Quality, Innovation, and Intensive Caring at End of Life

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May 21, 2026

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Executive Summary

Adoration Hospice delivers high-quality, person-centered hospice care within the broader BrightSpring Health Services platform. The model combines local interdisciplinary hospice teams, enterprise quality infrastructure, and integrated hospice pharmacy support through OnePoint Patient Care. The result is a practical operating system for comfort, dignity, family support, and responsible stewardship in the final chapter of life.

The outcomes show a clear story of reliability. In Q1 2026, Adoration Hospice achieved 95.1% hospice visits near death against an 89.3% benchmark and 72.1% visits in the last three days of life against a 48.3% national average. Total visits per patient per month were 17.2 compared with a 15.6 benchmark, and skilled nursing visits reached 8.5 per patient compared with a 7.8 national benchmark. These are not abstract process results. They are the measurable expression of a clinical promise: to be present, responsive, and prepared when patients and families need hospice most.[1]

95.1%	72.1%	17.2	87%
Hospice visits near death vs. 89.3% benchmark	**Visits in last 3 days** vs. 48.3% national	**Total visits** patient / month	**CAHPS overall** vs. 81% national benchmark

Quality performance extends beyond visit frequency. Adoration Hospice reported an 87% CAHPS overall rating versus an 81% national benchmark, a 73% SHP 4+ Stars predictor with a 10.7-point year-over-year improvement, an average star rating of 3.63 versus a 3.60 national average, 98.0% timely pain symptom follow-up visits, and 99.4% timely HUVs. These results are supported by physician engagement, standardized best-practice workflows, in-house hospice-dedicated triage, workforce flexibility, and a compliance-centered operating model that reinforces appropriate, well-documented, patient-centered care.[1,2]

Several operational differentiators strengthen this reliability. A highly engaged physician model aligns hospice medical directors through selective recruitment, structured onboarding, ongoing education, data transparency, and direct national medical director support. Adoration's after-hours triage is staffed by internal hospice-dedicated nurses rather than outsourced general call-center coverage, and its Internal Travel Nurse team provides fully onboarded hospice clinicians who can be deployed to under-resourced or high-demand markets while preserving clinical standards, documentation expectations, and organizational culture.[1]

A defining differentiator is hospice pharmacy integration with OnePoint Patient Care and the MyMetRx medication optimization program. In partnership with OnePoint, Adoration has advanced clinician education, formulary-driven prescribing, structured deprescribing, interdisciplinary review, and ongoing performance monitoring. Current MyMetRx performance of 7.0-7.4 medications per patient reflects disciplined, evidence-based prescribing that aligns medication regimens with patient-centered goals of care. Together, Journey's Ease and MyMetRx connect symptom treatment, medication access, formulary discipline, deprescribing, and quality oversight into one hospice medication operating model.[1,2,3,4]

This white paper explains how Adoration Hospice turns quality and innovation into compassionate practice. It places Adoration results in the context of CMS and MedPAC evidence, describes the clinical value of timely hospice, and shows how the model supports patients, families, referral partners, payers, and policymakers. Above all, it demonstrates how Adoration Hospice "lavishes the care" through intensive caring at the end of life - combining clinical discipline with presence, kindness, and a readiness to act.

INTRODUCTION: A Hospice Model Built Around Presence, Quality, and Integrated Care

Hospice is both a clinical service and a promise. Patients and families choose hospice because they need comfort, clarity, and confidence during a period when needs can change from hour to hour. The clinical work is complex: symptoms must be assessed, medications must be available, caregivers need practical teaching, family preferences should be honored, and emotional and spiritual needs require steady attention.

Adoration Hospice describes its service as care for patients with terminal illnesses and their families, offering options and opportunities to make important care decisions, retain control in difficult times, and receive expert medical care, pain management, symptom alleviation, support programs, counseling, and bereavement support. Its interdisciplinary hospice team includes physicians, a hospice medical director, nurses, social workers, home health aides, chaplains, counselors, and volunteers from the patient's community. A care team representative is available 24/7, including holidays, with readiness to dispatch nurses whenever urgent needs arise.[5]

BrightSpring Health Services adds scale, systems, and enterprise-level quality infrastructure. BrightSpring's broader platform spans home and community services, pharmacy services, and care for complex populations, with a stated commitment to measuring and improving key clinical quality indicators across lines of business.[6]

The challenge in end-of-life care

End-of-life care has a high emotional and clinical burden. A patient may have pain, dyspnea, agitation, delirium, nausea, secretions, anxiety, functional decline, wounds, or caregiver distress. Families often need help interpreting changes that are expected in the dying process while also knowing which symptoms require immediate clinical action. Because the hospice benefit is centered around an interdisciplinary plan of care, the quality question is not simply whether services are available. The question is whether the right services are reliably delivered at the right time.

The end-of-life period also has public-policy importance. Medicare hospice is a large, growing, and closely measured benefit. MedPAC reported that in 2024 more than 1.8 million Medicare beneficiaries received hospice services and Medicare hospice spending totaled about $28.3 billion. The share of Medicare decedents using hospice reached 52.9% in 2024, and the median lifetime length of stay among hospice decedents was 19 days.[7]

The Adoration Hospice response

Adoration Hospice responds with a model built on four linked disciplines: presence, symptom management, family experience, and accountability. Presence is measured through visits near death and visits in the last three days. Symptom management is reinforced through Journey's Ease Clinical Pathways, Journey's End, HOPE readiness, and integrated hospice pharmacy. Family experience is measured through CAHPS and supported through 24/7 in-house hospice triage. Accountability is strengthened through physician engagement, standardized best practices, compliance governance, star-rating progress, branch-level dashboards, and ongoing quality oversight.

This operating model is designed for real-world hospice care: local teams supported by enterprise infrastructure; compassionate clinicians supported by data; and patient-family goals supported by the pharmacy, medication review, and formulary capabilities needed to make comfort care reliable.

I. Industry, MedPAC, and CMS Evidence for the Hospice Model

The hospice model matters because it aligns clinical care, family goals, and public stewardship. At its best, hospice keeps patients in their preferred setting, anticipates needs, relieves suffering, supports caregivers, and avoids crisis-driven transitions that may be unwanted, burdensome, and costly.

