

Hospice Workforce:  
An Annotated Review of the Literature

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November 2013

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## METHODS

The search for literature was limited to peer reviewed journal articles between the years 2005 and 2013. Older articles were reviewed if they had been referenced in several other current resources. All reference lists were reviewed and abstracts of cited sources were assessed for inclusion. This process was followed until saturation was reached. Table 1 and Table 2 identify the search engines and key words employed for this review.

Table 1. Search Engines and Websites Employed for Review

<b>Search Engines/Websites</b>		
AAMC Center for Workforce Studies	EBSCOHost	PsychINFO
Academic Search Premier	Google Scholar	PubMed
CDC	HFA	RAC
CINAHL	NAHC	ScienceDirect
CMS	NHPCO	

Table 2. Keywords Employed in Search for Current Hospice Workforce Literature

<b>Keywords</b>		
Hospice workforce	Labor supply	Staff levels
Hospice work force	Staff hospice	Staffing levels hospice
Labor demand	Staffing hospice	
Hospice labor	Shift hospice	
Hospice labor supply	Shift patterns	

## ANNOTATED REVIEW OF HOSPICE WORKFORCE

## Most Frequently Cited Article on Hospice Workforce Issues

**Lupu D. (2010). Estimate of current hospice and palliative medicine physician workforce shortage. *Journal of Pain and Symptom Management*, 40(6), 899. doi:10.1016/j.jpainsymman.2010.07.004**

**Context**

In the context of the establishment of a new medical specialty, rapid growth in hospices and palliative care programs, and many anecdotal reports about long delays in filling open positions for hospice and palliative medicine (HPM) physicians, the American Academy of Hospice and Palliative Medicine (AAHPM) appointed a Workforce Task Force in 2008 to assess whether a physician shortage existed and to develop an estimate of the optimal number of HPM physicians needed.

**Objectives**

Develop estimates of the current supply and current need for HPM physicians. Determine whether a shortage exists and estimate size of shortage in full-time equivalents (FTEs) and individual physicians needed.

**Methods**

The Task Force projected national demand for physicians in hospice and in hospital-based palliative care by modeling hypothetical national demand on the observed pattern of physician use at selected exemplar institutions. The model was based on assumptions that all hospices and hospitals would provide an appropriate medical staffing level, which may not currently be the case.

**Results**

Approximately 4400 physicians are currently HPM physicians, as defined by board certification or membership in the AAHPM. Most practice HPM part time, leading to an estimated physician workforce level from 1700 FTEs to 3300 FTEs. An estimated 4487 hospice and 10,810 palliative care physician FTEs are needed to staff the current number of hospice- and hospital-based palliative care programs at appropriate levels. The estimated gap between the current supply and the hypothetical demand to reach mature physician staffing levels is thus 2787 FTEs to 7510 FTEs, which is equivalent to 6000-18,000 individual physicians, depending on what proportion of time each physician devotes to HPM practice.

**Conclusion**

An acute shortage of HPM physicians exists. The current capacity of fellowship programs is insufficient to fill the shortage. Changes in graduate medical education funding and structures are needed to foster the capacity to train sufficient numbers of HPM physicians.

## Articles by Date of Publication

**Lynch, S. (2013). Hospice and palliative care access issues in rural areas. *American Journal of Hospice & Palliative Medicine*, 30(2), 172. doi:10.1177/1049909112444592**

All individuals deserve to have access to quality end-of-life care. In rural communities within the United States, significant barriers limit access to hospice and palliative care. They include issues related to geography and supply, health care system eligibility criteria, limitations of the available workforce, educational deficits, and differences in cultural values. This article examines the barriers and potential solutions to address the gaps in hospice and palliative care services in rural communities. Strategies are proposed to strengthen hospice and palliative care delivery models to enhance earlier referrals and provide better facilitation and transition to hospice and palliative care. Future research should look at patient utilization questions specific to rural communities.

