Staffing Guidelines

for Hospice Home Care Teams

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INTRODUCTION

Background

Guidelines for staffing ratios were introduced by NHPCO as part of the Hospice Service Guidelines published in 1994. The Hospice Service Guidelines document was produced by the NHPCO Standards and Accreditation Committee as an effort to reflect industry practice and provide specific operational guidelines and benchmarks that were not incorporated into the Standards of Practice for Hospice Programs. In addition to staffing ratios, the guidelines included sections on admission and discharge policies and practices, levels of care, scope of services, and facility-based services. The staffing ratios section provided ranges for recommended caseload numbers for clinical staff and proved to be a useful and popular tool for hospice administrators and interdisciplinary team members.

The recommended numbers for staffing ratios in the Hospice Service Guidelines were developed when hospice was still in its formative years and data on hospice operations were sparse. At that time hospice service models were more basic and uniform, and the patient population served was quite different from the population served today by hospice programs. As hospice practice evolved and became more complex, the need for an up-to-date process to determine staffing ratios became evident. To meet that need NHPCO and the Standards and Quality Committee undertook the development of these Staffing Guidelines for Hospice Home Care Teams to provide hospices with a method for setting staffing caseloads that better reflects current practice.

No one "best standard" in the literature regarding hospice staffing caseloads currently exists. Around the nation, hospices have evolved in various directions, creating diverse models of care to serve hospice patients and families. The Staffing Guidelines for Hospice Home Care Teams is based on the recognition of the current diverse nature of hospice care and allows for individualization of staffing caseloads according to the organizational and environmental characteristics specific to each hospice, in much the same way hospices individualize patient care.

The Staffing Guidelines for Hospice Home Care Teams utilizes an assessment process to estimate optimal staffing levels for hospice programs that includes an analysis of the model of care delivery, characteristics of the patient population served, environmental considerations, and other circumstances unique to each hospice. However, it is important to keep in mind that the **primary consideration that should be used by a hospice to determine optimal staffing caseloads is the hospice's ability to meet the needs of patients and families through appropriate use of resources and achieving the quality goals set by the hospice program.**

(For more details on the creation of the Staffing Guidelines for Hospice Home Care Teams see the article titled *NHPCO's New Staffing Guidelines: No Longer a One Size-Fits All Approach* in NHPCO's *Newsline*, March 2011.)

Using the Staffing Guidelines for Hospice Home Care Teams

The purpose of these Guidelines is to help each hospice provider estimate optimal staffing caseloads that conform to their particular situation. The diverse models of hospice care which are driven by variation in patient populations, population density, travel time, and other factors inherent to the uniqueness of each hospice program require an innovative process to determine staffing ratios. The Staffing Guidelines for Hospice Home Care Teams presents a process to analyze these factors so that hospice programs can determine the staffing ratios that are appropriate for their hospice. Through the application of a systematic process grounded in critical thinking, the Guidelines also offers hospices with a mechanism to validate staffing caseload numbers that work best for their specific circumstances.

These guidelines differ from the previously published staffing ratios in that recommended ranges for caseloads are not provided. Instead, using the analysis process delineated in Guidelines, each hospice may determine an ideal caseload number for each discipline, with the understanding that day-to-day variation can be expected due to the changeable and unpredictable nature of hospice operations.

The Staffing Guidelines for Hospice Home Care Teams is divided into the following six sections:

I. **Preparation**

This section describes the NHPCO National Summary of Hospice Care focusing on specific statistics, along and other hospice operational factors to review before beginning the staffing analysis process. There are four steps to this section:

- Review the National Summary of Hospice Care tables (see Appendix) and compare current staffing caseloads to national statistics
- Review the description and table of Care Model Factors to Consider for Staffing Caseloads
- Review the list of Other Factors To Consider for Staffing Caseloads
- Review examples of completed Worksheets 1 and 2 for three hospice programs.

II. **Analysis**

The analysis section includes instructions that outline the specific steps to complete the worksheets using statistics and information provided for Care

Delivery Model Factors and the Other Factors. Complete the analysis to determine whether you should consider staffing caseloads that are smaller or larger than national norms, based on how your hospice's organizational characteristics compare to national norms and the how other organizational and environmental factors apply to your hospice.

- Groundwork – assemble your hospice's data and compare your current staffing caseloads to national caseload statistics
- Worksheets in this section to complete the analysis process:
  - Worksheet 1: Factors Associated with Care Delivery Models and
  - Worksheet 2: Other Factors to Consider for Staffing Caseloads

III. Evaluation

This section describes the importance of ongoing evaluation and includes a discussion of the Quality Assessment and Performance Improvement process (QAPI), the Family Evaluation of Hospice Care (FEHC), and other performance measurement tools that can be used in the evaluation process. Action steps for the evaluation process are provided.

IV. Hospice Program Examples

V. Glossary of Terms

VI. Appendix

The Appendix includes the most recent staffing and caseload information from the National Summary of Hospice Care. The Appendix will be updated yearly when the annual National Summary is released.

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Section I. Preparation

No research exists that provides evidence for the optimal staffing caseloads that can be linked to producing quality care. Therefore, the starting point used for the staffing caseloads analysis is a review of the sections of the **National Summary of Hospice Care** that are relevant to staffing, including the median statistics for patient caseloads for the various disciplines.

The National Summary, published annually by NHPCO, presents the two most recent consecutive years for which data are available. The National Summary statistics reflect current practice at the national level and provide a means for comparison to what other hospices are doing. This means that the statistics in the National Summary provide a picture of "what is" rather than ideal or recommended staffing caseload numbers.

