Rural Health Reform Policy
RESEARCH CENTER

POLICY BRIEF

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Perspectives of Rural Hospice Directors

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Key Findings

- Rural hospices struggle financially. Respondents tended to believe that there is an inadequate Medicare reimbursement system, especially when compared with urban providers. Rural providers believe they are providing the same service and at the same quality level as are urban providers; however, they noted that Medicare does not take into account rural factors such as reimbursement for "windshield time" There is, however, some level of optimism regarding a new reimbursement methodology.
- Perceptions of excessive regulatory requirements creates financial and workforce implications.
- Rural hospice workforce availability is influenced by a number of contextual conditions including the nature of the work environment, economics, demographic shifts, reimbursement rates and payment structures, and stringent regulations.
- The issue of travel and distance or the amount of "windshield time" required by rural hospice providers presents unique workforce, financial, and management implications for rural hospices. Rural hospices do not receive additional reimbursement to compensate for the added cost associated with windshield time (e.g., actual travel costs and lost productivity). This can increase the cost per visit.
- The six foremost issues described from this study (regulations, finance/reimbursement, workforce, general rural issues, relationships with other organizations, and technology) are not mutually exclusive as they tend to overlap and influence each other. This creates a complex and challenging environment for rural hospice organizations.

Introduction

Hospice care is an important part of the overall health system providing quality, compassionate care to people at the end of life. Within a rural context it is not only a health service, but also an important element in the social fabric of a rural community. Hospice in a rural setting is more likely to be provided by a local/area small non-profit, be staffed by local people, and serve a population that has lived in the area for many years (if not all of their lives) (Casey, 2005; NHPCO, 2013). These connections foster relationships between the hospice patient, their family members and caregivers, and the hospice staff.

Rural hospice care, as it is currently configured, is under pressure by a variety of factors (e.g., policy and regulation, economic and financial, and organizational and structural) which are reviewed in this document. However, a central core element of rural hospice remains the strong

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sense of community that is embodied in the system (i.e., typically a small non-profit arrangement) and design (i.e., a delivery system reliant on community connections and personal relationships) of care.

This policy brief is the result of a national phone survey of rural hospice directors or key staff in 47 states. Fifty-three directors or key staff members were interviewed during a three month period in 2013.

Background

Hospice care consists of an interdisciplinary team that provides medical, nursing, social, psychological, and emotional/spiritual care typically during the last six months of life. Hospice often relies on family members as caregivers in addition to the professional team. Its primary focus is to help people who are terminally ill (as certified by a physician or nurse practitioner) to live comfortably (comfort not curative). It is provided in 2, 90 day benefit periods with unlimited enrollments on a 60 day basis. Due to an increase in the number of hospice beneficiaries that were staying in hospice for longer time periods, in 2011 the Centers for Medicare and Medicaid Services (CMS) required a mandatory face-to-face encounter at six months between the patient and a physician or nurse practitioner. These visits are completed prior to the start of the third benefit period (prior to 180 days) and then every 60 days if necessary (Harrold, 2013). It is estimated that 1.5-1.6 million patients received hospice care in 2012 with total Medicare expenditures greater than $15 billion. This expenditure has been fueled, in part, by the significant increase in the number of people using hospice and growth in the lengths of stay. (NHPCO, 2012).

In 1982, a hospice benefit was added to the Medicare program. Medicare payments now account for 84 percent of all hospice payments and most (93 percent) hospice programs are Medicare certified (NHPCO, 2013; MedPAC, 2014). The vast majority of care is classified as routine home care (i.e., patient receives care in their home setting). Over 96 percent of the days of care are classified as routine, followed by general inpatient care (3 percent – care provided in an inpatient facility for pain control or acute or complex symptom management), continuous home care (0.5 percent - patient receives hospice care consisting predominantly of licensed nursing care on a continuous basis in the home setting during a short period of crisis) and respite care (0.3 percent – patient receives care in an approved facility on a short-term basis so as to provide a respite for the family care-giver) (NHPCO, 2013).

