NHPCO Hospice Staffing Framework

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NHPCO
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NHPCO Hospice Staffing Framework

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 optimal staffing became evident. To meet that need, NHPCO and the Quality and Standards and Regulatory Committees undertook the development of NHPCO Hospice Staffing Framework to provide hospices with a method for assessing their organizational staffing needs that aligns with the current realities of providing hospice care.

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 NHPCO Hospice Staffing Framework 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 NHPCO Hospice Staffing Framework utilizes an assessment process to help determine 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 quality outcomes. However, it is important to keep in mind that the primary consideration that should be used by a hospice to determine optimal staffing levels is the hospice's ability to meet the needs of patients and families through appropriate use of resources and achieving the quality and financial goals set by the hospice program.

Introduction to the NHPCO Hospice Staffing Framework

The purpose of this framework is to help each hospice provider assess a number of factors with the potential to impact staffing in order to better determine whether their current staffing framework is appropriate to their organizational needs. 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 appropriate staffing. The NHPCO Hospice Staffing Framework presents a process to analyze these factors so that hospice programs can evaluate their current staffing through the lens of a number of relevant variables and outcomes and determine where there may be a need to adjust staffing resources. Through the application of a systematic process grounded in critical thinking, the framework also offers hospices with a library of current staffing models that may be applicable to their organizational environment.

This framework differs from the previously published staffing ratios and guidelines in that recommended ranges for caseloads are not provided. Instead, using the analysis process delineated in the framework, each hospice may assess a number of variables and outcomes measures to identify whether there are opportunities to better tailor staffing to meet the needs of their organization.

The NHPCO Hospice Staffing Framework is divided into the following four sections:

Section 1. Using the NHPCO Hospice Staffing Framework

This section describes the steps that an organization should take in order to effectively utilize the NHPCO Staffing Framework for Hospice. There are five steps outlined in this section:

- **Review descriptions** of variables and outcome measures
- **Review additional factors** that may impact staffing decisions
- I**nput organizational metrics** into Staffing Framework Tool and compare to benchmarks
- **Determine need** for potential staffing adjustments
- **Review Staffing Models Reference Library** for creative staffing model options

Section 2. Variables, Outcomes, and Benchmarks

This section includes a description of each variable and outcome measure included in the Staffing Framework Tool, as well as an explanation of how to assess organizational metrics as compared to the available benchmarks. For example, for certain indicators an organizational metric below benchmark reference may indicate a need for increased staffing resources, while for other indicators an organizational metric above benchmark reference may indicate a need for increased staffing resources.

Section 3. NHPCO Hospice Staffing Framework Tool

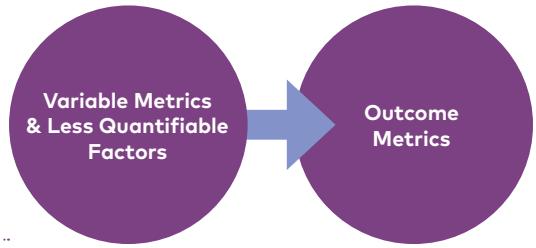
This section includes the NHPCO Hospice Staffing Framework Tool, a fillable document that organizations may complete in order to assess the impact of selected variables and outcomes on their staffing configuration.

Section 4. Staffing Models Reference Library

This section includes a list of staffing models for organizations to explore, including circumstances in which each model may be appropriate to consider.

Section 1: Using the NHPCO Hospice Staffing Framework

This section describes the steps that an organization should take in order to effectively utilize the NHPCO Staffing Framework for Hospice. **There are five steps outlined in this section:**



Step 1 – Review Descriptions of Variables and Outcome Measures

The NHPCO Staffing Framework for Hospice includes several organizational variables and outcome measures for organizations to consider when determining whether staffing adjustments need to be made. While there is no existing validated instrument capable of capturing the complexity of hospice care and determining staffing minimums by discipline, this tool is intended to highlight the multiple factors that organizations should assess when considering their staffing models, such as:

- Higher percentage of short length of stay (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 and higher percentage of GIP/CHC: 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 (GIP) level of care or receiving continuous care (CHC) at a higher rate) could be considered to have a patient population with a higher-than-average acuity level.
- Higher percentage of Open Access patients (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).

Please review the full NHPCO Hospice Staffing Framework Tool for complete variables and outcome measures.

Step 2 – Review Additional Factors that May Impact Staffing Decisions

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. If an organization determines that one or more of these factors impacts their operations, they are encouraged to incorporate the following considerations into their staffing decisions.