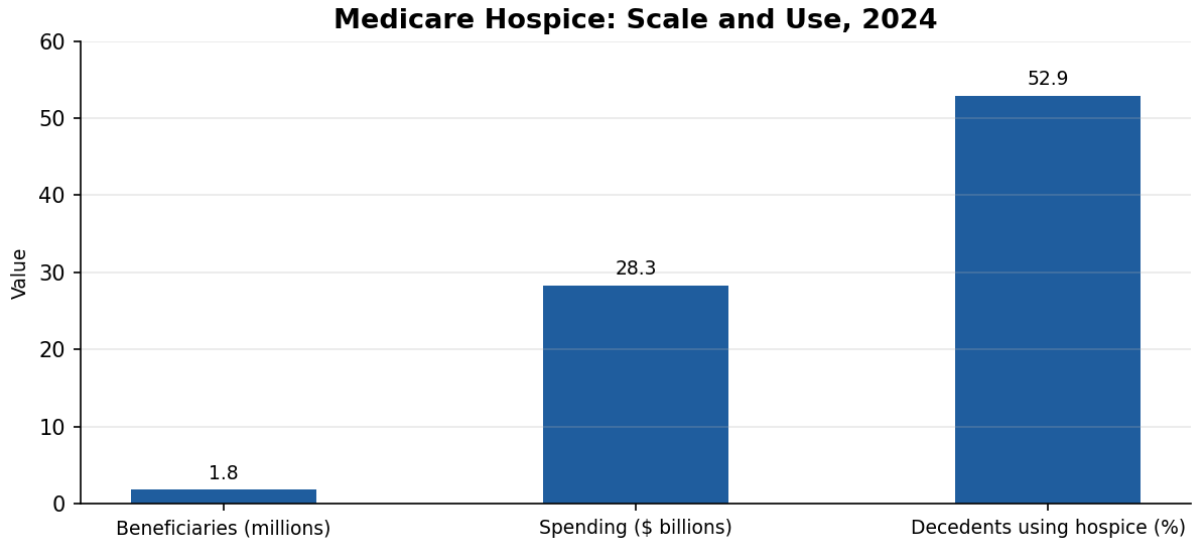

Figure 1. MedPAC 2026 reported 1.82 million Medicare hospice users, $28.3 billion in Medicare hospice spending, and hospice use by 52.9% of Medicare decedents in 2024.

A. Medicare hospice at national scale

MedPAC's 2026 hospice chapter shows the scale and policy relevance of hospice. Hospice use among decedents reached a new high in 2024, with 52.9% of Medicare decedents using hospice. The number of Medicare hospice users increased to 1.82 million, and hospice days furnished rose to about 148 million. MedPAC also notes that hospice care is most commonly provided in patients' homes, although it may be provided in nursing facilities, assisted living facilities, hospice facilities, and other inpatient settings.[7]

The same national data underscore the importance of timely, appropriate hospice election. MedPAC reported a median hospice length of stay of 19 days in 2024. That means many patients and families still experience hospice for a short window, making visit reliability, medication readiness, and caregiver teaching especially important in the final days.[7]

B. What the hospice benefit is designed to deliver

CMS describes the Medicare hospice benefit as a benefit for patients certified as terminally ill with a medical prognosis of six months or less if the illness runs its normal course, after the patient elects hospice. The benefit is organized around an individualized written plan of care established by the interdisciplinary group together with the attending physician, patient or representative, and primary caregiver.[8]

CMS lists a broad set of services included in the benefit: hospice physician and nurse practitioner services, nursing care, medical equipment and supplies, drugs to manage pain and symptoms, hospice aide and homemaker services, therapy services, medical social services, dietary counseling, spiritual counseling, grief and loss counseling before and after death, and short-term inpatient pain control, symptom management, and respite care.[8]

Why this matters

Hospice is not a single discipline. The benefit is designed as whole-person, interdisciplinary care. High-quality hospice therefore requires coordination across nursing, medical direction, aides, social work, spiritual care, bereavement support, and pharmacy.

C. Clinical quality, symptom management, and family experience

CMS Hospice Quality Reporting Program measures reflect the same clinical priorities. CMS uses HOPE assessment data, Medicare claims, and the CAHPS Hospice Survey to calculate quality measures. CMS describes the Hospice Visits in the Last Days of Life measure as the proportion of hospice patients who received in-person visits from a registered nurse or medical social worker on at least two of the final three days of life. CMS also describes the Hospice Care Index as a 10-indicator claims-based measure that includes gaps in skilled nursing visits, burdensome transitions, per-beneficiary Medicare spending, skilled nursing minutes, and visits near death.[9]

CMS also uses the CAHPS Hospice Survey to capture family experience. The survey is a national survey of family members or friends who cared for a patient who died while under hospice care. Publicly reported measures include communication with family, getting timely help, treating the patient with respect, emotional and spiritual support, help for pain and symptoms, care preferences, training family to care for the patient, rating of the hospice, and willingness to recommend.[10]

The broader palliative-care evidence base reinforces these priorities. A JAMA systematic review and meta-analysis found that palliative care was associated with improvements in quality of life and symptom burden, although caregiver outcomes were mixed and the evidence varied by study. This supports the central clinical logic of hospice: earlier identification of goals, proactive symptom management, and interdisciplinary support can improve the experience of serious illness.[11]

D. Cost stewardship and the value of timely hospice

High-quality hospice also has a cost-stewardship role. NORC at the University of Chicago estimated that, in the last year of life, total Medicare costs for beneficiaries who used hospice were 3.1% lower than adjusted spending for beneficiaries who did not use hospice, translating to an estimated $3.5 billion less in Medicare outlays. NORC also reported that spending was consistently lower for beneficiaries with hospice lengths of stay of 15 days or more and that savings began after day 10 before death. These findings should be interpreted as claims-based estimates, but they align with the operational logic of hospice: timely comfort-focused care can replace crisis-driven, high-intensity utilization that may not match patient and family goals.[12]

For referral partners and payers, the implication is clear. Hospice creates value when it is high-quality, appropriately timed, and reliable at the bedside. The strongest hospice models combine clinical presence, symptom management, family experience, documentation discipline, and medication stewardship.