Most hospices are organized as for-profits, 63 percent in 2012; non-profit, 32 percent; and 5 percent were government owned. A majority of hospices (57 percent in 2012) were free-standing independent organizations with about 21 percent being part of a hospital system, 17 percent home care system, and 5 percent with a nursing home (NHPCO, 2013). In terms of ownership status a higher percentage of urban hospice programs are for-profit than found in rural hospices; however, a higher percentage of rural hospices are government owned. The most common ownership status for both urban and rural hospices is non-profit. Additionally, with regard to facility type, a greater percentage of urban hospices are freestanding, home health based, and skilled nursing facility based than found in rural hospices, but a greater percentage of rural hospices are hospital based in comparison to urban hospices (NACRHHS, 2013). In 2012, there were 3,720 Medicare certified hospices nationally, which represented an increase from the prior year of about 4 percent. Almost all the growth was associated with the increase in for-profit arrangements (MedPAC, 2014).

About 27 percent of all hospices are located in rural areas, though the service areas of many urban-based hospices include rural areas. While the number of rural-based hospices increased by 25 percent from 2000 (788 rural hospices) to 2012 (982), the national percentage of hospices that are rural declined (from 36 percent in 2000 to 27 percent of all hospices by 2012). The number of urban hospices grew at much higher rate (85 percent increase from 2000 to 2012) and as a percentage of all hospices urban-based hospices grew from 64 percent of the total in 2000 to 73 percent by 2012. (MedPAC, 2014).

Hospices are reimbursed with a daily per diem rate. Rural hospices were reimbursed at a lower rate ($17 less per day than their urban counterparts) than urban hospices because of the wage index formula that is applied (NACRHHS, 2013). This reimbursement structure does not account for the comparatively higher costs found in rural hospices associated with higher travel costs to patient's homes (Casey, Moscovice, Virnig, and Durham, 2005). There are associated cost implications for the rural hospice agency (e.g., greater number of direct care encounters by a physician, nurse practitioner, nurse, social worker,

and/or ancillary personnel; increased travel costs from the hospice site to the patient's home; and lower staff productivity because of longer travel times). The higher level of direct care encounters is likely associated with rural patients receiving more hospice care in the home setting. In addition, the new face-to-face recertification requirement at 180 days will be more demanding of rural physicians and/or nurse practitioners compared to their urban colleagues. Financial margins are lower for rural hospices and with travel costs associated with a provider having to conduct a home visit for recertification, and the additional costs may exacerbate those margins even more (e.g., time away from office-based patients, time on the road, and the actual face-to-face visit being treated as an administrative function) (NACRHHS, 2013).

Ownership status and facility type also correlates with financial status. There are a lower number of rural for-profit and freestanding hospices (40 percent of urban hospices are for profit vs. 37 percent of rural; 74 percent of urban hospices are free-standing while 61 percent of rural hospices are of this facility type). Nationally, for-profit hospices received about 25 percent more Medicare reimbursement than non-profits and 33 percent more than government owned and freestanding received about 30 percent more than hospital-based hospices (NACRHHS, 2013). There are a lower number of rural non-profit hospices and rural freestanding hospices. Positive financial margins tend to be related to a longer average length of stay (ALOS) and the ALOS for both for-profits and freestanding agencies is over 20 days longer than for other types; nationally, for-profit margins in 2010 were 12.4 percent and freestanding were 10.7 percent. This contrasts with non-profits (3.2 percent) and hospital-based (3.2 percent) (NACRHHS, 2013). Correspondingly with a lower number of for-profit or freestanding agencies, and with a lower ALOS, rural hospices had margins of 5.3 percent in comparison to urban, 7.8 percent.