- **Psychosocially complex patients:** Hospices that care for a high number of patients with psychosocial issues of high complexity (e.g., a hospice specializing in serving patients with AIDS; a hospice with a high proportion of pediatric and/or young adult patients) may require additional staffing and lower caseloads. For example, hospices specializing in serving:
  - Patients with AIDS
  - Pediatric and/or young adult patients
  - Patients with mental health comorbidities
  - Complex family dynamics
  - Frequent need for translators
  - Diverse spiritual/cultural populations
  - Patients experiencing challenges with social determinants of health

- **Primary team performing CHC:** Hospices that rely on primary team members to implement and perform continuous home care, as opposed to a specialized CHC team, may find that they require additional staffing and lower patient caseloads.
- **Contracted GIP:** Hospices that rely on contract beds for GIP patients may find that a lower caseload for clinical team members is appropriate due to increased intensity and frequency of visits and care coordination.
- **IDT members with multiple roles:** Lower caseloads 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. Lower 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. In addition, organizations in which administrative or leadership staff are frequently called upon to serve in clinical roles, or clinical staff with multiple roles, may choose to implement lower caseloads.
- **High percentage of facility-based patients:** 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.
- **Supplemental/administrative support:** If office-based staff are utilized other than the primary IDT to provide administrative support, such as triaging patient calls, facilitating medication and supply orders, coordinating transportation needs, etc. during routine business hours, all IDT staff may be able to carry higher than median caseloads.
- **Specialty programs:** Hospices that utilize specialty/disease specific programs may be able to support a higher caseload for some staff, if teams providing specialty care relieve other core staff from providing direct care to the specialty patient population. A lower 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 caseload. A lower caseload for IDT members dedicated to serving pediatric patients may be appropriate due to longer visit times and complexity of care, along with additional collaboration with community/outside partners in care.
- **Rapid growth:** Lower caseloads for IDT members may be needed to maintain provision of quality care and manage the additional patients and multiple admissions that occur during growth spurts.
- **Community spiritual support:** A higher 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 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.
- **Staff safety issues:** 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.
- **Travel time:** Hospices may need to utilize lower 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.
- **Volunteer utilization:** A higher 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 the advantages of volunteer use to some degree.

Step 3 – Input Organizational Metrics into Staffing Framework Tool and Compare to Benchmarks

Review the following fillable NHPCO Staffing Framework tool and gather as many relevant organizational metrics as possible. Enter these values into the tool and compare them to the available benchmark references.

The NHPCO Staffing Framework Tool includes a description of each metric, as well as the potential significance of each in order to assist with interpreting the comparison of organizational metrics to benchmarks.

Step 4 – Determine Need for Potential Staffing Adjustments

Based on the comparison of organizational variables and outcomes to benchmarks, as well as a review of the additional factors listed above, organizations should identify whether the majority of their metrics indicate a need for increased staffing or that sufficient staffing is present. There is no specific number of metrics that should fall above or below benchmarks in order to indicate a need to adjust staffing. Using the analysis process delineated in the framework, each hospice should identify whether there are opportunities to better tailor staffing to meet the needs of their organization.

Organizations should first review the full list of variables, followed by analyzing performance on outcomes measures. If the organization is achieving outcomes at appropriate levels, it may be reasonable to forego staffing adjustments even if selected variables are outside of benchmark values.

Step 5 – Review Staffing Models Reference Library for Creative Staffing Model Options

The Staffing Models Reference Library is provided as a snapshot of frequently used staffing combinations that may help to address staffing challenges in a hospice organization. Based on the patterns identified after analysis of the NHPCO Staffing Framework Tool, hospices are encouraged to review the staffing models provided to identify whether any would meet the needs of their organization.

Section 2: Variables, Outcomes, and Benchmarks

This section includes a description of each variable and outcome measure included in the Staffing Framework Tool, as well as an explanation of how to assess organizational metrics as compared to the available benchmarks. For example, for certain indicators an organizational metric below benchmark reference may indicate a need for increased staffing resources, while for other indicators an organizational metric above benchmark reference may indicate a need for increased staffing resources.

Variable metrics are those data points that include aspects of the hospice organizational environment that are subject to change, such as patient census characteristics, admission patterns, and staffing mix. Outcome metrics include data points that result from hospice operations such as quality measures, staff satisfaction data, and financial data.

Each metric includes a brief description as well as an indicator of the significance of organizational performance against the selected benchmark. For example, for certain indicators an organizational metric *below* benchmark reference may indicate a need for increased staffing resources, while for other indicators an organizational metric *above* benchmark reference may indicate a need for increased staffing resources.

