Percentages may not sum to 100 due to rounding.

5.2.1 Level(s) of Reliability Testing Conducted

Accountable entity level (i.e., measure score) (e.g., signal-to-noise analysis)

5.2.2 Method(s) of Reliability Testing

We followed the methodological approach to reliability testing outlined in "The Reliability of Provider Profiling: A Tutorial" (Adams, 2009), which was featured in the National Quality Forum document "What Good Looks Like" for measure submission examples. The approach entails using a hierarchical model to obtain an estimate of provider-to-provider variance, and then applying that estimate along with estimates of individual provider error to the reliability formula.

This approach calculates what's known as the "signal-to-noise ratio" or “reliability score.” As described in the Adams (2009) report: “Conceptually, it is the ratio of signal to noise. The signal in this case is the proportion of variability in measured performance that can be explained by real differences in performance. There are 3 main drivers of reliability; sample size, differences between providers, and measurement error.” In other words, the reliability score indicates the extent to which the measure distinguishes performance of one hospice facility from another. If there is a large amount of between-subject variability (i.e., “signal”) compared to within-subject variability (i.e., “noise”), then there is more evidence that it is possible to discriminate performance among facilities.

Reliability scores vary from 0 to 1, with 0 indicating all variation is attributable to noise/measurement error and 1 indicating that all variation is attributable to real differences in performance across facilities.

Citation: Adams JL. The reliability of provider profiling: a tutorial. Santa Monica, CA: RAND; 2009. http://www.rand.org/pubs/technical_reports/TR653.html.

5.2.3 Reliability Testing Results

Our approach produces facility-level reliability scores for 4,455 facilities meeting CMS reporting thresholds (a denominator of at least 20); we present summary statistics below.

In general, the mean average reliability score was 0.96 and the median score was 0.98. There were 7.8% of hospices with signal-to-noise ratio values below 0.9, and just 14 (0.3%) had a ratio below 0.8.

5.2.4 Interpretation of Reliability Results

Although there is not a definite threshold that is considered reliable, per Adams (2009), values above 0.7 are considered sufficient to confidently detect differences between facilities. The reliability scores calculated here are almost all above 0.9 (and close to 100% are above 0.8), so reliability can be considered very good.

Table 2. Accountable Entity Level Reliability Testing Results by Denominator, Target Population Size

Accountable Entity-Level Reliability Testing Results

	Overall	Minimum	Decile_1	Decile_2	Decile_3	Decile_4	Decile_5	Decile_6	Decile_7	Decile_8	Decile_9	Decile_10	Maximum
Reliability	0.96	1.00	0.97	0.95	0.95	0.96	0.96	0.97	0.97	0.97	0.97	0.98	1.00
Mean Performance Score	54.3	0.0	10.0	27.6	40.3	48.7	55.7	61.4	66.4	71.2	76.6	84.2	100.0
N of Entities	4,455	39	445	443	441	450	444	444	451	446	444	447	1
N of Persons / Encounters / Episodes	1,689,061	1,605	50,618	109,346	152,697	228,866	206,358	204,647	207,094	192,588	181,702	155,145	84

5.3.1 Level(s) of Validity Testing Conducted

Accountable entity level (i.e., measure score) (e.g., criterion validity)

5.3.3 Method(s) of Validity Testing

We calculated (Pearson's) correlation coefficients for the association between hospice-level measure scores and responses from the CAHPS Hospice Survey. Hospice CAHPS outcome scores are an existing endorsed quality measure (CBE ID #2651) and best capture the caregiver's experiences of a patient's care. We are looking for concordance between CAHPS outcomes and Hospice Visits in the Last Days of Life; higher CAHPS scores indicate better quality hospices, so if we find facilities with higher rates of Hospice Visits in the Last Days of Life also have higher CAHPS scores, this finding would validate our process measure capturing an important aspect of care since it produced similar quality rankings of hospices. We would expect the measure to have modest positive correlations with CAHPS Hospice scores, as it captures a related (but different) construct. Note we used Medicare claims data for calculation, audited for payment purposes, and so considered complete.

5.3.4 Validity Testing Results

Correlation estimates are presented below. It should be noted that CAHPS Hospice data were only available for 2,999 providers (due to CAHPS suppression for minimum denominator reporting requirements); for the summary star rating, data was only available for 2,017 providers. Coefficient estimates below were all (positively) statistically significant with p-values <0.001. Note the magnitude of all correlations exceeds coefficients calculated when the measure was originally

endorsed three years earlier.

Correlation Coefficients for CAHPS Quality Measures

Communication with family: 0.3088

Getting timely help: 0.2984

Treating patient with respect: 0.3110

Emotional and spiritual support: 0.3178

Help for pain and symptoms: 0.2318

Training family to care for patient: 0.2151

Rating of this hospice: 0.3242

Willing to recommend this hospice: 0.3175

Summary Star Rating: 0.2911

5.3.5 Interpretation of Validity Results

These findings indicate positive correlation between Hospice Visits in the Last Days of Life and CAHPS Hospice indicators and establish consistent rankings of facilities in terms of CAHPS Hospice scores and measure performance rates. In other words, the hospices which most often provide visits at the end of life by registered nurses and social workers also have the highest ratings of experience as reported by caregivers. These findings validate our process measure, in that they suggest that high-quality hospices are most often performing visits at the end of life.

