CAHPS® Hospice Survey Results for Quality Improvement

The First Six Months of Data Collection

December 2015
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BACKGROUND

The Affordable Care Act of 2010 authorized the creation of the Hospice Quality Reporting Program (HQR) and enabled jurisdiction over the program to the Centers for Medicare and Medicaid Services (CMS). The primary mission of the HQR is to promote the delivery of high quality hospice services through the required reporting of quality measures.

In January 2015, CMS began the national implementation of the CAHPS® Hospice Survey. The survey is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) utilizing a standardized set of 47 questions designed to measure and assess the experiences of hospice patients and caregivers. CMS has previously implemented CAHPS surveys in ambulatory and inpatient settings.

To ensure that administration protocols are followed and survey data are properly collected, hospices are required to contract with a CMS-approved third party vendor to administer, capture, and report results from the survey.

The CAHPS® Hospice Survey will be used to calculate 11 Hospice Quality Measures:

**Composite Measures**
- Hospice Team Communication (Questions 6, 8, 9, 14, 35)
- Getting Timely Care (Questions 5, 7)
- Treating Family Member with Respect (Questions 11, 12)
- Providing Emotional support (Questions 37, 38)
- Getting Help for Symptoms (Questions 16, 22, 25, 27)
- Getting Hospice Care Training (Questions 19, 20, 23, 29)

**Single Item Measures**
- Support for Religious and Spiritual Beliefs (Question 28)
- Information Continuity (Question 10)
- Understanding Side Effects of Pain Medications (Question 18)

**Global Measures**
- Overall Rating of Hospice (Question 39)
- Recommend Hospice (Question 40)

While CMS has not provided specific information on how the CAHPS® Hospice Survey results will be shared, they have stated that the data will be publicly reported in the future.
PURPOSE OF THIS REPORT

In this report, we present an initial look at the first six months of the CAHPS® Hospice Survey results along with suggestions for how hospices can integrate results from the CAHPS® Hospice Survey questions into their quality improvement programs. Quarter 1 of 2015 was a Dry Run, or practice period. Although hospices were required to provide decedent/caregiver data for at least one of the three months, most participated for the entire three months. Quarter 2 began the official data collection period as required by CMS. Although only results provided by CMS are considered official results, CMS has indicated that hospices can use the results provided by CMS-approved survey vendors for quality improvement purposes.

CMS has indicated that they will not release benchmarks until at least four quarters of data can be analyzed and therefore benchmarks will not be available until Q3 2016 at the very earliest. Since the Dry Run period – the first three months of survey administration – is considered a practice period, Q1 2015 data will never be included in the CMS analysis. Moreover, with the availability of benchmark data still over a year away, setting internal performance goals may be challenging. For this reason, Deyta Analytics, a division of HEALTHCAREfirst, is making interim results available now for use in quality improvement programs. Results from the CAHPS® Hospice Survey can be integrated into quality improvement efforts to improve processes and ultimately the quality of care provided to both patients and caregivers.

Deyta Analytics Hospice CAHPS Dataset

Data included in this report are from surveys administered for all Deyta Analytics clients who provided survey administration data files for patient deaths between January 1 and June 30, 2015. Survey administration began in April 2015 for January deaths and data collection continued through mid-October when the data collection period for June 2015 deaths came to a close (42-days after each survey for June deaths was administered). Surveys were administered for decedent/caregiver records that met all of the following CMS eligibility criteria:

- Decedent was at least 18 years old at the time of death.
- Decedent’s death was at least 48 hours following the last admission to hospice.
- Decedent had a caregiver of record.
- Decedent’s caregiver of record was a family or friend and not a non-familial legal guardian.
- Decedent’s caregiver has a US or US Territory home address.

This report includes results from more than 67,000 completed surveys administered over the two quarters. In order to be identified as a completed survey, it must meet the following CMS criteria:

- The decedent/caregiver must meet the survey-eligibility criteria.
- The survey must be returned within the 42-day data collection period.
- The survey must include answers to at least 50% of the questions that are applicable to all survey respondents. (Questions 1-4, 6-13, 15, 17, 21, 24, 26, 28, 30-32 and 35-47)
INTERIM DATA FOR QUALITY IMPROVEMENT

Analyze Individual Survey Questions Within the Hospice Quality Measures

Six of the Hospice Quality Measures are based on results from multiple survey questions. By comparing the results for the individual survey questions within each composite measure, hospices can prioritize specific areas on which to focus.