**Medicare Payment Advisory Commission (MedPAC). (2013). *Report to Congress: Medicare Payment Policy, (Chapter five: Medicare hospice policy issues)*. Washington, D.C.: MedPAC. 117-142.**

The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

There is no mention of general hospice workforce; however, there is mention of duplicative services or reduced workload among nursing home residents accessing hospice services. “Because the nursing facility and the hospice both have responsibility for aspects of the patient’s care, the overlap can result in reduced workload for both entities.”

“One factor that may contribute to the more favorable margins observed among hospices with more patients in nursing facilities stems from the treatment of patients in a centralized location. A centralized location may afford a hospice the opportunity to reduce staff time required for travel between patients as well as mileage costs.”

“The provision of hospice aide visits in nursing facilities raises issues of duplicate payment. One role of nursing facilities is to assist patients with their personal care needs (e.g., activities of daily living). The nursing home room and board fees paid largely from Medicaid funds or by patients and families explicitly cover aide services provided by nursing facility staff to assist residents with their personal care needs. In the absence of hospice, aide services are fully provided by facility staff. One question that could be explored is: Should the Medicare hospice benefit include aide services for patients residing in nursing facilities? Currently, aide visits by hospice staff account for one-third of the average labor cost of hospice visits in nursing facilities.”

**National Hospice and Palliative Care Organization (NHPCO). (2013). *NHPCO Facts and Figures: Hospice Care in America*. (2013 ed.).**

*NHPCO Facts and Figures: Hospice Care in America* provides an annual overview of important trends in the growth, delivery and quality of hospice care across the country. The following data (pulled from the report) was provided through the National Data Set (NDS). The NDS includes program, patient, process, and financial statistics and is considered a comprehensive compilation of hospice trends in the U.S. NDS data is voluntarily self-reported by active hospice providers and includes hospice organizations that are not members of the NHPCO. Although the NHPCO’s data are derived from a convenience sample, the estimates have been found reliable and accurate.

Hospice staff time centers on direct care for the patient and family: 70.4% of home hospice full-time equivalent employees (FTEs) were designated for direct patient care or bereavement support in 2012.

The number of patients that a clinical staff member is typically responsible for varies by discipline. In 2012, the average patient caseload for a hospice aide was 11.01 patients, 11.31 patients for a nurse case manager, and 26.51 patients for a social worker.

Hospice is unique in that it is the only provider whose Medicare Conditions of Participation requires volunteers to provide at least 5% of total patient care hours. NHPCO estimates that in 2012, 400,000 hospice volunteers provided 19 million hours of service. Hospice volunteers provide service in three general areas:

- Spending time with patients and families (“direct support”)
- Providing clerical and other services that support patient care and clinical services (“clinical support”)
- Helping with fundraising efforts and/or the board of directors (“general support”).

In 2012, most volunteers were assisting with direct support (60.8%), 18.6% provided clinical care support and 20.7% provided general support. In 2012, 5.4% of all clinical staff hours were provided by volunteers. The typical hospice volunteer devoted 44.4 hours of service over the course of the year and patient care volunteers made an average of 21 visits to hospice patients.

**Center for Workforce Studies. (2012). Recent studies and reports on physician shortages in the US. *Association of American Medical Colleges.***

Over the past several years, a growing number of national, state and specialty specific studies have concluded that the US physician workforce is facing current or future shortages. This report presents a summary of these recent studies. The report is divided into three sections: 1) a summary of 33 state reports on physician shortages; 2) a summary of 22 specialty shortage reports; and 3) a summary of 6 national studies on the physician workforce. No mention of hospice care or specialties.

**National Hospice and Palliative Care Organization (NHPCO). (2012). *NHPCO Facts and Figures: Hospice Care in America.* (2012 ed.).**

*NHPCO Facts and Figures: Hospice Care in America* provides an annual overview of important trends in the growth, delivery and quality of hospice care across the country. The following data (pulled from the report) was provided through the National Data Set (NDS). The NDS includes program, patient, process, and financial statistics and is considered a comprehensive compilation of hospice trends in the U.S. NDS data is voluntarily self-reported by active hospice providers and includes hospice organizations that are not members of the NHPCO. Although the NHPCO's data are derived from a convenience sample, the estimates have been found reliable and accurate.