II. Adoration Hospice Quality and Outcomes

Adoration Hospice quality performance is strongest when viewed across multiple dimensions: end-of-life presence, symptom monitoring, patient and family experience, star-rating progress, HOPE readiness, pharmacy integration, physician engagement, standardized clinical practice, in-house hospice-dedicated triage, workforce resilience, and compliance discipline. Each metric tells one part of the quality story; together they show an operating model built for intensive caring.

A. Standardizing best practices in a variable clinical environment

Practice variability is common in clinical practice, including hospice. Some variation is appropriate because each patient's goals, disease trajectory, family system, and setting are different. Unwarranted variation is different: it can lead to inconsistent symptom assessment, uneven medication use, avoidable caregiver distress, and variable documentation. Adoration Hospice addresses this by standardizing best practices while preserving patient-specific, goal-concordant clinical judgment.

The standardization model is interdisciplinary. Physician medical directors, nurses, aides, social workers, chaplains, pharmacy partners, support teams, and compliance personnel each play a role in translating best practice into daily care. The goal is not rigid care. The goal is reliable care: a consistent clinical foundation, local team accountability, and enough flexibility to honor what matters most to the patient and family.

Standardization is operationalized through practical tools, not abstract policy alone. Journey's Ease gives clinicians a consistent approach to symptom assessment and intervention; Journey's End creates a structured response when the final-days trajectory is identified; the Rehospitalization Reduction Program uses risk stratification and proactive interventions; in-house triage reinforces expectations after hours; and dashboards help leaders identify variation that requires coaching or support.[1]

B. Physician engagement and medical director culture

Research on physician engagement in quality and safety emphasizes that physicians are central to consistent, high-quality care because they influence clinical decision-making and can help make quality and safety work operational rather than abstract. Best-practice frameworks emphasize engaged leadership, physician alignment, clinical data, feedback loops, and organizational support.[13]

Adoration operationalizes this through a highly engaged physician model built on deliberate alignment, leadership, data transparency, and strong operational support. A highly involved national medical director has cultivated a medical director culture that treats hospice physicians as active clinical leaders: engaged in eligibility thinking, plan-of-care oversight, symptom management, documentation integrity, compliance awareness, interdisciplinary education, and rapid problem-solving.[1]

That engagement starts with selective recruitment, structured onboarding, and ongoing physician-focused education. Physicians are aligned to shared standards of evidence-based hospice care and are supported through collaborative physician networks, active voice in clinical and operational decisions, and direct access to national medical director support. Frequent, transparent performance feedback enables continuous improvement and peer alignment across markets.[1]

Physicians are also equipped with structured guidance on hospice eligibility and targeted best practices for formulary management, prescribing, and deprescribing. In daily practice, this supports consistent symptom treatment, appropriate level-of-care decisions, clearer medical rationale for hospice, more reliable documentation, and stronger regulatory compliance. For referral partners and value-based organizations, the result is a physician model that makes care more clinically rigorous, operationally consistent, and easier to trust.[1,13]

C. Q1 2026 outcome highlights

The following outcomes reflect enterprise quality data for Adoration Hospice and related BrightSpring hospice operations, with Q1 2026 results unless otherwise noted.[1,2]

Domain	Metric	Adoration result	Benchmark / comparator	Why it matters
End-of-life presence	Hospice visits near death	**95.1%**	89.3% benchmark	Care team presence during the final week.
End-of-life presence	Visits in the last three days of life	**72.1%**	48.3% national average	RN / social work visits during the highest-need window.
Visit intensity	Total visits per patient per month	**17.2**	15.6 benchmark	Sustained monitoring and support.
Visit intensity	Skilled nursing visits per patient	**8.5**	7.8 national benchmark	Clinical assessment and symptom-management capacity.
Experience	CAHPS overall rating	**87%**	81% national benchmark	Family-reported experience.
Experience	Live discharges	**19.9%**	18.5% benchmark	Quality surveillance signal for continuity and appropriateness.
Stars	4+ Stars SHP predictor	**73%**	90% internal target	Progress toward enterprise Q4 2026 goals.
Stars	SHP 4+ Stars predictor YoY improvement	**+10.7 pts**	Year-over-year improvement	Evidence of rapid branch-level progress.
Stars	Average star rating	**3.63**	3.60 national average	Care Compare performance context.
Stars	Providers with 4+ Stars	**57.6%**	CMS Care Compare tracking	External public quality signal.
HOPE	Timely pain SFVs	**98.0%**	HOPE readiness	Symptom follow-up after pain assessment.
HOPE	Timely HUVs	**99.4%**	HOPE readiness	Timely follow-up visit performance.

D. End-of-life visit reliability: lavishing the care

Adoration Hospice's end-of-life presence metrics tell the clearest story of intensive caring. Visits near death reached 95.1% against an 89.3% benchmark. Visits in the last three days of life reached 72.1% against a national average of 48.3%. In practical terms, this means Adoration Hospice is substantially more likely than the national average to be physically present during the days when symptoms, caregiver concerns, and family needs are often most intense.[1]