**Target Lowest Scores**

Using benchmark data, hospices may identify specific questions that have a positive or negative influence on the composite measure. If a hospice chooses to target the question with the lowest score for improvement opportunities and is successful, the overall composite measure score will also improve assuming the other individual scores remain the same or improve as well.

For example, as shown in Figure 1 below, within the Getting Help with Symptoms measure, we notice a 21 percentage point difference between Question 16 and Question 27. Since Question 16 (Patient received help with pain), Question 22 (Patient received help for trouble breathing) and Question 25 (Patient received help with constipation) all show higher scores, focusing on improving the care provided to manage a patient’s anxiety or sadness (Question 27) may be the most optimal area to focus on to increase the overall composite measure score.

**Figure 1: Getting Help with Symptoms Measure**

A similar range is apparent between questions within the Hospice Team Communications measure (Figure 2), with a 16 percentage point difference between Question 6 (Hospice team kept you informed about when they would arrive) and Question 35 (Hospice team listened carefully to you). Therefore, if a hospice wanted to improve this composite measure’s score, they may choose to focus on reviewing and revising their protocols around communicating and updating timeframes for staff visits with caregivers, which again may lead to higher scores for Question 6 and ultimately for the Hospice Team Communications measure.
Focus on Low Hanging Fruit

On the other hand, as the benchmark data demonstrates in Figure 3 below, if there is not a difference between individual question scores as seen in the Getting Timely Care measure, hospices may find one of the questions easier to address than the other. For instance, both Question 5 (Received help during evenings, weekends and holidays) and Question 7 (Received help as soon as wanted) address the responsiveness of the hospice to the patient/caregiver’s needs. However, since Question 5 is focused on responsiveness during a specific timeframe (evenings, weekends and holidays), it may be easier to identify a smaller set of variables that would have a direct impact on Question 5 than on Question 7 which looks at overall responsiveness to patient/caregiver needs.
Similarly, as shown in Figure 4, both questions within the Providing Emotional Support measure have comparable scores and both address the emotional support provided to the caregiver. However, Question 37 (Amount of emotional support for caregiver) focuses on support provided during the patient’s hospice stay while Question 38 (Amount of emotional support in weeks after death) specifically addresses support provided in the weeks after the patient’s death. Since Question 38 refers to a specific care period (after death), hospices may find addressing this question by analyzing internal protocols around the timing and type of support offered to caregivers after the death of their loved one as a more attainable goal than considering all encompassing processes to ensure caregivers receive the emotional support needed.

Figure 4: Providing Emotional Support Measure

Consider the Caregiver’s Perception of the Question Wording

As demonstrated with the data presented in Figure 5 for the Treating Family Member with Respect measure, both Question 11 (Patient treated with dignity and respect) and Question 12 (Hospice team really cared about the patient) focus on respect for and caring about the patient, and both have relatively high performance scores. However, the 8.6 percentage point spread between the two questions indicates a potential difference in how the wording of the questions is interpreted by the caregiver. The lower score for Question 12 may highlight that caregivers perceive caring and respect quite differently. This may suggest that hospices need to explore different methods to cultivate a true sense of caring between the team and the patient. Applying different methods to help the caregiver feel that the team genuinely cares about the patient may be difficult, but will result in a more positive experience for both the patient and caregiver and increased satisfaction scores.
Identify the Need for Training

The Getting Hospice Care Training measure incorporates four questions that measure the caregiver’s perception of symptom management training around side effects of pain medications (Question 19), when or if to give more pain medications (Question 20), problems with breathing (Question 23) and what to do if the patient becomes restless or agitated (Question 29). The 16 percentage point difference between Questions 19 and 20 shown in Figure 6 appears to indicate that caregivers know when and if to give more pain medications, however they may perceive that they were not counseled on what side effects might arise as a result of their actions. Thus, if hospices work on relating the action of providing more pain medication with the potential side effect rather than just information or education about side effects, it may result in caregivers understanding more about the side effects of pain medications which could improve their scores on Question 19.