Hospice staff time centers on direct care for the patient and family: 70.7% of home hospice full-time equivalent employees (FTEs) were designated for direct patient care or bereavement support in 2011.

Nursing staff continues to comprise the largest percentage of FTEs by discipline, while bereavement staff represent the smallest.

The number of patients that a clinical staff member is typically responsible for varies by discipline. In 2011, the average patient caseload for a home health aide was 10.6 patients, 11.0 patients for a nurse case manager, and 24.9 patients for a social worker.

The U.S. hospice movement was founded by volunteers and there is continued commitment to volunteer service. NHPCO estimates that in 2011, 450,000 hospice volunteers provided 21 million hours of service. In 2011, most volunteers were assisting with direct support (60.0%), 19.0% provided clinical care support and 21.0% provided general support. In 2011, 4.8% of all clinical staff hours were provided by volunteers. The typical hospice volunteer devoted 44.4 hours of service over the course of the year and patient care volunteers made an average of 20 visits to hospice patients.

**Casarett, D. (2011). One big happy family? interdisciplinary variation in job satisfaction among hospice providers. *Journal of Palliative Medicine*, 14(8), 913. doi:10.1089/jpm.2011.0057**

### **Background**

Job satisfaction is particularly important in the hospice industry, given the emotional and interpersonal challenges that hospice staff face in providing care to patients near the end of life and their families. However, little is known about the job satisfaction of hospice providers, or about variation in satisfaction among disciplines.

### **Methods**

Staff at participating hospices completed the Survey of Team Attitudes and Relationships (STAR) using an online user interface. The STAR has 6 domains that comprise 45 items.

### **Results**

Results were submitted for 8,495 staff from 177 hospices in 41 states. The mean total score was 28 on a 0–100 scale (range, 0–100; interquartile range, 8–45) and hospice-level scores ranged from 15 to 44. Nonclinical staff (n=43260) and clinical staff (n=45235) had similar total scores (28 for both). Among clinical staff, in a mixed effects model adjusting for individual and hospice characteristics, physicians had the highest total scores (adjusted mean 42; 95% confidence interval: 35–46) compared to chaplains (30; 28–33), bereavement coordinators (27; 24–30), nurses' aides (29; 27–33); nurses (26; 28–33), and social workers (25; 23–26).

### **Conclusions**

There is significant variation in job satisfaction both among hospices and disciplines.

Hospice professions were categorized as:

- Physician
- Nurse (RN, LVN, LPN)
- Chaplain
- Social work
- Nurses' aide
- Bereavement

**Meier, D. E. (2011). Increased access to palliative care and hospice services: Opportunities to improve value in health care. *The Milbank Quarterly*, 89(3), 343-380.**

A small proportion of patients with serious illness or multiple chronic conditions account for the majority of health care spending. Despite the high cost, evidence demonstrates that these patients receive health care of inadequate quality, characterized by fragmentation, overuse, medical errors, and poor quality of life.

This article examines data demonstrating the impact of the U.S. health care system on clinical care outcomes and costs for the sickest and most vulnerable patients. It also defines palliative care and hospice, synthesizes studies of the outcomes of palliative care and hospice services, reviews variables predicting access to palliative care and hospice services, and identifies those policy priorities necessary to strengthen access to high-quality palliative care.

**Block EM. (2010). Got volunteers? association of hospice use of volunteers with bereaved family members' overall rating of the quality of end-of-life care. *Journal of Pain and Symptom Management*, 39(3), 502. doi:10.1016/j.jpainsymman.2009.11.310**

### **Context**

Volunteers are a key component of hospice, and they are required by Medicare conditions of participation in the United States. Yet, little is known about the impact of volunteers in hospice.

### **Objectives**

The goal of this study was to characterize whether bereaved family members in hospice programs with increased use of volunteer hours per patient day report higher overall satisfaction with hospice services.