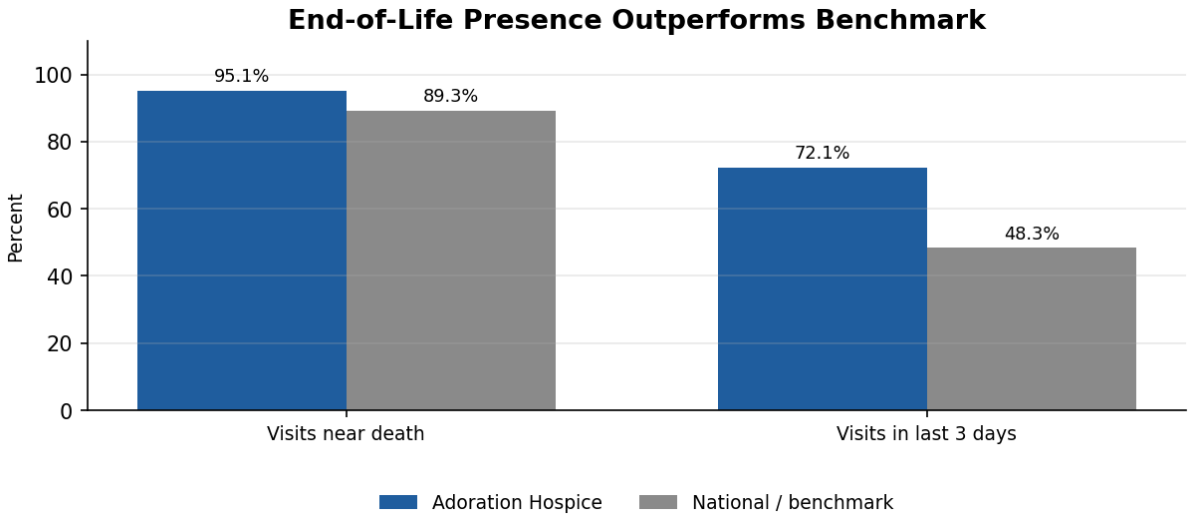

Figure 2. Adoration Hospice outperforms the benchmark on visits near death and the national average on visits in the last three days of life.

CMS treats visits in the last days of life as a claims-based quality measure because the final days are a high-need clinical period. The measure focuses on in-person visits from registered nurses or medical social workers on at least two of the final three days of life. Adoration's 72.1% performance therefore directly supports a CMS-recognized dimension of hospice quality.[1,9]

The organization also sustains broad visit volume, with 17.2 total visits per patient per month. That visit intensity supports symptom monitoring, medication assessment, caregiver teaching, psychosocial support, and timely escalation when a patient's condition changes.

Journey's End operationalizes this final-days focus. A weighted End-of-Life Risk Assessment embedded in the electronic medical record alerts clinicians when a patient demonstrates indicators consistent with the last seven days of life, including physiologic decline, neurologic changes, behavioral shifts, and key end-stage symptoms. Once triggered, teams adjust the plan of care with increased visit frequency, enhanced family communication, caregiver education, and holistic interventions tailored to physical, emotional, and spiritual needs.[1]

E. Experience, stars, HOPE, and live-discharge surveillance

Patient and family experience is one of the most important expressions of hospice quality. Adoration Hospice's CAHPS overall rating of 87% exceeds the 81% national benchmark. The result aligns with the Adoration care model, which emphasizes 24/7 accessibility, interdisciplinary support, and individualized plans of care.[1,5,10]

Star-rating progress is also meaningful. The SHP 4+ Stars predictor reached 73%, a 10.7-point year-over-year improvement. Average star rating reached 3.63 compared with a 3.60 national average, and providers with 4+ Stars reached 57.6% based on CMS Care Compare tracking. These measures provide an external quality lens and a practical roadmap for branch-level improvement.[1]

HOPE readiness metrics show strong performance on symptom follow-up. Timely pain symptom follow-up visits reached 98.0%, and timely HUVs reached 99.4%. These results matter because CMS quality measurement increasingly emphasizes structured, patient-centered assessment and follow-up around symptoms, care preferences, and family needs.[1,9]

Live-discharge performance is monitored as a quality surveillance signal. Adoration reported a 19.9% live-discharge rate compared with an 18.5% benchmark. The appropriate goal is not simply to minimize or

maximize live discharges, but to monitor patterns, understand drivers, and ensure that discharge decisions reflect patient status, eligibility, goals of care, and continuity of support.

F. Preventing Fraud and Abuse

Preventing fraud and abuse is a quality function. Strong quality begets compliance: when hospice eligibility is clinically clear, the interdisciplinary plan of care is current, physician engagement is strong, symptoms are managed through standardized pathways, and documentation accurately reflects patient need, the organization is less likely to drift into practices that create patient, payer, or referral-partner risk.

Adoration Hospice's compliance program is designed as an industry-leading quality partner in a highly regulated benefit. Compliance personnel, clinical leaders, medical directors, and operational teams work together so that quality improvement, documentation discipline, billing integrity, training, and regulatory expectations are aligned. This is not a back-office activity; it is part of how safe, appropriate, and accountable hospice care is delivered.

This discipline is especially important for ACOs, narrow networks, and other value-based partners, which are accountable for attributed-member outcomes, utilization, total cost of care, and organizational risk. A hospice partner with strong quality and compliance discipline helps mitigate risk by supporting appropriate hospice election, goal-concordant care, avoidable-utilization reduction, and defensible operations.

III. Intensive Caring at the End of Life

The phrase "lavish the care" captures a hospice truth: at the end of life, presence is not wasteful; it is therapeutic. Intensive caring means the team anticipates needs, returns when symptoms change, teaches families what to expect, and stays close enough to prevent fear from becoming crisis.

A. Presence as a clinical intervention

A hospice visit near death is more than a visit count. It is a chance to assess pain, dyspnea, agitation, anxiety, secretions, bowel function, skin integrity, caregiver coping, spiritual distress, and environmental safety. It is also a chance to affirm the care plan and make sure medications, equipment, and supplies are available.

The final three days of life are often when families most need reassurance. Normal changes in breathing, intake, alertness, restlessness, and circulation can be frightening without skilled explanation. When a nurse or social worker is present, the family receives both clinical assessment and human grounding. This is why the Adoration visits-in-the-last-three-days result is a powerful indicator of intensive caring.

- Proactive bedside assessment of pain, dyspnea, agitation, anxiety, secretions, constipation, and nausea.
- Medication review and confirmation that comfort medications are available and understood.
- Caregiver teaching about expected changes and when to call the hospice team.
- Coordination of aide, social work, chaplain, volunteer, and bereavement support as family needs evolve.
- Rapid escalation for uncontrolled symptoms, including clinical direction and pharmacy coordination.