NHPCO National Summary of Hospice Care

The National Hospice and Palliative Care Organization's **National Summary of Hospice Care** contains comprehensive national estimates and statistical trends for the multiple areas of hospice care. The tables from the National Summary that include staffing and caseload information used in the analysis are reproduced in the Appendix. The full National Summary report can be accessed from the NDS page of the NHPCO website.

The primary source of the information presented in the National Summary is data provided by members who participate in NHPCO's *National Data Set*, a comprehensive annual survey supported by many state hospice organization partners. To produce the National Summary, National Data Set (NDS) data are supplemented by data from NHPCO's membership database, state-mandated surveys, and the CMS Provider of Services file, as well as Medicare cost data.

It is important to keep in mind that the data presented in the National Summary are descriptive only, are illustrative of what hospices are currently doing, and do not represent "best practice." In addition, because multiple data sources are utilized and sometimes combined in calculating the statistics presented, the number of hospices contributing data (N in the tables) can differ considerably across and within sections. Consequently, results based on data from a smaller number of hospices may not be as representative as those with a larger N.

- **Staff Management Statistics (Table 14)** The Staff Management table presents the most current patient caseload statistics. These statistics are used as the baseline for adjusting caseload numbers. The median is the more representative and stable statistic. Therefore the median - rather than the mean - is the statistic that should be used for caseload baseline comparison.

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Step 1: Review National Summary of Hospice Care tables (See Appendix):

- Staff Management (Table 14)
- Length of Service (Table 7)
- Level of Care (Table 9)
- Paid Staff Distribution (Table 11)
- Turnover (Table 11)

Step 2: Review Factors Associated with National Summary of Hospice Care Statistics and Care Model Characteristics

The analysis includes care delivery model characteristics that have been identified as key factors that should be considered in estimating staffing caseloads. Some of the factors have median, mean/average, or percentage data reported in the National Summary of Hospice Care (e.g., length of service, staff turnover rate). Other factors may either be present or absent (e.g., a hospice either utilizes a dedicated inpatient unit or it does not).

The care model factors were chosen because of their potential influence on staffing caseloads. The Analysis section of the Guidelines delineates the nature of this influence for each factor. In carrying out the analysis, you evaluate the care model characteristics of your hospice compared to the information provided for each factor. Based on this comparison, you may consider adjusting caseloads for staff in the direction (smaller or larger) indicated.

The factors are categorized under three major hospice characteristics including length of stay, staffing model, and organization model. The table below lists the care delivery model factors used in the analysis for determining staffing caseloads.

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Care Model Factors to Consider for Staffing Caseloads

Length of Service Characteristics	Staffing Model Characteristics	Organization characteristics
Short Length of Service (LOS): % <7 days (Table 7)	Admission Model (See Glossary)	Percent of routine level of care (Table 9)
	On Call Model (See Glossary)	Access (Concurrent Care Model)
	RN/LPN Model (See glossary)	Aide/Homemaker utilization (Table 11)
	Shared Team Model (See Glossary)	Use of ancillary services (See Glossary)
	Bereavement Model (See Glossary)	
	Staff turnover rate (Table 11)	

A note on Acuity

While it would be ideal to compare caseloads based on level of patient acuity, currently there is no validated instrument in common use by hospices that would allow for such a comparison. Some of the following factors were chosen as surrogates of acuity, such as:

- **Higher percentage of short LOS patients**: A hospice that has a higher percentage of short length of service (LOS) patients, compared to the national average, could be considered to have a patient caseload that has higher than average acuity. Evidence exists indicating that the intensity of services provided in the first and last week or two of service may be higher than in the interim period, and patients who die within one week are generally more resource intensive, with higher acuity than patients who live for longer periods of time.

- **Lower percentage of routine home care patients**: A hospice that has a lower percentage of routine level of care patients than the national average (and thus a higher percent of patients at a general inpatient level of care or receiving continuous care at a

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higher rate) could be considered to have a patient population with a higher than average acuity level.

- **ACCESS (ADMISSION OF PATIENTS RECEIVING DISEASE-MODIFYING THERAPIES)**: A hospice that admits patients who are receiving disease-modifying therapies may have a patient population in need of higher intensity of services. For example, if patients remain on disease modifying therapy, they may require close monitoring and intensive treatment for side effects of therapy (e.g. cancer patients on chemotherapy), or have interventions requiring frequent monitoring and increased levels of expertise with invasive technology (e.g., patients on ventilators).

  Some of the **Other Factors to Consider for Staffing Caseloads,** discussed below in Step 3, are also surrogate markers for acuity when they impact the entire hospice service area. Examples include:

  - Psychosocial issues of high complexity (e.g., a hospice specializing in serving patients with AIDS; a hospice with a high proportion of pediatric patients); and
  - Staff safety issues (e.g., a hospice situated in a high crime area)

Step 3: Review the Other Factors to Consider for Staffing Caseloads

Other Factors that are more difficult to quantify may also impact the staffing caseload for one or more disciplines, and should be carefully considered when making adjustments to caseloads. Below is a list of common major factors that may influence caseload estimation. The list is not intended to be all inclusive; individual hospices may encounter other influential factors specific to their situation.

NOTE: the factors are **not** listed in order of importance.

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Other Factors to Consider for Staffing Caseloads

1. **Pattern of Utilization of Continuous Care:**
Does your hospice utilize continuous care for patients with complex care needs (e.g., management of uncontrolled symptoms)?