While it is common for hospice patients to present with certain symptoms more or less frequently depending on their diagnosis, Question 29, which has the lowest score in this measure, looks at the training around restlessness and agitation, symptoms that are less common with some diagnoses. The 18 percentage point difference between Questions 20 and 29 may indicate a need for hospices to focus on the patient groups that most frequently present with restlessness and agitation. This ensures that caregiver training around the management of these symptoms becomes a more routine part of the visit.
Importance of Trending Data

It is important to not only look at overall performance scores, but to also trend results to understand if scores are increasing, decreasing or remaining steady over time. As graphed in Figure 7 below, the three Single Item Measures (Support for Religious and Spiritual Beliefs, Information Continuity and Understanding Side Effects of Pain Medications) highlight two important factors to consider when analyzing CAHPS® Hospice Survey results:

Include Only Consistent Data from Dry Run

Performance for all three measures remains fairly consistent over time, even though the first three months display data from the Q1 Dry Run, or practice period. While CMS will not include this data in their analysis of CAHPS® Hospice Survey results, hospices that can incorporate Q1 data into analysis of their CAHPS® Hospice Survey results will be able to take advantage of having access to a full calendar year trend for 2015. On the other hand, if the Dry Run results look very different than the results from the beginning of the official data collection, ignore them. Any number of factors could have impacted the results during this practice period and their inclusion may skew the findings which is problematic.

Identify Question-Specific Performance Targets

With unofficial benchmarks like those we present in this report, hospices can utilize comparative data to establish internal performance targets. However, when establishing performance targets, it is important to analyze each survey question separately and establish goals relative to both the current scores and the reasonableness of attainment.

Figure 7: Single Item Measures
For example, establishing a performance target of 85% for the Information Continuity measure (Question 10) may be an attainable goal since we see that currently the benchmark for this measure is approximately 86%. However, using the same performance target of 85% across all three measures would result in a target that may always be surpassed for the Support for Religious and Spiritual Beliefs measure (Question 36) and one that may never be achieved for the Understanding Side Effects of Pain Medications measure (Question 18).

Closed vs. Open Data Periods

Understandably, many hospices look for survey results as soon as possible. However, while hospices may have great visibility into surveys as they are returned and data reviewed through “real time” reporting during open data periods, it is important to understand the potential variability in scores that are based on scores that are available during open data collection periods. As newly received surveys are added into the existing batch of surveys, aggregate scores may very well fluctuate until the close of the data collection window when no new surveys are introduced into the results. We call this the closed data period.

Figure 8 displays both closed results (solid line) and open results (dotted line) for June surveys. The closed results reflect scores from all surveys received throughout the 42-day data collection period. The open results below are based on surveys received within the first four weeks of the data collection period. Both of the Global Measures - Overall Rating of Hospice (Question 39) and Recommend Hospice (Question 40) - display an increase for June results, highlighting the importance of understanding whether the reporting period is open or closed at the time of analysis. Analyzing open or partial results may lead to incorrect assumptions about performance. For example, while we could speculate that satisfied caregivers tend to respond sooner than others, we recognize that many other factors could contribute to the higher performance scores seen during the open period.

Figure 8: Global Measures
CONCLUSION

This report demonstrates the importance of using interim results now in quality programs rather than waiting until the official results are released by CMS, which is expected to be sometime in late 2016. By using CAHPS® Hospice Survey results strategically, hospices can establish targets for their 2016 quality improvement programs. In this report, we suggest several ways to utilize the data from both the composite and single item quality measures. However, it is important to note the measures that we specifically chose to use in our examples above could be used interchangeably within multiple sections in the report.

Using the Deyta Analytics Hospice CAHPS dataset, we present numerous examples of how hospices can use both benchmark data and their own results to begin the process of identifying specific areas to focus on, with the overarching goal of improving performance scores for both the individual, and when applicable, composite measures. Moreover, we tried to present clear examples of how hospices can address their goals. Our examples are drawn from our work with individual hospice agencies and the lessons that they have shared with us. It is important to recognize that not all suggestions provided are appropriate for all hospices and are just meant to demonstrate the process that a hospice may go through as they begin to review and use their CAHPS® Hospice Survey data.

We made several explicit suggestions in this report and alluded to others. Below we summarize the key recommendations:

- Analyze individual survey questions within the composite measures.
- Focus on areas with the biggest opportunity for improvement.
- Think strategically by selecting areas that may be easier to improve than others.
- Understand the factors that may impact the caregiver’s perception of the care provided.
- Establish question-specific performance targets.
- Review trends over time.
- Incorporate Q1 data for quality improvement efforts only if the data are consistent with Q2 findings.
- Understand the benefits and limitations of viewing real-time results.
- Use closed data periods when analyzing results to identify improvement opportunities.