Methods

A qualitative study approach was used based on phone interviews with rural hospice agency directors (or key staff) from 47 states. Rural providers in Massachusetts, New Jersey, and Rhode Island were not identified and those states were excluded from the study. The pre-interview process used three steps. The first step involved consultations with the National Hospice and Palliative Care Organization's Rural Health Task Force (NHPCO). For purposes of the study, they served as an expert panel to provide an overview of rural hospice operations, environmental conditions, terminology, and overall contextual descriptions. Throughout the research process the task force or key members were updated and consulted. The second step was a focus group with rural hospice directors who were members of the Kentucky Hospice Association. The focus group also served as a means to assist the research team to better understand rural hospice issues. The third step was to conduct a literature review.

Based on input from the task force, focus group, and literature search, the research team identified six primary issues: finance, regulations, workforce, relationships with other providers, rural factors, and technology. The NPCHO identified the names of directors or key staff from 47 states and provided contact information. In total, 53 rural hospice directors or program representatives were interviewed out of a total list of 58. There were five who were initially identified who were unavailable for interviews. When this happened the NPCHO was contacted for another name for that state. Interviews were recorded, along with hand written notes for clarity, and the recordings were transcribed.

The data analysis was based on a review of the interview narratives to determine thematic codes. Thematic analysis involves the identification of patterns of thought and expression. Priority issues identified by respondents were categorized and are presented in Table 1.

Findings

Table 1: Findings

Finance	15 *respondents identified as their top concern*
Rural Factors	15
Regulations	11
Workforce	9
Relationship with other providers	3
Technology	0

Overall Findings

When the six foremost issues were ranked by the respondents (based on their assessment of what was the most important issue they faced) finance and rural factors tied as their most pressing issue. This was followed by regulatory environment; hospice workforce issues;

relationships with other providers (e.g., other hospice organizations, hospitals, and nursing homes); and technology as their primary concern. It is important to understand that the ranking is based solely on the hospice director stating that the issue was their number one concern from the six that were provided to them. The ranking represents the number of times an issue was identified as the greatest concern or problem by the 53 interviewees. No respondents identified technology at their chief concern, yet many outlined difficulty with technology issues.

As the background section previously established, rural hospices face a number of ***financial*** issues (e.g., level and adequacy of reimbursement, operational costs that are not factored into the per diem rate, equity with urban hospices, and other factors). These were all supported by the interviews. The ability to remain financially viable so as to continue to serve their clients was of paramount concern.