### **Methods**

A secondary analysis of the 2006 Family Evaluation of Hospice Care data repository with hospice organization data regarding the number of volunteer hours in direct patient care and the total number of patient days served. A multivariate model examined the association of institutional rate of bereaved family members stating end-of-life care was excellent with that of hospices' rate of volunteer hours per patient day, controlling for other organizational characteristics.

### **Results**

Three hundred five hospice programs (67% freestanding and 20.7% for profit) submitted 57,353 surveys in 2006 (54.2% female decedents and 47.4% with cancer). Hospice programs reported on average 0.71 hours per patient week (25th percentile: 0.245 hours per patient week; 75th percentile: 0.91 volunteer hours per patient week; and 99th percentile: 3.3 hours per patient week). Those hospice programs in the highest quartile of volunteer usage had higher overall satisfaction compared with those in the lowest-quartile usage of volunteers (75.8% reported excellent overall quality of care compared with 67.8% reporting excellent in the lowest quartile. After adjustment for hospice program characteristics, hospice programs in the highest quartile had highest overall rating of the quality of care (coefficient  $\frac{1}{4}$  0.06, 95% confidence interval  $\frac{1}{4}$  0.04, 0.09).

### **Conclusion**

In this cross-sectional study, hospice programs with higher use of volunteers per patient day were associated with bereaved family member reports that the hospice program quality of care was excellent.

**Cherlin EJ. (2010). Interdisciplinary staffing patterns: Do for-profit and nonprofit hospices differ? *Journal of Palliative Medicine*, 13(4), 389. doi:10.1089/jpm.2009.0306**

### **Background**

Interdisciplinary care is fundamental to the hospice philosophy and is a key component of high quality hospice care. However, little is known about how hospices differ in their interdisciplinary staffing patterns, particularly across nonprofit and for-profit hospices. The purpose of this study was to examine potential differences in the staffing patterns of for-profit and nonprofit hospices.

### **Subjects and Design**

Using the 2006 Medicare Provider of Services (POS) survey, we conducted a cross-sectional analysis of staffing patterns within Medicare-certified hospices operating in the United States in 2006. In bivariate and multivariable analyses, we examined differences in staffing patterns measured by the existence of a full range of interdisciplinary staff (defined as having at least 1 full-time equivalent (FTE) staff in each of 4 disciplines ascertained by the survey: physician, nursing, psychosocial, and home health aide) and by the professional mix of staff within each discipline.

### **Results**

For-profit hospices had a wider range of paid staff but there were no differences by ownerships when volunteer staff were included. For-profit hospices had significantly fewer registered nurse FTEs as a proportion of nursing staff, fewer medical social worker FTEs as a proportion of psychosocial staff, and fewer clinician FTEs as a proportion of total staff ( p values <0.05). Compared to nonprofit hospices, for-profit and government owned hospices also used proportionally fewer volunteer FTEs.

### **Conclusions**

Hospice staffing patterns differed significantly by ownership type. Future research should evaluate the impact of these differences on quality of care and satisfaction among patients and families using hospice.

Disciplines surveyed included:

- Physicians (Volunteer and paid separately)
- Nurses (Volunteer and paid separately)
- Psychosocial staff (Volunteer and paid separately)
- Home health aides (Volunteer and paid separately)

**Dill JS. (2010). Caregiving in a patient's place of residence: Turnover of direct care workers in home care and hospice agencies. *Journal of Aging and Health*, 22(6), 713. doi:10.1177/0898264310373390**

### **Objectives**

High turnover and staff shortages among home care and hospice workers may compromise the quality and availability of in-home care. This study explores turnover rates of direct care workers for home care and hospice agencies.

### **Methods**

OLS (ordinary least square) regression models are run using organizational data from 93 home care agencies and 29 hospice agencies in North Carolina.

### **Results**

Home care agencies have higher total turnover rates than hospice agencies, but profit status may be an important covariate. Higher unemployment rates are associated with lower voluntary turnover. Agencies that do not offer health benefits experience higher involuntary turnover.