While it is still unclear when or how CMS will disclose the results of the CAHPS® Hospice Survey, we do know that ultimately the results will be shared publicly as they are with other settings of care. Moreover, it has been suggested that hospice will be moving to a value-based purchasing payment program at some point in the future. Hospice agencies do not have time to wait to begin their improvement processes related to the CAHPS questions. Changes in processes and performance during patient care can take months, if not years, to be realized in improved scores. Therefore, the sooner that hospices begin to utilize their satisfaction data, the sooner they will see improved performance scores. Or more importantly, the sooner patients and caregivers will report the highest degree of satisfaction with the finest quality of hospice care.
WHY DEYTA ANALYTICS?

Deyta Analytics makes CMS compliance with Hospice CAHPS simple. We manage the entire survey process so that your team can focus on using the results to improve patient care. Deyta will collect, analyze, and report Hospice CAHPS data as required per CMS regulations. Our program also provides an entire suite of comprehensive reports that allow you to drill down into the results and analyze performance from many perspectives to drive meaningful improvement.

• Standard survey administration includes a valuable supplemental question set to provide additional data for enhanced performance improvement.
• Fully transcribed comments and verbatim comment reporting groups caregiver comments by category to provide the greatest insights into what your caregivers are truly saying.
• Comment Alert! system that quickly notifies your agency by email of any negative or serious comments so that you can quickly take action and prompt service recovery.
• Database built for meaningful benchmarking with state, national, and peer group level benchmarks, as well as the Deyta Leaders benchmark inclusive of those agencies who are raising the bar on performance by outperforming the national benchmark.
• A comprehensive suite of reports including quality dashboards and patient-level drilldown helps you quickly pinpoint opportunities for improvement.
• Month-of-service reporting matches the timeframe that CMS will be using to evaluate performance and easily ties results back to operations, offering greater insights into what is driving your performance.
• Real-time access to survey results as they are processed. Results are delivered in a dynamic reporting platform for quick tracking and trending, and can also be exported into Excel for limitless reporting and data analysis.
• Integration with Deyta Analytics’ Quality Actionboards for detailed performance analysis on the HIS quality measures.

ABOUT HEALTHCAREfirst

HEALTHCAREfirst provides cloud-based technologies and services to improve business and clinical operations for over four thousand home health and hospice providers across the United States. Based in Springfield, MO and one of the fastest growing providers of its kind, the company provides agency and clinical management software, cloud-based “Deyta” analytics and program management solutions, and outsourced revenue cycle management services (billing, coding, and chart audits), in any combination.

HEALTHCAREfirst’s breadth of solutions offer agencies a single source to improve patient care, create operational efficiencies, increase profitability, and simplify CMS compliance. With HEALTHCAREfirst, agencies can focus on patients instead of paperwork.

For more information call 888.893.1937 or visit the company’s websites at www.healthcarefirst.com and www.deyta.com.
CAHPS® Hospice Survey Hospice Quality Measures

GLOBAL MEASURES

Overall Rating of Hospice
39. Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care?

Recommend Hospice
40. Would you recommend this hospice to your friends and family?

SINGLE ITEM MEASURES

Providing Support for Religious and Spiritual Beliefs
36. Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs. While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?

Information Continuity
10. While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member's condition or care?

Understanding Side Effects of Pain Medication
18. Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with you or your family member?

COMPOSITE MEASURES

Hospice Team Communications
6. While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family?
8. While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?
9. While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?
14. How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?
35. While your family member was in hospice care, how often did the hospice team listen carefully to you?

Getting Timely Care
5. How often did you get the help you needed from the hospice team during evenings, weekends or holidays?
7. While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?

Treating Family Member with Respect
11. While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?
12. While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member?

Providing Emotional Support
37. While your family member was in hospice care, how much emotional support did you get from the hospice team?
38. In the weeks after your family member died, how much emotional support did you get from the hospice team?

Getting Help for Symptoms
16. Did your family member get as much help with pain as he or she needed?
22. How often did your family member get the help he or she needed for trouble breathing?
25. How often did your family member get the help he or she needed for trouble with constipation?
27. How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness?

Getting Hospice Care Training
19. Did the hospice team give you the training you needed about what side effects to watch for from pain medicine?
20. Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member?
23. Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing?
29. Did the hospice team give you the training you needed about what to do if your family member became restless or agitated?
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