- Some hospices utilize continuous care for patients with complex care needs (e.g., for management of uncontrolled symptoms) more frequently than other hospices and thus may be able to support a higher than median caseload for the interdisciplinary team (IDT). However, this may be mitigated for the home care nurse case manager because of the supervisory responsibilities inherent in provision of continuous care.
- A hospice that relies more on the primary care team, volunteers, or transfer to a general inpatient level of care to meet complex patient/family care needs may find caseloads at or below the median to be optimal.

2. **Pattern of Utilization of General Inpatient (GIP) Level of Care:**
Does your hospice have a dedicated inpatient unit(s) that can be readily accessed for GIP level of care for patients with complex symptom management?

- Hospices with dedicated inpatient units, which are easily accessible to patients and families, may utilize transfer to a GIP level of care for patients with complex symptom management needs more frequently. This shift of more high intensity patients to units staffed by hospice personnel, rather than having complex care provided at home, may enable utilization of a caseload above the median for the home nurse case manager.

Does your hospice rely on contract beds for GIP?

- Hospices that rely solely on contract beds for GIP may find that a lower than median caseload for homecare nurse case managers and social workers is appropriate due to increased intensity and frequency of visits and care coordination.
- Lower than median caseload for the IDT members may be appropriate if the hospice is in a region with less convenient access to GIP and consequently must manage complex patients in the home setting.
- The degree of utilization of the GIP level of care (number of GIP days) may also be a consideration, with higher GIP utilization indicating lower caseload numbers.

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3. **MULTIPLE ROLES FOR THE IDT:**
Do IDT members routinely function in multiple roles in addition to being core team members?

- Lower than median caseload may be appropriate for those IDT members who have additional roles such as teaching/mentoring other staff or health professionals in training or involvement in research activities.

4. **FACILITY-BASED VARIABLES (ROUTINE HOME CARE):**
Does your hospice have a high percentage of patients who reside in a facility? Are your facility based patients spread out in multiple facilities? Do you have a dedicated facility-based home care team?

- Hospices with a high percentage of patients who reside in a facility, that do not have a dedicated facility-based homecare team†, or who have patients spread out in multiple facilities, may need a lower than median caseload for the IDT members.
- Hospices with a concentration of patients in one facility and/or that have dedicated facility-based homecare teams may be able to utilize a higher than median caseload. However, also take into consideration that maintenance of a good relationship with a facility requires constant effort to communicate collaboratively, ongoing education for facility staff (which generally have a high turnover rate), and additional time and effort to communicate with families who may not be present during hospice staff visits to patients.
- A greater time commitment on the part of the hospice core interdisciplinary may be required to assure regulatory requirements for hospice care in skilled nursing facilities is met. Consequently, hospices with a high concentration of patients in skilled nursing facilities may need to utilize a lower than median caseload.

5. **PRIMARY CARE TEAM MODEL†:**
What does your hospices Primary Care Team Model look like?

- Some hospices utilize staff other than the primary nurse to handle patient calls during routine business hours and problem solve over the phone before referring calls to the primary nurse. If staff other than the primary nurse handle patient calls during routine business hours before referring calls to the primary nurse, the nurse case manager may be able to support a higher than median caseload.
- If office-based staff are utilized other than the primary IDT to triage patient calls during routine business hours, all IDT staff may be able to carry higher than median caseloads.

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6. Provision of Community Services:
What are the expectations for IDT staff in provision of community outreach service?

- Less than median caseloads for IDT members, such as social workers and chaplains, may be appropriate if core IDT members routinely provide services to the community such as crisis outreach and bereavement services to non-hospice individuals.

7. Psychosocial Issues:
Does your hospice have a high proportion of patients and families with complex psychosocial issues? Or a high proportion of patients who live alone?

- Hospices with a high proportion of patients and families with complex psychosocial issues (e.g., hospices specializing in serving patients with AIDS), or a high proportion of patients who live alone, may consider utilization of lower than median caseloads for IDT members.

8. Rate of Growth
Is your hospice growing rapidly?

- Lower than median caseload for the IDT members may be needed to maintain provision of quality care and manage the additional patients and multiple admissions that occur during growth spurts.

9. Specialty Programs:
Does your hospice utilize disease, condition, or treatment specific programs?

- Hospices that utilize specialty/ disease specific programs may be able to support a higher than median caseload for some staff, if teams providing specialty care relieve other core staff from providing direct care to the specialty patient population.
- A lower than median caseload for staff providing care in the specialty/disease specific program may be appropriate, if intensity of services or monitoring is increased.
- Hospices that utilize dedicated staff to manage specific aspects of a patient’s illness (for instance, pressure ulcers managed by a clinical nurse specialist in wound care, or intravenous therapy managed by an intravenous therapy nurse specialist) may be able to have homecare nurse case-managers carry a higher than median caseload.

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10. Spiritual Care Support Model:
What does your spiritual care support model look like?

- A higher than median caseload for hospice chaplains may be appropriate for hospices that routinely utilize community clergy to provide direct services to most patients. However, this may be mitigated by the greater outreach and education efforts hospice chaplains may need to employ in this circumstance.
- A lower than median caseload for chaplains may be appropriate for hospices whose chaplains are routinely heavily involved in providing or participating in funeral and memorial services for their patients who have died.

11. Staff Safety Issues:
Does your hospice provide services in high crime areas?

- Hospices that provide services in high crime areas may need to utilize a lower than median caseload for their IDT members, because IDT members may need to do joint visits for safety reasons which results in less efficient use of staff time.