### **Conclusion**

Differences in turnover between hospice and home health agencies suggest that organizational characteristics of hospice care contribute to lower turnover rates. However, the variation in turnover rates is not fully explained by the proposed multivariate models. Future research should explore individual and structural-level variables that affect voluntary and involuntary turnover in these settings.

Did not measure turnover by hospice career/profession –all direct care workers as collective sample.

**Maison D. (2010). Workforce shortage: A staggering need and a call to action. *Journal of Pain and Symptom Management*, 40(6), 912. doi:10.1016/j.jpainsymman.2010.09.011**

### **[Commentary – not original research]**

The American Academy of Hospice and Palliative Medicine (AAHPM) Task Force article, “Estimate of Current Hospice and Palliative Medicine Physician Workforce Shortage,” very clearly and thoroughly describes the disparity between the current hospice and palliative care physician supply and the projected future need. Anyone who has been engaged in hospice and palliative medicine will tell you that we are rarely limited by demand for our services but rather by the supply of health care providers with the right skills and training. In fact, a big part of every lead hospice physician’s job is physician recruitment. Recent changes in the Medicare conditions of participation and upcoming requirements for face-to-face visits with long-term patients will only compound the challenge of adequate staffing.

Clearly, there is a tremendous need for more well-qualified hospice and palliative care physicians, and this need will only continue to increase in the future. This fact leaves all of us with one overriding question: How are we going to overcome this rapidly growing gap between what we have and what we need? In broad strokes, our choices seem to either increase fellowship training or continue to recruit practicing physicians to change careers and join our ever-growing ranks (or likely a combination of both).

**Nelson, J. (2010). Rural health: Access to care and services. *Home Health Care Management & Practice*, 22(5), 339. doi:10.1177/1084822309353552**

### **[Not original research]**

Lack of access to quality health care has been a long-standing risk for rural Americans. Multiple factors are emerging that may increase this risk in the future. The National Association for Home Care continuously keeps rural access on the radar and supports legislation that will preserve home care access to vulnerable rural areas. Of special interest are the rural elderly.

Rural residents older than the age of 65 years represent a large portion of the nation's home care recipients. Although people older than 65 years are living longer, healthier lives, they frequently require quality health care to make that possible. This population is also more likely to have complex medical issues requiring health care interventions. A review of current literature shows that there are many emerging trends posing a significant risk to the future of home care in rural America. This article discusses resources as well as initiatives undertaken to identify successful rural care delivery models.

**Campbell, C., Merwin, E., & Yan, G. (2009). Factors that influence the presence of a hospice in a rural community. *Journal of Nursing Scholarship*, 41(4), 420-428.**

### **Purpose**

The purpose of this study was to identify socioeconomic, physician related, and rural-urban factors that may influence the presence of a Medicare certified hospice in three rural-urban areas.

### **Design**

This was secondary analysis of selected socioeconomic, physician related, and rural-urban data from 3,140 counties using the 2005 Area Resource File, a county-level database. The county was the unit of analysis.

### **Methods**

Descriptive statistics were calculated for selected socioeconomic, physician, and rural-urban variables for the data set of 3,140 counties. Logistic regression was used to identify variables that influenced the presence of a Medicare-certified hospice across three rural-urban areas.

## Findings

As the rural-urban classification progressed from metropolitan (least rural) to rural-nonadjacent (most rural), the physician rate, racial-ethnic diversity, and number of counties with at least one Medicare-certified hospice decreased. However, in all three rural-urban areas only the physician rate was consistently significantly associated with the presence of a Medicare-certified hospice.

The study found that the “odds of a county having at least one Medicare-certified hospice increased 10% for every 1-unit increase in the county physician rate” (p. 425). Among the 3,140 counties in 2005, the mean physician rate was 12.61 and the mean number of Medicare hospices was .83. The average physician rate in metropolitan counties (18.99) was much higher than that of nonmetro adjacent (8.98) and rural (9.48) counties. The percentage of counties with at least one certified hospice was also much higher in metro areas (59%) than nonmetro adjacent (39%) and rural (36%) counties.