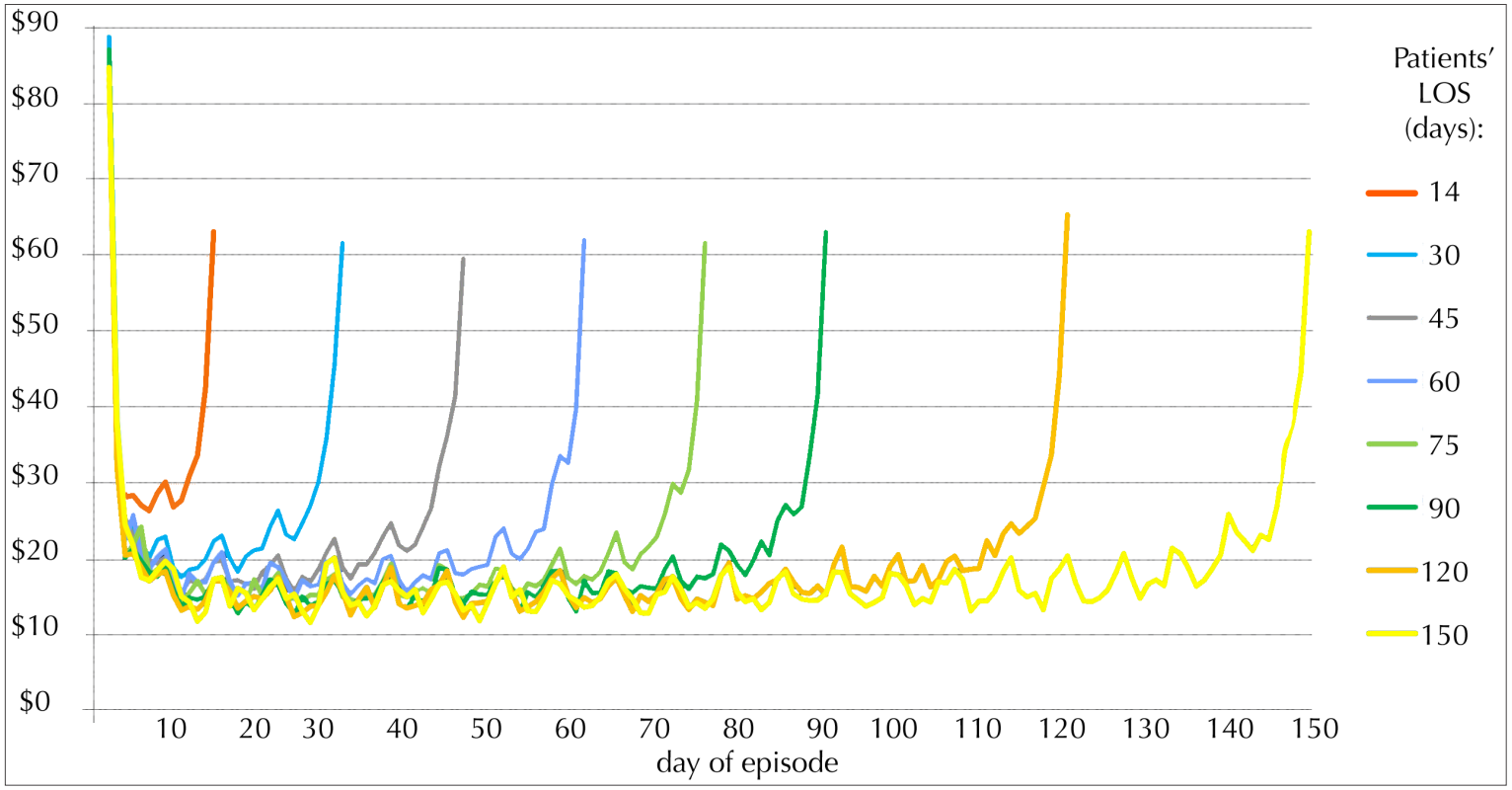
Important sub-themes included a new reimbursement methodology generally referred to as the "U-shaped curve" (please see Exhibit 1), general reimbursement/ payment concerns, sequestration impact (yearly percentage reduction in Medicare payments), and travel and distance ramifications.

The most common financial theme was the prospect of a new reimbursement model, the ***U-shaped curve***. Twenty-seven hospice programs commented on this matter. Currently hospices are reimbursed on a straight per diem, with a differential that favors urban based hospices based on the area wage index. Rural hospices in 2013 were reimbursed $17 less per day than an urban hospice. Much of the research has shown that higher costs occur in hospices at the beginning of client service and at the end stage with a lower cost in the middle (hence the cost structure looks like a "U", please see Exhibit 2). When commenting on the

Exhibit 1: What is U Shaped Curve Reimbursement?

One recommendation from MedPAC (Medicare Payment Advisory Commission) is to modify the per diem hospice payments to include what has been referred to as a "U shaped curve." This is also referred to as an intensity-adjusted payment. Hospice costs typically follow a U-shaped curve with higher costs being noted at the beginning of the care period and at the end of care, with lower costs in the middle of the stay. The U shaped methodology simply states that payments would be higher at the beginning and end periods and lower in the middle part of the stay. In this manner the payment configuration corresponds to the cost structure. The policy implication is to discourage very long stays in hospice as there has been an increase in that area. *Source: Abt Associates, 2013*

Exhibit 2: Hospice Labor Costs and Length of Stay



Source: Medicare Hospice Policy Issue, Neuman, K. and Sadownik, S., April 4, 2013 (MedPac Powerpoint presentation).