12. Travel Time Issues:
How much travel is involved for your IDT members?

- Hospices may need to utilize lower than median caseloads for the IDT members if an inordinately long time is necessary for between-visit travel.
- Travel time may be lengthened for a number of reasons such as high absolute square mileage of service area per team, traffic congestion in urban/suburban areas, etc.
- Travel time is a particularly important factor for determining caseloads for “frontier” hospice providers, because hours may be required between visits for travel.

13. Volunteer Utilization:
How are your volunteers used?

- A higher than median caseload may be appropriate for hospices that effectively use well-trained patient volunteers.
- However, the time needed for close supervision and support of the volunteers may offset advantages of volunteer use to some degree.

† See Section V, Glossary of Term

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SECTION II: ANALYSIS PROCESS

The purpose of this section is to help each hospice provider estimate the optimal staffing caseload for their program based on an analysis of their care delivery model and other factors specific to their situation. Once the staffing caseload has been estimated using the worksheets provided, an individual hospice can evaluate whether or not these caseloads effectively produce the outcomes and results that the hospice desires.

Analysis Instructions

GROUNDWORK

STEP 1: Assemble your hospice's data including:

- staffing caseloads
- average length of service (LOS)
- staff turnover rate
- percent routine level of care (LOC)
- percent of hospice aides FTE's (compared to total clinical staff FTE's)

STEP 2: Compare your current staffing caseloads to national caseload statistics.

- Locate the NHPCO **National Summary of Hospice Care**, Table 14: Staff Management (see Appendix).
- Compare your current discipline-specific staffing caseloads to the median† statistics for caseloads reported in the Staff Management table.
- How do the caseloads you are currently using compare to the median statistics for caseloads in the table? Note whether your hospice's caseloads are the same or how far above or below the national median statistics for each discipline.

STEP 3: Review symbols in the key below which are utilized in the analysis to indicate direction of possible adjustment of staffing caseloads.

- **[+]** Indicates the possible ability to sustain higher than median caseload
- **[-]** Indicates the possible need to assign lower than median caseloads
- **[=]** Indicates neutral impact of factor on caseload, so likely ability approximates median
- **[+/-]** Indicates directionality may be in either direction for a particular factor
- **[?]** Indicates unknown impact of factor on caseloads

STEP 4: Review the hospice program examples.

Section IV includes completed worksheets and analysis summaries for three sample hospices. Reviewing these examples prior to beginning your own analysis will reinforce your understanding of the analysis process and expedite completion of the worksheets.

ANALYSIS

STEP 1: Begin the analysis using **Worksheet 1** by locating the column labeled "**FACTOR**" in the worksheet. (Column 1)

STEP 2: Locate the comparative data from the National Summary of Hospice Care for the relevant factors (see Appendix):

- LOS (Table 7)
- staff turnover rate (Table 11)
- percent of routine level of care (Table 9)
- percent hospice aide FTE's (Table 11)

STEP 3: Utilizing the (+) or (-) or (=) symbols as described in the key, for each factor listed:

- Compare your hospice's data with the comparable statistic in the National Summary of Hospice Care table or factor description
- Decide whether your hospice would fit in the category: **Consider smaller caseload than NDS Median [-]** (second column in the worksheet); or **Consider larger caseload than NDS Median [+]** (third column in the worksheet).
- Fill in appropriate symbol [(+) or (-) or (=)] in the column marked "**OUR HOSPICE**" (fourth column on the worksheet).
- If there are any extenuating circumstances or clarifications that help explain the reasoning behind your choice for any factor, write them in the fifth column, marked "**COMMENTS**."

STEP 4: Proceed to **Worksheet 2.**

STEP 5: Locate the list titled **OTHER FACTORS TO CONSIDER FOR STAFFING CASELOADS** in Section I, page 10.

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Step 6: Using the descriptions provided for each factor, determine in which direction these factors may influence your caseloads based on how the factors apply to your hospice.

- Mark the estimated caseload direction [+] or [-] in column 2 "**OUR HOSPICE**" for each factor in the **Other Factors** list.
- Fill in any clarifying explanations in column 3 "**COMMENTS**" for each factor.

Step 7: Estimate staffing caseloads.

- Review entries for each factor from **Worksheets 1 and 2** .
- Tally the number of [+] and [-] symbols in the "**OUR HOSPICE**" columns. How many factors fall in the [+] category (consider larger than NDS median caseload) versus the [-] category (consider smaller than NDS median caseload)?
- Where does the preponderance of factors lie for your hospice? [+] or [-]? Did you analysis yield more [+] or [-] symbols?

Step 8: Evaluate the results of the analysis.

- Locate the comparison of your current staffing caseloads to the median statistics for caseloads reported in the Staff Management Table that you performed in Step 3 of Preparation.
- Are the results of this comparison consistent with the [+] [-] results of the analysis?
    - If yes, and your performance measure scores related to staffing are satisfactory, then your current staffing caseloads are probably appropriate
    - If not, give consideration to the reason(s) the two results are different. Can the difference be attributed to one or more factors that are especially important to your situation? Or, perhaps your hospice would be better served by a model with a staffing caseload in the direction of the preponderance of factors.

NOTE: There are currently no data upon which to base a relative weighting of the impact of each factor on staffing requirements.

The plus/minus rating system treat all factors as though they have the same level of importance for all hospices. However, not all factors will have the same level of importance for all hospices. Each hospice will need to assess whether a particular factor is especially important for their specific situation. For example, a frontier hospice routinely requires between-visit travel times of longer than an hour and may want to weight travel time more heavily than the other factors after tallying the pluses and minuses in the analysis.