**Miller P. (2008). The relationship between job satisfaction and intention to leave of hospice nurses in a for-profit corporation. *Journal of hospice & palliative nursing*. Philadelphia, PA: Lippincott Williams & Wilkins, Inc. doi:10.1097/01.NJH.0000306711.65786.75**

The nursing shortage and nurse turnover challenge the hospice industry. Job satisfaction (general, intrinsic, and extrinsic job satisfaction) and intention to leave among hospice nurses in a for-profit corporation were studied to determine why hospice nurses leave the corporation. Using a correlational survey design, this study administered surveys to 777 hospice nurses in 60 site locations of a hospice corporation. A total of 302 surveys were returned, which equated to a 39% response rate. Quantitative analysis determined that the hospice nurses' intention-to-leave score had significant negative correlations with all three types of job satisfaction. The study also determined that there were no significant differences in the relationship between job satisfaction and intention to leave by any of the hospice nurse demographic variables of age, level of education, ethnicity, tenure in nursing, and/or job tenure. This study also revealed the hospice nurses' top-ranked job satisfiers and dissatisfiers.

**Chiarella M. (2007). Workforce issues in palliative and end-of-life care. *Journal of Hospice and Palliative Nursing*, 9(6), 334. doi:10.1097/01.NJH.0000299315.07139.72**

This article examines the development of and demand for palliative and end-of life (EOL) care in developed countries and explores the implication of this development in relation to available workforce and future workforce planning. It begins with an overview of the development of palliative and EOL care and moves into an analysis of the implications for future workforce planning.

**Clark, L. (2007). Spirituality and job satisfaction among hospice interdisciplinary team members. *Journal of Palliative Medicine*, 10(6), 1321. doi:10.1089/jpm.2007.0035**

As a continuing effort to enhance the quality of palliative care for the dying, this study examined (1) the prevalence of spirituality among hospice interdisciplinary team (IDT) members; (2) whether spirituality is related to job satisfaction; and (3) the structural path relationships among four variables: spiritual belief, integration of spirituality at work, self actualization and job satisfaction. The study surveyed 215 hospice IDT members who completed the Jarel Spiritual Well-Being Scale, the Chamiec-Case Spirituality Integration and Job Satisfaction Scales. Multiple regression and structural path modeling methods were applied to explain the path relationships involving all four variables.

The IDT members surveyed were: nurses, 46.4%; home health aids, 24.9%; social workers, 17.4%; chaplains, 4.2%; physicians, 2.3%; and other, 4.8%. Ninety-eight percent of the respondents viewed themselves as having spiritual well-being. IDT member's integration of their spirituality at work and greater self actualization significantly improve job satisfaction.

**Casey MM. (2005). Providing hospice care in rural areas: Challenges and strategies. *American Journal of Hospice & Palliative Medicine*, 22(5), 363. doi:10.1177/104990910502200509**

Hospices in rural settings face challenges in the provision of hospice care as a result of their location and the size of their service area population. To ascertain the challenges that hospices face in serving rural communities, researchers conducted in-depth case studies of four different models of hospice care in rural areas. The authors describe strategies used by the case study hospices and recommend policies that could increase access to hospice care for rural Medicare beneficiaries and other rural residents. National initiatives to improve end-of-life care need to consider the special challenges faced by rural hospices.

“For rural hospices, staffing challenges are exacerbated by shortages of nurses, social workers, and other health professionals. Rural hospices with low patient volumes are often unable to fund full-time positions, and those that cover large geographic areas may have difficulty finding staffing willing to travel to remote areas. Hospice workers may be at particular risk for burnout and compassion fatigue in resource-poor rural areas, especially when the boundaries between their work and personal lives are blurred.”

“Hospices serving rural areas, especially low-volume hospices and those with large service areas, face challenges recruiting and retaining staff and providing coverage 24 hours a day, seven days a week. The case study hospices employ a variety of strategies to address staffing needs.”