B. Triage, caregiver support, and after-hours responsiveness

Hospice quality is tested after hours. Adoration states that a care team representative is available 24/7, including holidays, to support patients and families and respond promptly in emergencies. That promise is operationally important because symptom crises and caregiver concerns rarely follow business hours.[5]

After-hours triage must combine empathy with clinical precision: coaching and medication guidance, urgent visit dispatch, or higher level-of-care escalation. Integrated pharmacy support helps ensure regimens, refills, and delivery logistics are aligned with clinical need.

Adoration’s after-hours triage is performed by dedicated internal hospice nurses rather than outsourced call centers or generic cross-service-line coverage. These clinicians focus exclusively on hospice and use hospice-specific triage protocols to provide evidence-based guidance, real-time decision-making, and timely escalation under experienced registered-nurse oversight.[1]

Across a broad 24/7 multi-state footprint, this specialization supports accurate recognition of active dying, unmanaged symptoms, medication needs, caregiver anxiety, equipment or supply problems, and triggers for urgent visits or higher levels of care. It also creates a seamless feedback loop to the daytime interdisciplinary team and reinforces standardized expectations across markets.[1]

C. The human return on investment

The human return on hospice quality is measured in relief, confidence, and the absence of avoidable distress. A family that understands what is happening is less likely to feel abandoned. A caregiver who can reach a nurse at night is less likely to call 911 out of fear. A patient whose medication regimen has been reviewed is more likely to receive symptom relief without unnecessary medication burden.

Adoration’s quality outcomes show the relationship between data and humanity. High visit frequency, strong CAHPS performance, timely HOPE follow-up, and integrated medication support are not separate initiatives. They are different views of the same care philosophy: be present, manage symptoms, honor goals, support the family, and make the final days as peaceful as possible.

IV. Integrated Hospice Pharmacy: OnePoint Patient Care

Medication therapy is central to hospice because symptoms can change quickly and distress can escalate rapidly. Pain, dyspnea, agitation, anxiety, nausea, constipation, secretions, and delirium often require evidence-based medication protocols, careful monitoring, and real-time communication between the hospice team, prescribers, pharmacists, patients, and caregivers.

OnePoint Patient Care is a hospice-dedicated pharmacy and PBM platform that supports the full hospice pharmacy experience from dispense to delivery. Its platform includes local dispensing and delivery, PBM capabilities, integrated technology, and clinical resources designed for hospice operations.[3]

A. Evidence-based symptom medication support

The purpose of hospice medication management is not to increase medication volume. The purpose is to match each medication to a comfort-focused clinical goal: relieve pain, ease breathing, reduce agitation, treat anxiety, prevent opioid-related constipation, manage nausea, reduce secretions, and discontinue medications that no longer support the patient's prognosis, preferences, or goals of care.

OnePoint's clinical resources support this approach through CoP-compliant medication reviews, customized formularies, drug-use evaluations, cost-saving alternatives, and MyMetRx analytics. Specially trained pharmacists review medication regimens for clinical appropriateness using hospice-specific factors and advise on appropriate coverage and cost-avoidance strategies.[4]

Medication stewardship principle

The right hospice medication strategy is evidence-based, patient-specific, and goal-concordant: the right medication, at the right dose, at the right time, for the right symptom, with the lowest unnecessary medication burden.

B. Journey's Ease: Clinical Pathways for Symptom Management

Adoration Hospice has rolled out Journey's Ease, a comprehensive symptom-management program built on 11 proprietary, evidence-based clinical pathways designed to bring consistency, clarity, and confidence to every patient encounter. The pathways address anxiety, constipation, delirium, diarrhea, nausea, vomiting, neuropathic pain, pain, restlessness and agitation, shortness of breath, and terminal secretions while preserving clinician judgment for patient-specific circumstances.[1]

Each Journey's Ease pathway outlines a practical care sequence: focused assessment, immediate non-pharmacologic comfort measures, critical-thinking prompts to identify root causes, evidence-aligned medication options, physician-communication scripts, reassessment timing, caregiver teaching, documentation, and plan-of-care updates. The reassessment component is especially important. Hospice quality is not simply whether an intervention was ordered; it is whether the team returned to the symptom, assessed the effect, adjusted the plan when needed, and communicated clearly with caregivers.[1]

- Focused assessment and standardized symptom documentation across branches.
- Immediate non-pharmacologic comfort measures and evidence-aligned medication options.
- Critical-thinking prompts, physician-communication support, and clear reassessment timing.
- Integration with OnePoint Patient Care so medication access, formulary choices, and pharmacist support reinforce the pathway.

C. MyMetRx, formulary discipline, and medication stewardship

BrightSpring's MyMetRx program, developed in partnership with OnePoint Patient Care, advances medication optimization through clinician education, formulary-driven prescribing, structured deprescribing, interdisciplinary review, and ongoing performance monitoring. The program targets ineffective or non-

beneficial therapies, reinforces formulary alignment, and reduces unwarranted prescribing variation across the organization.[2,4]

Implementation has produced best-in-class medication utilization of approximately 7.0-7.4 medications per patient. By August 2025, Rx per patient reached the national goal of 7.0, formulary compliance reached 93% toward a 95% goal, and medication cost-per-patient-day savings reached $0.92 per patient day. In published hospice and palliative/end-of-life literature, medication counts frequently reach double digits; one end-of-life cohort reported an average of 11.5 medications, and a scoping review found average prescribed medications ranging from 3 to 23 per patient across studies.[2,14,15]

Clinically, lower medication burden matters. Polypharmacy is associated with greater symptom burden, lower quality of life, adverse drug events, drug interactions, caregiver workload, and medication-related costs. MyMetRx keeps each medication tied to a comfort-focused goal as the patient's condition evolves, reflecting lower polypharmacy burden, evidence-based prescribing consistency, and strong alignment with patient-centered goals of care.[16]

The program is grounded in the palliative-care principle that the expected time-to-benefit of a medication should be weighed against prognosis and goals of care. A pragmatic randomized trial of statin discontinuation in advanced life-limiting illness found no significant difference in mortality and suggested improved quality of life, fewer medications, and lower medication costs when preventive statins were stopped thoughtfully.[17]