possibility of a U-shaped reimbursement curve – intended to link the payment structure with the cost structure to better reflect market conditions - a majority of the hospice program respondents were favorably disposed; however, there was some skepticism and concern. Those who favored it felt that they and other rural hospices had shorter lengths of stay and that a U-shaped payment structure would benefit their operations. They agreed that their costs followed a U-shape. Those who had concerns tended to frame it as not knowing the details of how a payment structure based on three periods of care would work (e.g., are the phases measured as a specified number of days for each of the three periods, or is the total time divided into thirds – basically how would it be measured?) There was concern that some patients do not follow this format because there are consistent costs across time and tend to generate higher costs overall. Some interviewees shared that they thought it was unlikely that federal policy would result in a reimbursement method that treated rural hospice agencies as fairly as they perceived urban hospices to be considered.

Rural factors are generally not discussed to a significant degree in the hospice literature. However, for most rural health providers and organizations, including hospice, the rural environment presents unique challenges. For the purposes of this study, rural factors refer to elements in the rural environment that while not necessarily unique to rural hospice, are contextual factors that often adversely influence hospices, as well as other rural health organizations (e.g., hospitals). These factors include population change (e.g., both increasing and declining rural populations can impact the number of people in the workforce, number of volunteers, perceived livability of the community for recruitment purposes, and an aging workforce) ; rural economics (e.g., rates of poverty, income levels, fluctuating economic conditions, and changes in the composition of economic sectors); culture (not only racial and/or ethnic composition but the more generalized "how we do things or how we work together" as ways of rural life); geography (e.g., distance, travel time, weather, and topography); and the culture of rural organizations (e.g., primarily collaborative, less formal).

Travel and distance was the most common theme identified under rural factors. Thirty-three of the 53 respondents referenced this theme. Travel, distance, weather conditions, and geography are physical constraints that rural hospice agencies must contend with to do their jobs. Many of these interviewee hospices have very large service areas. Respondents used different metrics to establish the size of their service areas. Some mentioned the distance to travel to see a patient (e.g., 50 miles and 125 miles one-way were often described), while others noted the service area in land mass was also commonly listed (e.g., 10,000 square miles, 18,000, 20,000, and 22,000 were identified). Some respondents used the measure of time (e.g., 1.5 hours one-way, 2.0 hours, and 2.5 hours). Regardless of the measure, rural hospices tended to perceive travel or "windshield time" as factors that negatively influences their ability to provide care. These physical constraints produced added costs in the form of paying nurses, social workers, physicians, and aides during "down-time" or "lost productivity" as they spent two, four, or even six hours in a car for one visit. Some respondents stressed that the per diem does not adequately account for lost hours on the road. Other implications associated with the travel and distance subtheme of rural factors included delayed response time for emergencies, needing to strategically station staff across the service area, staff burn-out, difficulty in hiring staff, difficulty in disseminating medications over distance because of inadequate pharmacy hours and distance, problems with distance and weather, and difficultly with after hour call schedule. The overall economic implication was that the per diem was not in line with real costs.

Regulations covered a wide variety of sub-themes including workforce/staffing barriers, the advent of a new patient recertification requirement called the "face-to-face" rule, the general regulatory environment, and other specific regulations. Comments on regulations were almost exclusively focused on federal regulations. Regulatory observations were more likely to fuse with payment/reimbursement remarks than with any other theme. The regulatory environment can have a profound effect on a small hospice as it relates to the allocation of resources (including staff time away from direct care and expenses to maintain regulatory compliance); morale (burn-out, a sense of being overwhelmed by an escalation in federal regulation and paperwork, and even anxiety); and the relationship between regulation and finance.

Staffing was the leading theme with 24 coded comments. The regulatory process affects hospice staffing in a number of ways. Hospice program officials experience an increased workload because of the number of rules and the pace

of issuance of new rules and/or rule changes. There was a strong view that rule making is important as its primary purpose is to address quality, safety, and fraud. However, it was noted that it also adds to the cost structure of rural hospices in the form of needing to hire additional staff (particularly administrative and some believed at the expense of improving care giving), overburdening current staff, and equipment purchases (e.g., computers and software). There was a perception that while regulations increased there was a relative decrease in overall reimbursement.