**Shield RR. (2005). Physicians "missing in action": Family perspectives on physician and staffing problems in end-of-life care in the nursing home. *Journal of the American Geriatrics Society*, 53(10), 1651. doi:10.1111/j.1532-5415.2005.53505.x**

### **Objectives**

To understand the roles of physicians and staff in nursing homes in relation to end-of-life care through narrative interviews with family members close to a decedent. DESIGN: Qualitative follow-up interviews with 54 respondents who had participated in an earlier national survey of 1,578 informants.

### **Setting**

Brown University interviewers conducted telephone interviews with participants throughout the United States.

### **Participants**

The 54 participants agreed to a follow up qualitative interview and were family members or close to the decedent.

### **Measurements**

A five-member, multidisciplinary team to identify overarching themes taped, transcribed, and then coded interviews.

### **Results**

Respondents report that healthcare professionals often insufficiently address the needs of dying patients in nursing homes and that “missing in action” physicians and insufficient staffing create extra burdens on dying nursing home residents and their families.

### **Conclusion**

Sustained efforts to increase the presence of physicians and improve staffing in nursing homes are suggested to improve end-of-life care for dying residents in nursing homes.

**Connor, S. (2004). Measuring hospice care: The national hospice and palliative care organization national hospice data set. *Journal of Pain and Symptom Management*, 28(4), 316. doi:10.1016/j.jpainsymman.2004.07.003**

Hospice has seen rapid growth in recent years, but there is a lack of consistency among hospices when it comes to compliance with standards of care. Consequently, hospices vary in performance and in services they provide. With state hospice organizations, the NHPCO developed a National Data Set (NDS) intended to understand demographics, practices, and outcomes; illustrate industry effectiveness; facilitate communication of industry legislative needs; and to support agency performance and improvement. Our paper describes development of the NDS and data that are being collected, and summarizes key findings from the 2000, 2001, and 2002 NDS. The data collection process, which began in 1999, has evolved substantially over

a 4-year period to the point that we believe the 2002 NDS represents a well-designed core that will receive only minor modifications annually. This database will be invaluable for comparative audit, clinical practice and managing services because only that which is measured can be improved.

The conventional wisdom about significant staffing ratio and skill mix differences between large and small agencies was largely shown to be incorrect. The average large, medium, and small agencies had very similar staffing statistics, and agencies of all sizes had clear opportunities to improve, in comparison with national statistics.

Productivity and cost of care section of survey collected on: FTEs, visits case load, inpatient facility FTEs, total employees (no PRN), total PRN employees, and total separations for nurses, social services, and other clinical staff.

The reported data can help hospices define strategic goals, set operating targets, and improve practices like community and referral source education and staff recruitment and retention.

**Dunham W. (2003). Hospice forum. obstacles to the delivery of acceptable standards of care in rural home hospices. *American Journal of Hospice & Palliative Medicine*, 20(4), 259. doi:10.1177/104990910302000405**

Case study that highlights the importance of adequate staff and workforce issues among rural hospices. Cited in Casey MM (2005).

### Hospice Health Professions/Disciplines

The Hospice Foundation of America, the Hospice Education Network, Inc., and the Hospice College of America partnered to provide “Hospice Choices” – [www.hospicechoices.com](http://www.hospicechoices.com). The webpage lists job openings in hospice care throughout the U.S.

Careers are also pulled from NHPCO webpage and <http://www.medicare.gov/what-medicare-covers/part-a/how-hospice-works.html>.

*NHPCO Facts and Figures* also identifies hospice professions.

Hospice professions/disciplines most commonly listed in literature are: physician, nurse (LPN, LVN, RN), home health aides, chaplains, and social workers.

#### **Collective List:**

- RN
- ARNP
- LPN/LVN
- CNA/Home health aid
- Physician/Medical director
- Social worker
- Case manager/Team coordinator
- Counselor
- Nutritionist
- Therapist
- Chaplain
- Bereavement counselor
- Volunteer
- Triage
- Admissions nurse
- Pharmacist
- Nurse practitioner
- Palliative care manager
- Physical therapist
- Occupational therapist
- Speech therapist

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