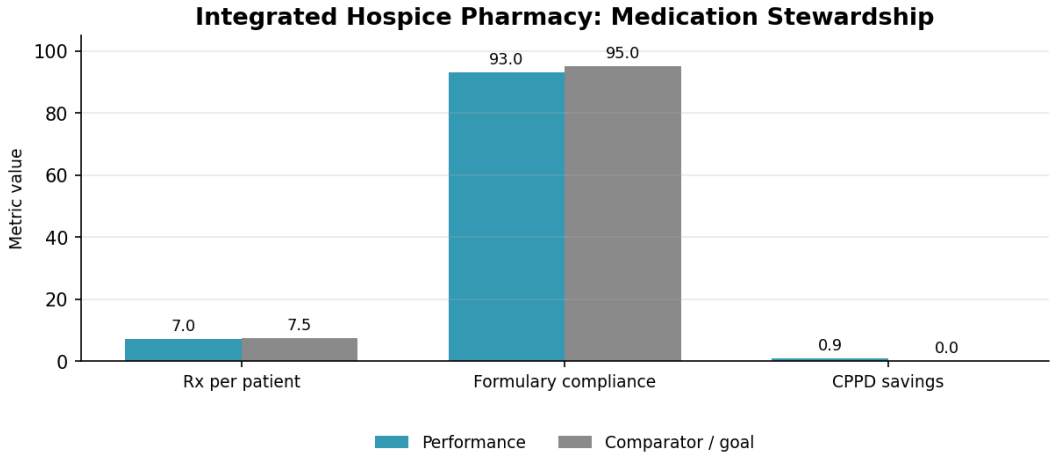

Figure 3. Hospice pharmacy integration supports medication stewardship through Rx-per-patient discipline, formulary use, and cost-per-patient-day savings.

Together, these results show how clinical quality and cost stewardship can reinforce each other. Appropriate prescribing can reduce unnecessary medication burden, simplify caregiver administration, decrease medication-related risk, and focus resources on therapies that relieve symptoms. Formulary discipline can also reduce practice variation and support timely access to core comfort medications.

D. Coordinating pharmacy, clinicians, patients, and caregivers

Integrated hospice pharmacy creates value at the operational level. When clinicians, prescribers, and pharmacists work from aligned medication information, the team can reduce delays, clarify coverage, address refills, identify cost-saving alternatives, and help caregivers understand how and when medications should be used. OnePoint's technology and clinical resources are designed to streamline medication ordering and management, improve patient care, and boost nurse satisfaction.[3]

For patients and families, the value is practical: fewer confusing medication changes, better confidence that comfort medications are available, and more support when symptoms change. For referral partners and

payers, the value is a hospice model that links symptom relief, medication safety, formulary management, and cost stewardship in one operating system.

Key performance indicator: Medication optimization in hospice

BrightSpring MyMetRx: 7.0-7.4 medications per patient.[2]

Published comparator: roughly 10-16+ medications per patient across hospice and palliative/end-of-life medication profiles.[14,15]

What this reflects: lower polypharmacy burden; evidence-based prescribing consistency; and strong alignment with patient-centered goals of care.

V. Hospice Programs and Specialty Models

Adoration Hospice's quality model is also expressed through focused programs that translate enterprise standards into specialized workflows for patients with complex symptom, transition, caregiver, veteran, emotional, spiritual, and disease-specific needs. Some programs are deployed across the division; others are strong agency-level programs that can be spread as best practices across markets.

A. Palliative care program

The palliative care program supports seriously ill patients with symptom burden, complex goals-of-care needs, or high utilization risk before hospice election is appropriate. It creates an earlier layer of support focused on symptom relief, advance care planning, and alignment between treatment intensity and what matters most to the patient.

For referral partners, palliative care can function as a bridge between disease-directed treatment and hospice, supporting earlier conversations and smoother transitions when goals and eligibility align.

B. Journey's End

Journey's End is designed around the highest-need window of hospice care: the final days of life. Powered by a weighted End-of-Life Risk Assessment embedded directly into the electronic medical record, clinicians are alerted when a patient exhibits evidence-based indicators consistent with the last seven days of life, including physiologic decline, neurologic changes, behavioral shifts, and key end-stage symptoms.[1]

Once Journey's End is triggered, the care team is prompted to adjust the plan of care with increased visit frequency across nursing, social work, chaplain, and aide disciplines; enhanced family communication and caregiver education; and holistic interventions tailored to physical, emotional, and spiritual needs. The program helps families prepare for changes in breathing, intake, alertness, restlessness, and circulation; confirm comfort medications and equipment; and know how to reach hospice support at any hour.[1]

C. Rehospitalization Reduction Program

The Rehospitalization Reduction Program focuses on patients at elevated risk for avoidable emergency department visits or hospital transfers. Integrated into the RN admission process, a weighted assessment identifies clinical, emotional, and behavioral factors that increase the likelihood of a return to the hospital setting. Patients are risk-stratified so the right interventions can be activated early.[1]

For medium- and high-risk patients, the program activates an immediate stabilization protocol that can include increased interdisciplinary touchpoints, added after-hours support, comprehensive patient and family education, medication-access planning, and escalation planning. This program is valuable for hospitals, post-acute partners, ACOs, and narrow networks because it supports smoother transitions, goal-concordant care, reduced avoidable readmissions, and total-cost-of-care stewardship while still escalating appropriately when a higher level of care is needed.[1]

D. Dementia Care Program

The dementia program recognizes that patients with advanced cognitive impairment often express symptoms through behavior, functional decline, aspiration risk, weight loss, sleep disruption, agitation, or caregiver exhaustion rather than conventional verbal reporting. The program helps teams assess comfort, teach caregivers, anticipate decline, and align care with the patient's values and stage of illness.

Key elements include caregiver education, safety planning, feeding and swallowing support, management of agitation or distress, medication review, and goals-of-care communication around burdensome interventions.

For families, this support can reduce fear and isolation; for partners, it supports a more reliable approach to a complex hospice population.