† See Section V, Glossary of Terms

Worksheet 1

Factors Associated with Care Model

FACTOR	Consider smaller caseload than NDS Median [-]	Consider larger caseload than NDS Median [+]	OUR HOSPICE	COMMENTS
Length of Stay				
Short Length of Service (LOS) (% Discharges 1-7 days) **[Table 7]***	Percent (%) is Above mean [-]	Percent (%) is Below mean [+]		
Staffing Model				
Admission Model	Does not use admission specialist [-]	Uses admission specialist [+]		
On Call Model	Does not use dedicated on call staff [-]	Uses dedicated on call staff [+]		
RN/LPN Model	Not in use [-]	In use [+] (for the RN case manager only)		
Shared Team Model	Not in use [-]	In use [+] (for RN case manager only)		
Bereavement Model	IDT performs bereavement [-]	Dedicated bereavement staff [+]		

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Staff turnover rate **[Table 11]***	Above mean percent[-]	Below mean percent[+]		
Organizational Model				
Percent of routine level of care **[Table 9]***	Below average % [-]	Above average % [+]		
Access	Disease-modifying therapy included as a covered service in the hospice plan of care (i.e., chemo/XRT) [-]	Disease-modifying therapy not included as a covered service in the hospice plan of care [+]		
Aide/Homemaker delivery model **[Table 11]***	Home Health Aide distribution of home hospice FTE below mean percent[-]	Home Health Aide distribution of home hospice FTE above mean percent[+]		
Use of ancillary therapy e.g. art, massage, music, PT/OT	Not emphasized [-]	Actively encouraged [+]		

* See Appendix.

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Worksheet 2

Other Factors to Consider for Staffing Caseloads

(Refer to narrative descriptions of OTHER FACTORS in Section I, Page 10)

FACTOR	OUR HOSPICE	COMMENTS
GIP and Continuous Care variables		
Multiple non-core roles for IDT		
Facility-based variables (routine home care)		
Primary Care Team Model		
Provision of community services		
Psychosocial Issues: high social complexity		
Rate of growth		
Specialty programs		
Spiritual Care Support Model		
Travel Time: increased		
Volunteer Utilization		
Staff-safety: require multiple staff or escorts/visits		
Other		

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Summary of Analysis

SECTION III: EVALUATION PROCESS

Examining the major factors that affect staffing caseloads is only the initial stage in setting staffing caseloads. Any staffing matrix that is implemented must then be evaluated on an ongoing basis to ensure that the needs of patients and families are met, that staff are able to perform at an optimal level, and that quality outcomes are achieved.

The Quality Assessment and Performance Improvement (QAPI) process should be used to identify challenges which may be related to staffing caseloads, to plan an intervention (e.g., change in staffing caseload for a particular discipline), to implement the intervention, to evaluate the impact of the change, and, if the change has had a favorable impact, to institute the intervention as standard practice and monitor periodically to assure that quality gains have been maintained.

It is recommended that hospices routinely compare their performance using appropriate performance measurement tools such as those described below, to determine if scores related to meeting patient/family needs are maintained or improve after making changes in staffing caseloads.

- **Staff Satisfaction:** To validate that the caseloads implemented do not cause undue stress on homecare staff, the hospice may consider monitoring and comparing **staff turnover** rates for any adverse changes, or compare its **STAR** survey results (or other nationally known and used measure of staff satisfaction) to assure favorable scores in relation to national scores for select items. The STAR is the first systematically developed job satisfaction measure reflecting the unique needs and work environment of hospice care delivery. The STAR covers multiple staff satisfaction domains and has several questions relating to workload, such as #29: "I have a manageable workload." A hospice's scores on STAR pre and post changes in staffing caseloads may serve as an indicator of the impact of a change in caseload on staff. Information about the STAR survey and implementation is available at www.nhpco.org/STAR.

- **Quality Partners Self-Assessment:** Hospices may find items in the NHPCO Quality Partners Self-Assessment (SAS) that could be useful in monitoring the impact of changes on staffing caseloads. For example, the description for Standard PFC7.1 states "The interdisciplinary team members provide services according to the scope and frequency identified in the Plan of Care." The ability to substantially meet this indicator may depend, in part, on staffing caseloads for the members of the interdisciplinary team. Information on the Self-Assessment is available at www.nhpco.org/Quality.

- **Family Evaluation of Hospice Care (FEHC) Survey:** Although satisfaction with care is influenced by a multitude of factors, if a hospice desires to institute a change in staffing caseloads for one or more disciplines, monitoring possible effects of the change on the quality of care by tracking the results of specific questions on the Family Evaluation of Hospice Care (FEHC) survey might prove useful. For example, if Social Worker staffing caseloads are changed, the hospice can monitor changes in scores on

question B10 on the FEHC survey, which asks if the patient got the right amount of help in dealing with feelings of anxiety and sadness. FEHC survey question scores that may possibly be influenced by changing staffing caseloads for one or more disciplines include:

- weekend and evening responsiveness to needs
- the amount of contact related to spiritual support
- the amount of contact related to emotional support
- the degree of symptom control (pain, difficulty breathing, anxiety)
- how well personal care needs (bathing, etc.) are attended to

The FEHC survey and information on administration and reporting for FEHC is available at www.nhpcor.org/FEHC.

Action Steps for Evaluation Process

- Utilize the QAPI process to evaluate the effectiveness of staffing changes undertaken following the completion of a Staffing Guidelines analysis.
  - What was the impact of the change on measures of patient outcomes, patient and family satisfaction, &/or staff satisfaction?
  - What was the impact on program efficiency and cost-effectiveness?