The Patient Protection and Affordable Care Act of 2010 (ACA) required that a hospice physician or nurse practitioner must have a *face-to-face encounter with every hospice patient* to determine the continued eligibility of that patient prior to the 180th day (six months) recertification, and prior to each subsequent recertification. The new face-to-face requirement is controversial for rural hospices and was raised as a theme by 20 of the 53 respondents. On the one hand, a number of hospice program officials felt it was important and necessary to have a reassessment of the patient in order to assure the appropriate use of the benefit and to serve as a quality of care process. On the other hand, they pointed to a number of inequities (e.g., travel costs, lost productivity, and resource allocation) that place additional burden on their agency and staff.

Workforce was a significant issue facing rural hospice agencies. While hospice workforce was ranked fourth overall with only 9 of 53 respondents ranking it as their primary concern, it elicited the highest number of overall comments and had the highest number of respondents making observations. Fully 51 of the 53 respondents (96 percent) commented on workforce issues. Hospice workforce is a complicated, problematic, and multi-faceted issue. It encompasses facets of financial and regulatory issues, policy and rural cultural dynamics, relationships with other entities and internal organizational interactions and affiliations, and population and economic qualities.

Workforce environment covered supply and demand factors, workplace setting, competition, economics, rural factors, and regulations. Supply and demand generally dealt with problems with recruiting and retaining qualified staff. Some of this was associated with competition with urban providers that could offer better salaries, benefits, hours, and little road time. Reference was also made that while the current staffing was adequate there were concerns about the ability to identify and hire in the future. Some hospice directors also stated that in a large service area there were issues concerning where the staff lived relative to where the hospice was located. In other cases, hospice interviewees felt their staffing was adequate and they had long-term, loyal employees. Competition for trained staff, particularly between non-profit hospices and nursing homes, was noted as a challenge. In addition, urban hospices were reported to offer better compensation packages (salaries and benefits) than rural hospices; therefore, rural non-profit hospices believed they were at a disadvantage for recruiting staff. Other workplace factors included heavy workloads, small staffs, staff members serving multiple roles (wearing "many hats"), staff burn-out, and limited options for education and training.

There were 11 ***specific workforce disciplines*** that were addressed with 39 comments on nursing, 30 for social work, and 27 with physicians. A number of respondents noted that their current nursing supply was adequate. Yet many respondents reported that nursing was the most challenging discipline to recruit because of the unique nature of the work, high turnover, travel requirements and traveling alone to a client's home, growing administrative and regulatory demands, physical location of the nurse relative to the workplace site, competition with other providers that can offer better salaries, and experience levels. Social work issues were primarily related to the MSW (Master in Social Work) requirement (i.e., all hospice agencies must have a MSW employed or under contract to supervise LSW – Licensed Social Workers) and the difficulty in meeting this stipulation. Concern was expressed about the ability to meet the face-to-face requirement when a physician has a private practice and then must travel an hour or two one-way for an in-home visit. There were concerns that the next generation of physicians may not be as willing to accommodate the challenges found in rural hospice as are today's physicians.

There are a number of ***organizational relationships with other health providers*** that are centered on business considerations such as referrals, purchasing, employment, and other organizational matters. Other relationships may revolve around community dynamics and/or social considerations. Some of these are based on need and mutual benefit; others produce elements of competition for scarce resources. The interviews produced comments that reflected both the collaborative nature found in many rural organizations and the wariness associated with competition.

Respondents raised concerns associated with competition with urban and/or for-profit hospice programs, either stand-alone entities or parts of larger systems. There was some perception that the urban/larger hospice programs had more resources and could in some cases "cherry-pick" patients and service areas, leaving what they deemed as more undesirable cases for traditional rural hospices. In general, comments about rural hospitals, such as Critical Access Hospitals, were positive. Respondents did note more competition with nursing homes. Overall, there was more of a sense of cooperation and collaboration than competition; nevertheless, when there were concerns over competition it tended to be perceived as larger, for-profit, and/or urban against the limited resources of the traditional rural hospice.