E. We Honor Veterans and Moments of Music

Across selected agencies, Adoration also supports programs that address identity, meaning, recognition, and comfort beyond conventional clinical tasks. We Honor Veterans supports veteran-centered recognition, awareness of military experiences that may shape end-of-life needs, and coordination of respectful rituals or resources when appropriate.[1]

Moments of Music uses music as a non-pharmacologic comfort intervention and a human connection tool. For some patients, familiar music can reduce anxiety, support reminiscence, facilitate family connection, and bring comfort when verbal communication becomes limited. These programs reinforce the larger hospice promise: care should address the whole person, not only the diagnosis.[1]

VI. Quality Infrastructure, Documentation Discipline, and Continuous Improvement

Adoration Hospice quality outcomes are supported by BrightSpring's broader Quality First framework and hospice-specific operating infrastructure. The framework emphasizes technology, training, signature programs, data analysis, compliance, culture, accreditation, and workforce stability. In hospice, those disciplines translate into visit reliability, patient and family experience, symptom follow-up, medication management, physician engagement, documentation clarity, staffing resilience, and accountable operations.

A. Quality First translated to hospice

BrightSpring's Quality First foundation has historically been built around people, training, monitoring, signature programs, accreditation, advocacy, and technologies to support quality, compliance, and safety. The enterprise has made significant investments in quality and compliance infrastructure, including a dedicated team of quality and compliance professionals and required annual safety, quality, and compliance training. In hospice, this foundation supports consistent branch-level attention to the outcomes that matter most to patients and families.[18]

This foundation has produced sustained hospice quality over time. BrightSpring hospice services have been recognized in the top 5% of providers by Homecare Homebase. Historical hospice results also exceeded national averages, including 69.9% hospice visits in the last days of life versus 62.1%, 98.3% comprehensive assessment at admission versus 97.5%, and a Hospice Care Index of 8.9 out of 10 versus a 7.8 national benchmark. The Q1 2026 Adoration results show that this quality focus has continued and strengthened.[18]

B. Data, dashboards, and branch-level action

High-quality hospice requires fast feedback. Enterprise dashboards convert operational and clinical data into action: visits near death, visits in the last three days, visit volume, CAHPS, live discharges, star predictors, HOPE readiness, pharmacy metrics, compliance indicators, and program performance. Leaders can identify variation, support branches, and replicate best practices from high-performing teams.

- Measurement: standard definitions for end-of-life visits, experience, star ratings, HOPE readiness, pharmacy metrics, compliance indicators, and program outcomes.
- Transparency: branch, region, and enterprise visibility into performance trends.
- Action: targeted coaching, clinician education, pharmacy outreach, and workflow support when variation appears.
- Learning: high-performing branches share playbooks with peers to spread effective practices quickly.

Documentation discipline is part of quality infrastructure because hospice care must be clinically clear, patient-specific, and externally supportable. Clear documentation helps the interdisciplinary team communicate, supports appropriate eligibility and plan-of-care decisions, reinforces compliance, and gives referral partners confidence that hospice care is clinically grounded and responsibly managed.

C. Internal Travel Nurse team and workforce consistency

The Internal Travel Nurse team is a strategic asset for consistent hospice quality across markets. Unlike traditional agency nurses, these clinicians are fully onboarded Adoration employees who receive comprehensive training in hospice philosophy, clinical competencies, documentation standards, and organizational policies. That preparation allows them to align quickly with the care model and regulatory expectations when deployed.[1]

The model provides rapid staffing flexibility in under-resourced or high-demand areas while preserving continuity of care and reducing onboarding risk. Because Internal Travel Nurses are embedded in the organization's culture and interdisciplinary expectations, they can collaborate seamlessly with local teams, reinforce standardized care delivery, and uphold consistent documentation and quality practices.[1]

Many Internal Travel Nurses also serve as experienced preceptors and mentors, supporting the training and orientation of new hires. In that role, they strengthen workforce stability, spread best practices, and help make quality portable across the hospice continuum.[1]

D. Accreditations, training, and external accountability

BrightSpring's broader platform holds numerous accreditations across pharmacy and healthcare services, including relationships with organizations such as CHAP, CARF, NABP, URAC, and others. Accreditation is important because it subjects operations to independent standards and reinforces a culture of readiness, quality, and safety.[18]

Training reinforces the same quality system. Hospice University, role-specific orientation, annual training requirements, preceptor programs, professional continuing education, leadership training, and trend-based education create a workforce prepared for both clinical skill and compassionate communication. In hospice, this combination is essential because technical proficiency and empathy are inseparable.

VII. People, Culture, and Community Impact

Hospice is ultimately delivered person to person. The best systems matter because they help clinicians, aides, social workers, chaplains, volunteers, pharmacists, and leaders deliver care with consistency and heart. Adoration's quality story therefore includes both measurable outcomes and the culture that makes those outcomes possible.

A. LEGACY values and Hospice University

BrightSpring's LEGACY values - Leadership, Environment, Get Going, Attitude, Communication, and You - provide a shared culture across service lines. In hospice, those values become practical behaviors: lead with service, create a people-focused environment, act with urgency, approach difficult moments with compassion, communicate clearly, and take personal responsibility for the experience of each patient and family.

Hospice University and related training programs reinforce the clinical and human competencies required for end-of-life care. Team members need symptom-assessment skills, documentation skill, medication knowledge, caregiver teaching, grief communication, and the ability to remain calm and present in emotionally intense situations. A strong hospice workforce is trained not only to complete tasks but to bring steadiness into the home.

B. Foundation support, scholarships, and community engagement

BrightSpring's hospice culture extends beyond reimbursed clinical services. The BrightSpring Hospice Foundation supports hospice patients and families with non-healthcare-related needs beyond the limitations of hospice services. In 2022, the Foundation awarded $102,107 to nearly 150 hospice patients in need, supporting items such as comfort care and personal items, final arrangements, home care and sitting support, and other expenses beyond the scope of hospice coverage.[18]

The BrightSpring Hospice Nursing Scholarship supports nursing students enrolled in accredited RN or BSN programs who choose hospice as their practice area after graduation. The scholarship awards four $5,000 scholarships each year and is renewable for up to two years, reinforcing a pipeline of clinicians committed to end-of-life care.[18]

VIII. Strategic Lessons for Payers, Referral Partners, and Policymakers

Adoration Hospice's outcomes and operating model offer practical lessons for stakeholders who need high-quality, reliable, and accountable hospice partners.