- Repeat your Staffing Guidelines analysis at an appropriate interval after instituting caseload changes, and continuously monitor your hospice's comparative performance on performance measurement tools such as the FEHC and the STAR, as well as using your other program quality measures to assure continued high quality patient care and high levels of staff performance and well-being.

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SECTION IV: HOSPICE PROGRAM EXAMPLES: HOSPICE HOMECARE STAFFING GUIDELINES ANALYSIS FOR HOSPICES A, B, & C

KEY
[+] Indicates the possible ability to sustain higher than median caseload
[-] Indicates the possible need to assign lower than median caseloads
[=] Indicates neutral impact of factor on caseload, so likely ability approximates median
[+/-] Indicates directionality may be in either direction for a particular factor
[?] Indicates unknown impact of factor on caseloads

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FACTOR	Consider smaller caseload than NDS median [-]	Consider larger caseload than NDS median [+]	Hospice A Census: 0-50 ADC In start-up phase	Hospice B Census: >100 Shared-team model	Hospice C Census: >500 ADC Established hospice
Length of Stay Characteristics					
Short Length of Service (% Discharges 1-7 days) [**Table 7**]*	Above mean % [-]	Below mean % [+]	5% above mean [-]	Above mean [-]	6% below mean [+]
Staffing Model Characteristics					
Admission Model	Does not use admission specialist [-]	Uses admission specialist [+]	Does not use admission specialists [-]	Uses admission specialists [+]	Uses admission specialists [+]
On Call Model	Does not use dedicated on call staff [-]	Uses dedicated on call staff [+]	Does not use dedicated on- call staff [-]	Uses dedicated on-call staff [+]	Uses dedicated on-call staff [+]
RN/LPN Model	Not in use [-]	In use [+] (for the RN case manager)	Not in use. LPN's used for cont. care [-/+]	Not in use. LPN's for cont. care [-/+]	1 LPN per 4 RN's [+]
Shared Team Model	Not in use [-]	In use [+] (for RN)	Not in use [-]	In use, RN carries higher caseload [+], SW & chaplain carries lower caseload [-]	Not in use [-]

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Bereavement Model	IDT performs bereavement [-]	Dedicated bereavement staff [+] (for core IDT members other than bereavement)	Dedicated bereavement staff [+]	Dedicated bereavement staff [+]	Dedicated bereavement staff [+]
Staff turnover rate **[Table 11]***	Above mean % [-]	Below mean % [+]	Below mean [+]	Below mean [+]	Below mean [+]
Organization Characteristics					
Percent of routine level of care **[Table 9]***	Below average % [-]	Above average % [+]	Above average [+] 98%	Below average [-] 94%	Above average [+] 97%
Access	Disease-modifying therapy included as a covered service in the hospice plan of care (i.e., chemo/XRT) [-]	Disease-modifying therapy not included as a covered service in the hospice plan of care [+]	Covers disease-modifying therapy [-]	Covers disease-modifying therapy , has palliative home care program, & palliative consults [-/+]	Covers disease-modifying therapy on a case-by-case basis[-]
Aide/Homemaker delivery model **[Table 11]***	Home Health Aide distribution of home hospice FTE below mean % [-]	Home Health Aide distribution of home hospice FTE above mean % [+]	8 % above mean [+]	2 % above mean [+]	10% above mean [+]
Use of ancillary therapy, e.g. art, massage, music, PT/OT	Not emphasized [-]	Actively encouraged [+]	Encourages use of PT/OT/massage, music therapy [+]	Strong Complementary therapy program [+]	Not emphasized [-]

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Other Factors to Consider for Homecare Staffing Caseloads

FACTOR	Hospice A	Hospice B	Hospice C
Utilization of GIP and Continuous Care	16 bed GIP unit/ readily available NH beds. Routinely uses continuous care, has dedicated team [+]	Readily available contracted beds Routinely uses continuous care [+]	10 bed GIP unit/readily available contracted beds. Uses continuous care off and on [+]
Multiple non-core roles for IDT	Have dedicated staff preceptors. IDT available for shadowing during training [+]	IDT available for shadowing during training. No internships from outside agencies yet. [=]	Dedicated staff preceptors. IDT available for shadowing during training. [+]
Facility-based variables (routine home care)	22% NH census (= median). No separate NH team. [=]	18% NH census (<mean). No separate NH team [?]	34% NH census (>mean). No separate NH team. [+]?(depends on if concentrated in few facilities or scattered through many facilities)
Primary Care Team Model	Utilizes middle managers to triage calls during routine work hours [+]	Primary RN's triage calls during routine work hours [-]	Utilizes SW & SCC in shared team model to triage calls during routine work hours [+] (for nursing)
Provision of community services	Dedicated bereavement staff [+]	Dedicated bereavement staff [+]	Dedicated bereavement staff [+]
Psychosocial Issues: high social complexity	Not felt to be an issue [=]	Not felt to be an issue [=]	Not felt to be an issue [=]
Rate of growth	3% last year (felt to be manageable) [=]	Just developing. [-]?	12% last year (felt to be manageable) [=]
Specialty programs	No specialty disease programs [=]	None as of yet [=]	Cardiac hospice program, developing pulmonary hospice program. Separate palliative home health care team. [+]

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Spiritual Care Support Model	Some community clergy involvement. Some provision of funerals and memorials by hospice chaplains. [+/-]	Some community clergy involvement. Some provision of funerals and memorials by hospice chaplains. [+/-]	Some community clergy involvement. Some provision of funerals and memorials by hospice chaplains. [+/-]
Staff safety: require multiple staff or escorts/visit	Minimal safety issues [=]	Minimal safety issues [=]	Minimal safety issues [=]
Travel time: increased	Not an issue [=]	Some rural areas, increased travel time [-]	Some rural areas, increased travel time urban areas [-]
Volunteer utilization	Effectively use volunteers. 6-7% of staff hrs. [+]	22% volunteer y-t-d. Starting a volunteer vigil program [+]	5.1% volunteer vigil program [+]?