The final issue, ***technology***, while not seen as a primary issue –none of the 53 respondents identified it as their highest rated concern; however, technology issues did generate a number of specific concerns, such as connectivity in rural areas, efficiency, the possible utilization of more technology in direct patient care, financial and added cost implications, and adaptability to new and/or complex technology. Connectivity concerns revolved around either the lack of connectivity or limited access. For example, access to Internet service was a significant issue which included: no Internet service available, speed constraints, blackouts, dead zones, power outages, and other factors. A typical problem identified was access in a private residence. While the central hospice site may have Internet access, it was difficult to access in many homes. Nurses and other providers need to record their data and when there was limited or unreliable access to technology, the nurse would have to take additional time at the central site to transfer their paper notes electronically. In addition, the patient reports are required to be electronically recorded, stored, and transferred. A number of respondents commented on the connectivity problem related to inefficiency for the organization. This lack of access was viewed as a loss of productivity and another source of frustration on the part of staff which could compound the workforce issue faced by hospices.

Connectivity problems were also identified regarding limited cell phone coverage and in a few cases teleconferencing. One hospice respondent described the situation they faced in this manner: "There is no cell phone coverage. We talk about telemedicine, telehealth but are not able to set up at the remote patients' home where they would benefit most from this technology. We don't have the ability, we are trying to do point of care charting but just don't have the access. If we can't access when needed it is hard to rely on."

About 90 percent of the respondents had an electronic medical record (EMR) or were scheduled to receive a system; however, there was a relatively high degree of frustration. Respondents were supportive of technology as a way to improve quality and had a basic belief that it should increase efficiency but generally felt there were added (and even hidden) costs, increased workloads (additional time in the main office to transfer paper data), and that overall the anticipated organizational efficiency was not being achieved. One hospice respondent summed up her situation in the following: "Idea was to cut down on time and expense but reality just doesn't work out that way. Have to use written documentation still with many patients and then transfer it electronically."

Another facet of technology was the applicability of it in a person's home. A number of issues were raised: CMS does not allow for the use of technology to replace face-to-face contact with the patient; patients are elderly and either do not use technology themselves or are skeptical and even a little afraid of it; the nature of hospice is personal touch and one-on-one care, looking for the non-verbals; connectivity issues; and cost factors. Yet, there were some signs that under the right conditions, for the right patient greater utilization of technology could be beneficial. One hospice respondent stated that in an environment of financial constraints and increased regulation there was a need to leverage technology "to work smarter to assist RNs (registered nurses) with their case load and for better management." Another commented on the utility of in-home medication dispensers to help the elderly caregiver. One respondent noted that the regulatory environment was not keeping pace with the technology and that regulations prevented the use of more technology. The idea of blending some levels of teleconferencing (such as Skype) with face-to-face to augment, but not to replace, the in-person encounter was discussed.

Conclusions

Hospice care is an important service in the rural health delivery system. Based on the interviews with 53 rural hospice directors and/or key staff hospice providers are dedicated to their patients, caregivers, and communities; they are passionate about their work; and they willingly make sacrifices for the benefit of the patient and the good of

the community. Still, they operate in a complex system that is influenced by demanding financial conditions; increasing regulations; workforce shortages; complex relationships with other providers; technology concerns; and an overall rural environment where factors such as community economics, fluctuating demographics, and location and distance come into play.