- For referral partners: hospice quality should be evaluated by presence, responsiveness, symptom management, medication access, family experience, physician engagement, in-house triage, workforce reliability, and compliance accountability - not by census or geography alone.
- For payers and ACO narrow networks: high-quality hospice can support goal-concordant care and reduce avoidable crisis utilization, especially when patients are referred early enough to benefit from interdisciplinary support. Strong compliance discipline also mitigates attributed-member and organizational risk.
- For policymakers: CMS and MedPAC measures are most useful when they encourage meaningful care at the bedside, including visits in the last days, symptom follow-up, skilled nursing support, family training, and transparency around spending and transitions.
- For health systems: integrated pharmacy, in-house hospice-trained triage, Journey's Ease symptom pathways, Journey's End final-days protocols, and rehospitalization risk stratification are strategic assets because medication delays, regimen complexity, unmanaged symptoms, after-hours uncertainty, and avoidable hospital returns are common pathways to distress and unwanted utilization.
- For hospice organizations: quality improvement must be local enough to change branch behavior and enterprise-supported enough to sustain improvement at scale, with physicians, nurses, pharmacy, support teams, Internal Travel Nurses, triage nurses, and compliance personnel aligned around common standards.

The core lesson is that hospice quality is multidimensional. A single star rating or claims measure cannot fully describe care. But when strong CAHPS performance, visits near death, visits in the last three days, HOPE readiness, pharmacy stewardship, Journey's Ease, Journey's End, physician engagement, in-house triage, workforce resilience, and compliance discipline point in the same direction, they provide persuasive evidence of a high-functioning hospice model.

IX. Future Roadmap and Conclusion

The next phase of Adoration Hospice quality improvement should build on the same foundation: deepen end-of-life presence, continue star-rating progress, expand HOPE readiness, strengthen in-house after-hours triage, further integrate OnePoint Patient Care, spread Journey's Ease and Journey's End, continue cultivating physician engagement, support workforce consistency through the Internal Travel Nurse team, and use data to identify patients and branches that need additional support.

Key priorities include:

- Advance HOPE implementation as a clinical quality tool, not merely a reporting requirement.
- Scale Journey's Ease Clinical Pathways for Symptom Management and monitor whether reassessment confirms treatment effectiveness.
- Continue strengthening medical director engagement as a driver of standardization, symptom management, eligibility clarity, and compliance culture.
- Expand specialty programs, including palliative care, Journey's End, rehospitalization reduction, dementia-focused care, We Honor Veterans, and Moments of Music where appropriate.
- Continue improving the SHP 4+ Stars predictor toward the 90% internal enterprise goal.
- Sustain visits-near-death and visits-in-last-three-days performance as visible indicators of intensive caring.
- Use MyMetRx and pharmacist medication reviews to support symptom control, formulary discipline, evidence-based deprescribing, lower polypharmacy burden, appropriate prescribing, and cost stewardship.
- Strengthen in-house hospice-dedicated after-hours triage and caregiver teaching so families receive timely help when fear and symptoms peak.
- Replicate best practices from high-performing branches through peer learning, Internal Travel Nurse mentoring, and rapid-cycle improvement.

Adoration Hospice's quality story is ultimately a story of presence. It is the nurse who arrives when breathing changes. It is the social worker who supports a frightened caregiver. It is the pharmacist who helps ensure the right comfort medication is available. It is the aide, chaplain, volunteer, physician, and bereavement team who help the family feel less alone. The data matter because they show that this care is reliable, measurable, and improving.

Hospice quality and innovation are not separate ideas. Innovation gives the team better tools, better data, and better medication support. Quality ensures those tools translate into the patient's home. Compassion gives the work its purpose. For Adoration Hospice, the future of hospice care is not only to manage the end of life well. It is to lavish the care, intensively and reliably, so that patients and families experience comfort, dignity, and support when they need it most.

Appendix A - Methods and Data Sources

This white paper integrates Adoration Hospice and BrightSpring Health Services enterprise quality data with external CMS, MedPAC, and peer-reviewed evidence. Enterprise outcomes are presented as Q1 2026 results unless otherwise noted. Medication stewardship data reflect OnePoint Patient Care/MyMetRx operational data from 2025. Enterprise quality, program, compliance, and community-impact information is included to show the operating model behind the outcomes.

Metrics and definitions:

- Visits in the last three days of life: aligned with the CMS HVLDL concept of in-person registered nurse or social worker visits on at least two of the final three days of life.
- Visits near death: an HCI-related quality signal focused on presence near the end of life.
- CAHPS overall rating: patient/family experience performance based on hospice CAHPS methodology and enterprise reporting.
- SHP star predictor and average star rating: star-rating progress indicators used for branch-level performance tracking and improvement.
- HOPE timely pain SFVs and HUVs: readiness indicators for structured hospice assessment and follow-up workflows.
- Journey's Ease Clinical Pathways for Symptom Management: standardized, evidence-based pathways addressing 11 common hospice symptom domains with assessment, comfort measures, root-cause prompts, medication options, physician communication, caregiver teaching, documentation, and reassessment expectations.
- Specialty hospice programs: palliative care, Journey's Ease, Journey's End, rehospitalization reduction, dementia-focused care, We Honor Veterans, and Moments of Music workflows used to support specific serious-illness, transition, identity, comfort, and end-of-life needs.
- Compliance and documentation discipline: governance, training, documentation clarity, and quality oversight used to support appropriate eligibility, care planning, billing integrity, and accountable operations.
- In-house hospice triage: dedicated internal hospice nurses who provide 24/7 hospice-specific guidance, escalation, and coordination across the patient-family journey.
- Internal Travel Nurse team: fully onboarded hospice nurses deployed to under-resourced or high-demand markets to support staffing flexibility, standardized care, documentation reliability, and new-hire mentorship.
- MyMetRx pharmacy metrics: medications per patient, Rx per patient, formulary compliance, deprescribing opportunities, and medication cost-per-patient-day savings used to monitor appropriate prescribing, formulary discipline, patient-centered medication optimization, and medication stewardship.

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