5.3.2 Type of Accountable Entity Level Validity Testing Conducted (derived)

Empirical validity testing at the accountable entity-level (e.g., criterion validity, construct validity, known groups analysis)

5.4.1 Methods Used to Address Risk Factors

No risk adjustment or stratification

6.1.1 Current Status

In use

6.1.3 Current Use(s)

Public Reporting

6.1.3 Program Details

Name of the program and sponsor
Hospice Quality Reporting Program (HQRP); Centers for Medicaid and Medicaid Services (CMS)

URL of the program
https://www.cms.gov/medicare/quality/hospice
Purpose of the program
The HQRP is intended to support hospice quality improvement activities and help to inform consumer choice of hospice providers.
Geographic area and percentage of accountable entities and patients included
All Medicare-certified hospices in the U.S. are required to submit facility-level quality measure data to CMS.
Applicable level of analysis and care setting

Hospice facility-level

6.2.1 Actions of Measured Entities to Improve Performance

The intent of the measure is that collection of information about hospice staff visits near death will encourage hospices to better monitor patients' status for signs of impending death, and, at the appropriate time, visit patients and caregivers and provide services that will address their care needs. This may lead to improved quality of care for patients and their caregivers during the patients' last days of life. Post-pandemic hospice workforce shortages may pose a challenge to in-person visits at end of life; however, representatives from hospice provider associations noted that hospices are monitoring their HVLDL data on Care Compare and using the information for process improvement to ensure patient and family needs are met. Some hospices are also using predictive analytics to ensure staff availability for providing visits in the last days of life.

6.2.2 Feedback on Measure Performance

CMS held a meeting with hospice provider associations in August 2024 to discuss provider feedback on the HVLDL measure, including usefulness of the measure to improve quality of care, steps hospices can take to improve performance, barriers and facilitators to performance improvement, and potential unintended consequences of measure implementation. Representatives from hospice provider associations noted that hospices are monitoring their HVLDL data on Care Compare and using the information for process improvement to ensure patient and family needs are met. Some hospices are using predictive analytics to ensure staff availability for providing visits in the last days of life. Several attendees noted concerns around visits being limited to a registered nurse or social worker; they suggested expanding the range of clinicians to include other members of the interdisciplinary team who may visit patients and families at end of life, particularly LPNs/LVNs. Another suggestion was to allow hospices to document patient/family preferences for visits at end of life, as visits to the home at end of life are not always congruent with cultural norms, and some families decline these visits. Attendees also noted concerns that the measure does not acknowledge telehealth in addition to in-person visits, as post-pandemic workforce shortages pose a challenge to in-person visits for many hospices, and in some cases families may prefer to receive visits via telehealth.

6.2.3 Consideration of Measure Feedback

Representatives from hospice provider associations suggested inclusion of other disciplines in the measure, particularly LPNs/LVNs, to ensure hospices can provide continuity of care at end of life with the clinicians that know patients and families best. The disciplines included in this measure – registered nurse and medical social worker visits – were selected because empirical testing found these visits had the highest correlation with CAHPS Hospice scores.Notably, in analyses completed during measure testing, LPN visits in the last days of life were negatively correlated with all CAHPS Hospice survey outcomes. These findings are described in the measure testing report (Abt, 2020). However, in the future we will continue to explore inclusion of other disciplines in the measure. In addition, in response to provider feedback that visits to the home at end of life are not always congruent with cultural norms or patient/family preferences, we will explore inclusion of an item in the HOPE assessment to allow hospices to document patient/family preferences for visits at end of life.

Citation: Abt (2020). Hospice Visits When Death is Imminent: Measure Validity Testing Summary and Re-Specifications. Retrieved from: https://www.cms.gov/files/document/hqrphospice-visits-when-death-immine…

6.2.4 Progress on Improvement

The measure was first publicly reported in 2022, based on eight quarters of data from April-December 2019 and July 2020 – September 2021 (note at the time CMS was not publicly reporting data from the first two quarters of 2020 due to the Public Health Emergency); measure performance was 50.5%. As noted in Section 2.4 (Performance Gap), current performance (based on Calendar Years 2022-2023) is 54.3% – about a four percentage point increase in two years. We will continue to monitor whether these improvement trends continue.

6.2.5 Unexpected Findings

Feedback on measure implementation was positive overall; hospice provider associations noted that hospices are using HVLDL performance data for process improvement to ensure patient and family needs are met in the last days of life. Representatives from provider associations also noted that the goal of this measure should be to ensure that hospices meet the individualized needs of patients and families, so a potential unintended consequence is that hospices may make visits at end of life to ensure they meet expectations for the measure, rather than developing a plan of care purely focused on patient/family wishes. In addition, hospice care teams often include other interdisciplinary team members who know the patient and family best, so hospices may be forced to choose between meeting the measure criteria and ensuring the best quality and continuity of care in the last days of life. We have taken this feedback into consideration and will continue to explore inclusion of other disciplines in the measure. We will also explore inclusion of an item in the HOPE assessment to allow hospices to document patient/family preferences for visits at end of life.

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