* Appendix ***National Summary of Hospice Care*** **Tables**.

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Hospice A - Census: 0-50 ADC

RN: 10-12 [=]; SW: 30 [=]; Chaplain: 40 [-]; Aide: 10 [=]

- Hospice A is in the start-up phase, and IDT staff do tasks such as on-call and admissions that are done by dedicated staff in other hospices and has an above mean % of short LOS patients (i.e., patients have a shorter LOS).
- This would seem to indicate that hospice A should support less than the median caseload. However, Hospice A also encourages the use of ancillary services such as PT/OT, massage and music therapy, which might lean in the direction of supporting a caseload greater than the median.
- In addition, LPN's are available for continuous care, which helps the nurse case manager manage a caseload with shorter stay patients and turnover.
- Hospice A decides on a median caseload for its primary care nurse, SW and Aide staff. Chaplain caseload is slightly below the median due to low census, but shorter length of stay patients require more frequency of visits for SCC and SW. The Chaplain caseload is expected to increase with increasing census to ~50 (with the expectation that not all patients/families desire visits from the hospice chaplain).

Hospice B - Census: >100

RN: 18-22 [↑]; SW: 18 [↓]; Chaplain: 36 [=]; Aide: 18 [↑]

- Hospice B has a unique model of care delivery, the shared team model.
- Although the nursing caseload is 50% or higher than the national median, the SW caseload is 50% less than the national median.
- In addition, Hospice B has many characteristics that would predict the ability for nursing staff to maintain a higher than median caseload, with dedicated services for admission and on-call, and availability of complementary services. The social worker and chaplain take routine calls during working hours, freeing the primary RN to perform patient care.
- The impact of admitting patients on disease-modifying therapy on staffing requirements may be mitigated by the availability of a palliative home care program and palliative consult services.

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Hospice C - Census: >500 ADC

RN: 15-18 [↑]; SW: 25-27 [=]; Chaplain: 60-70 [↑↑]; Aide: 12-14

- Given that Hospice C has a large number of factors associated with the probable ability to sustain a nursing caseload above the median, Hospice C decides on a caseload for its primary nurse case managers of 15-18/RN. The SW caseload is at the median. Home Health Aide is above the median, however, continuous care teams help reduce intensity for aides.
- Staff turnover is below the mean.
- Chaplain potential caseload is twice the median. However, chaplains are not actively visiting all patients. Hospice C decides to analyze the adequacy of its chaplaincy services in more depth to assure spiritual needs of patients and families are being met.

Summary

Analyzing factors that affect staffing caseloads only provides a starting point for planning. Any staffing matrix that is implemented must then be evaluated in an ongoing fashion to be sure the needs of patients and families are met and that staff are able to perform at an optimal level.

To validate that these caseloads allow staff to meet the needs of the patient population served each hospice should routinely examine their performance on performance measurement tools, and monitor changes in scores that may be attributed to changes in staffing caseloads.

To validate that these caseloads do not cause undue stress on caregiving staff, Hospice A, B and C could continue to monitor and compare staff turnover rates for any adverse changes, and scrutinize items on staff satisfaction instruments such as the STAR that may be impacted by changes in staffing caseloads before and after initiating the staffing caseload changes.

If any of the above indicates less than optimal outcomes for one or more of the hospices, that hospice should consider engaging in a QAPI process for determining staffing caseloads that best meet the needs of patients and families, while allowing staff to operate at peak levels.

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Section V. Glossary of Terms

Ancillary Therapy (or Allied Therapy): Services provided by health professionals who are not usually a part of the core interdisciplinary team. This includes therapies mandated to be available to patients and families by Medicare, such as physical, occupational, and speech therapy, as well as therapies that are not mandated, such as music therapy, massage therapy, art therapy, therapeutic touch, yoga, etc. The therapists may be available by contract, or may be employees of the hospice. The extent to which these therapies are employed by the hospice is determined by both patient/family need, as well as philosophy of care of the individual hospice. If the hospice encourages high utilization of ancillary therapies, the core team may be able to carry a higher caseload, since the patient's/family's needs are being met by multiple disciplines other than the core team.

Caseload:

- **Mean Caseload:** The mathematical average when combining caseloads reported by all hospices and dividing by the number of hospices. The mean is also known as the average. (This value can be skewed by a small # of outliers.)
- **Median Caseload:** The middle caseload, above and below which lie an equal # of caseloads listed by the various hospices.
- **25th Percentile:** the caseload at which ¼ of hospices have a caseload less than this # (¾ have a caseload higher).
- **75th Percentile:** The caseload at which ¼ of hospices have a caseload higher than this # (¾ have a caseload lower).

Facility-Based Homecare Team: Dedicated home care interdisciplinary team that serves patients residing in facilities such as skilled nursing facilities, assisted living facilities, residential facilities, group homes, etc.