The discussion focused on the qualities and conditions that are associated with individual factors that influence rural hospices. In reality the nature of rural is such that contextual factors frequently coalesce amplifying the complexity and the impact on rural hospices care. For example, while a regulatory environment and a payment system can be seen as separate systems, they do inter-relate in a manner adding to the difficulty of having effective and efficient rural hospices. Regulations are important for patient safety and performance integrity yet they come with financial costs in the form of increased demands on staff and technology costs. A challenging reimbursement structure makes it more difficult to meet the costs of added regulations in the form of adequate staff, time to administer and monitor regulations, and technology costs. In a similar way, regulations produce effects on workforce demand and supply; workforce is influenced by financial considerations including payment streams; competition or lack of competition is shaped by financial issues, regulations, rural environmental factors, and workforce supply; and the broader contextual environment (e.g. distance, location, travel time) was found in the interviews to be pervasive as the rural environment influences all the other key factors reviewed in this study. Thus, rural hospice is a very complex subject. Nevertheless, respondents found that those engaged in the pursuit of providing a high level of care to those in their final stage of life remain dedicated. The interviews produced both a sense of pessimism about the future of rural hospice (i.e. a general feeling that rural hospice as it exists today will be eclipsed by urban and/or for-profit systems) with a strong sense of professionalism, compassion, and dedication to patients, caregivers, and rural communities.

Policy Implications

Reimbursement and Payment. Rural hospice reimbursement needs to better reflect the unique challenges found in a rural environment (e.g., travel time, lost productivity, and reimbursement to providers for the time associated with the face-to-face encounters). Capital grants, especially for technology (e.g., electronic health records, tele-hospice), can be considered. In addition, there needs to be an in-depth examination, which includes direct input from rural hospice representatives, regarding the implications of the proposed "U-shaped" reimbursement model on rural hospices.

Regulation. Greater flexibility in terms of adequately exploring the potential effect of regulatory changes on rural hospices should be considered. Regulations can and do have unintended consequences. Regulations in the pursuit of better patient safety, quality, and organizational/system performance are necessary, but sometimes they can have a negative effect on workforce supply and demand. In an effort to improve quality and performance they can, at times, produce disincentives. Respondents mentioned the rule precluding the use of physician assistants (PAs) in a hospice setting, along with the role of federally certified Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC). Services provided by physicians or nurse practitioners are allowable, but services provided by a physician assistant are not. A physician and/or a nurse practitioner can be employed by a federally certified RHC or a FQHC; however, hospice services provided by these providers can only be conducted when the provider is not working for the RHC or FQHC. These provider types (RHC and FQHC) are not authorized to be hospice attending practitioners. In light of the difficulty hospice programs have in securing the services of rural health providers, this restriction creates another obstacle to providing services and should be studied. In addition, policy makers should consider the use of enhanced in-home technology, not as a means to avoid the face-to-face encounter, but as a means to enhance that process and to improve the quality of care.

Workforce. Workforce presents unique policy concerns related to both the financial construct shaping rural hospice workforce issues and fairly common issues associated with the supply and demand function. Addressing some of the financial disincentives in the current system would improve the organizational capacity of many rural hospices (e.g., financial inefficiencies associated with "windshield time" and lost productivity, accounting for the face-to-face encounter requirements, inclusion of physician assistants as a recognized provider group, and more flexibility for supervisory arrangements such as found for MSWs). In

addition, targeted scholarship and/or loan repayment options should be explored for professionals willing to work for rural hospices in isolated rural and frontier areas.

Rural Factors. While health policy cannot change the nature of the rural environment, there is a need for policy makers to be more cognizant of how those rural characteristics are influenced and impacted by policy, especially reimbursement and regulatory policies. Rural hospice providers and their national association need to continue to educate and inform policy makers on the unique composition and challenges found in the rural hospice setting.

Relationships with Other Providers. This study found a relatively high level of concern from rural non-profit interviewees about more urban-based, larger for-profits. There was a sense that policy structures in the form of payment methodologies, regulations, and workforce composition favored one group over the other. Just as policy makers should not favor one type of organizational structure over another, so too they should be cognizant of unintentionally placing one at risk. Policy makers should be made aware of how policy changes can impact organizational structure and the decisions made within those organizations

Technology. Policy makers need to be aware of the connectivity issues found in rural areas both for internet connections and cell phone coverage. Geographical conditions, cost factors, and workforce implications are impediments to full technology access for rural hospices. Health care increasingly becomes more and more reliant on technological change. Rural hospice cannot afford to be left behind.

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Additional Information

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