Staffing Model: The various ways that the work of hospice can be divided among core and specialty teams, e.g.:

- **Admission Model:** Many hospices have found that designating a separate interdisciplinary team that may consist of at least an RN, and possibly other disciplines, to perform the admission assessment is less disruptive to the core interdisciplinary team workflow, and improves access by making admissions more timely for patients and families. Some hospices even utilize non-clinical staff to guide the patient and family through the admission paperwork process.
- **On-Call Model:** Many hospices have hired dedicated health professional staff, at a minimum, nursing staff, other than the assigned core interdisciplinary team to respond to patient and family needs after business hours and on weekends. Dedicated on-call services can be configured differently, with some utilizing separate **Phone Triage** staff to field patient and family telephone calls, problem solve telephonically, and deploy **field on-call nurses** to visit the home as needed for problems that cannot be solved over the phone. Other hospices will use the on-call nurse to both do telephone triage and visits. Some hospices have interdisciplinary members of the core interdisciplinary team "take call" during nights and weekends on a rotating basis. Nurses are usually more heavily impacted during after-hours

on call than other members of the interdisciplinary team. The ratio of on-call staff to numbers of hospice patients covered will impact work intensity. Day-time duties of core staff who take call will need to be adjusted to accommodate the increased demands of being on-call.

- **RN/LPN Model:** Some hospices use a model of nursing care where patient home visits as specified on the plan of care are shared between the RN Case Manager and an LPN who is partnered with him/her. The LPN may be assigned to more than one RN Case Manager. The LPN performs nursing visits to patients, as determined by the RN Case Manager. Since the RN Case Manager shares the patient visits with the LPN, the RN Case Manager may be able to carry a larger caseload than he/she would if the patient visits were not shared.
- **Shared Team Model:** Some hospices designate other non-nurse members of the core interdisciplinary team to triage patient/family calls during business hours, thus lightening the call load for the nurse case manager. With fewer distractions due to interrupting calls, the nurse case manager may be able to complete home visits more efficiently than if he/she were constantly being interrupted during patient visits to answer calls from other patients and families. Some hospices actually use nurse managers who are not in the field to answer patient and family calls during the day, and problem solve telephonically in much the same way the after-hours on call triage nurse would.
- **Bereavement Team Model:** Many hospices have dedicated bereavement teams consisting of professionals and volunteers to do bereavement follow up for families whose loved ones have died in the program. If the primary home care team does not have to do formal bereavement follow up, this is less disruptive to their work caring for patients who are still alive.
- **Spiritual Care Support Model:** Hospices differ in the way in which they meet the spiritual needs of patients and families. Some hospices expect the core team chaplain/spiritual counselor to visit all patients on the team, unless chaplain services are specifically declined. Some hospices arrange chaplain/spiritual counselor visitation at the specific request of the patient and family. Other hospices rely on the patient's faith community to provide primary spiritual care with support and guidance from the hospice core team chaplain. The characteristics of how spiritual support is provided to patients and families will impact the caseload of the hospice chaplain/spiritual counselor.
- **Specialty Teams:** Some hospices have formed interdisciplinary teams around specific conditions in order to meet the unique patient/family needs of a specific population. For instance, some hospices have designated specific interdisciplinary teams to care for dementia patients, or patients with end-stage cardiac disease, or end-stage pulmonary disease. The members of the team often have additional competencies related to that disease category in addition to competencies related to hospice and palliative care. The intensity of the care needs of the patients in a specific disease category and the types of therapy, including potentially disease-modifying therapy, will impact the optimal staffing caseloads for these team members. In addition to specialty teams formed around specific diagnoses, some hospices have staff with extra competency in certain care areas, such as a nurse specialist in wound/ostomy care, or a specialist in placing and managing intravenous therapy.

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Appendix

The following tables are taken from the **NHPCO 2011 National Summary of Hospice Care**. For the complete National Summary of Hospice Care report, go to www.nhpco.org/nds.

TABLE 7. LENGTH OF SERVICE

		Percentile			
	Agency Mean	25th	50th (median)	75th	N
Average LOS	69.1	53.0	65.0	81.9	686
Median LOS	19.1	12.0	16.0	22.0	664
% Discharges w/ LOS 1 to 7 days	35.8%				266

TABLE 9. LEVEL OF CARE

Level of Care	Percent of Patient Days	N
Routine Homecare	97.1%	880
General Inpatient care	2.2%	828
Continuous Care	0.4%	857
Respite care	0.3%	870

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TABLE 11. PAID STAFF DISTRIBUTION AND TURNOVER

Distribution of Home Hospice FTEs	Agency Mean	N
Clinical (direct patient care)	66.3%	360
Nursing	30.2%	356
Nurse Practitioner	0.6%	306
Hospice Aide	18.8%	356
Social Services	8.7%	356
Physician (excluding volunteers)	2.9%	346
Chaplain	4.3%	328
Other Clinical	1.9%	328
Nursing (indirect clinical)	7.2%	354
Non-Clinical (administrative/general)	21.8%	357
Volunteer Coordinator	3.6%	135
Bereavement	4.4%	344
Turnover rate for all staff	23.6%	375

TABLE 14. STAFF MANAGEMENT

		Percentile			
Patient Caseload	**Agency Mean**	**25th**	**50th (median)**	**75th**	**N**
Nurse Case Manager	11.4	10.0	12.0	13.0	472
Social Services	25.9	20.0	25.0	32.0	472
Hospice Aide	11.1	7.0	10.0	14.0	456
Chaplain	37.7	25.0	36.0	50.0	448
Volunteer Coordinator	52.4	18.0	35.0	80.0	331
Medical Director	48.2	14.0	35.0	75.0	293

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