Section 3: NHPCO Hospice Staffing Framework Tool

VARIABLE METRICS

Variable	Description	Significance
Acuity		
Median Length of Stay (LOS)	Shorter median LOS often indicates higher patient acuity	Below benchmark may indicate need for additional staffing
% of patients with LOS <5 days	Higher percentage of patients with short length of stay often indicates higher acuity	Above benchmark may indicate need for additional staffing
Patient Mix		
% Hospital Referrals	Higher percentage of hospital referrals often indicates higher patient acuity	Higher percentages may indicate need for additional staffing
% Cancer patients	Higher percentage of cancer patients often indicates higher patient acuity	Above benchmark may indicate need for additional staffing
% patients residing in Nursing Facilities, Skilled Nursing Facilities, and Long-Term Care Facilities	Higher percentage of facility patients may indicate less travel time between patients, and often facility patients have longer length of stay and lower acuity	Below benchmark may indicate need for additional staffing
% patients receiving Open Access/ Complex palliative treatments and services	Higher percentage of Open Access patients often indicates higher patient acuity	Higher percentages may indicate need for additional staffing
% total days General Inpatient (GIP) level of care	Higher percentage of GIP patients often indicates higher acuity, more transitions in care, and additional administrative/ professional management	Above benchmark may indicate need for additional staffing
% total days Continuous Home Care (CHC) level of care	Higher percentage of CHC patients often indicates higher acuity, more transitions in care, and additional administrative/ professional management	Above benchmark may indicate need for additional staffing
Organizational Characteristics		
ADC	Organizations with a smaller census may have fewer staffing resources and less ability for staff to flex to cover increased patient care needs	Rapid increases or decreases in ADC may indicate need for reevaluation of staffing needs
Turnover % (annual)	Higher turnover rates may indicate increased staffing resources dedicated to orientation and precepting and reduced ability make patient visits	Higher percentages may indicate need for additional staffing
Referral/Admission Conversion Rate	Lower conversion rates may indicate inadequate staffing resources dedicated to admitting and supporting new patients	Below benchmark may indicate need for additional staffing
Staffing Characteristics		
% Full Time Employees	Higher percentage of full-time employees may indicate more stable staffing, better coordination of care, and less stress on staff	Below benchmark may indicate need for additional staffing
% Part Time or PRN Employees	Higher percentage of full-time employees may indicate more flexibility but limited coordination of care and additional stress of staff	Above benchmark may indicate need for additional staffing

VARIABLE METRICS

Variable	Description	Significance
% Salaried Employees	Higher percentage of salaried employees may indicate fewer labor costs attributable to overtime	Below benchmark may indicate need for additional staffing
% Hourly Employees	Higher percentage of hourly employees may indicate additional labor costs attributable to overtime	Above benchmark may indicate need for additional staffing
Length of Employment		
Less than 1 year	Higher percentage of new employees may indicate high turnover, staffing resources dedicated to orientation and precepting, and reduced ability to make patient visits	Above benchmark may indicate need for additional staffing
Hospice-certified staff	Higher percentage of certified hospice staff may indicate more experience and improved ability to manage caseloads	Lower percentages may indicate need for additional staffing
Visit Patterns		
Average number of visits per patient per week: **RN and LPN**	Average number of visits per patient/per week, by discipline	Below benchmark may indicate need for additional staffing
Average number of visits per patient per week: **Aide**	Average number of visits per patient/per week, by discipline	Below benchmark may indicate need for additional staffing
Average number of visits per patient per week: **Social worker**	Average number of visits per patient/per week, by discipline	Below benchmark may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Significance
Quality Metrics		
HCI Indicator 5: Burdensome Transitions Type 1	The percentage of all live discharges from hospice that were followed by hospitalization within two days and followed by hospital readmission within two days of hospital discharge. Higher percentages may indicate poor care coordination.	Above benchmark may indicate need for additional staffing
HCI Indicator 6: Burdensome Transitions Type 2	The percentage of all live discharges from hospice that were followed by hospitalization within two days, and where the patient also died during the inpatient hospitalization stay. Higher percentages may indicate poor care coordination.	Above benchmark may indicate need for additional staffing
HCI Indicator 8: Skilled Nursing Care Minutes per RHC day	Average total skilled nurse minutes provided by hospices on all Routine Home Care (RHC) service days: the total number of skilled nurse minutes provided by the hospice on all RHC service days divided by the total number of RHC days the hospice serviced.	Below benchmark may indicate need for additional staffing
HCI Indicator 9: Skilled Nursing Visits on Weekends	The percentage of skilled nurse visits minutes that occurred on Saturdays or Sundays out of all skilled nurse visits provided by the hospice during RHC service days.	Below benchmark may indicate need for additional staffing
HCI Indicator 10: Visits Near Death	The percentage of beneficiaries receiving at least one visit by a skilled nurse or social worker during the last three days of the patient's life (a visit on the date of death, the date prior to the date of death, or two days prior to the date of death).	Below benchmark may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Significance
HVLDL (Hospice Visits Last Days of Life)	The percentage of patients who received in-person visits from a registered nurse (RN) or medical social worker (MSW) on at least two out of the final three days of the patient's life.	Below benchmark may indicate need for additional staffing
Complaints/Concerns per 1000 patient days	Higher rate of complaints/concerns may indicate that patient and family needs are not being met due to staffing constraints.	Above benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on providing timely help	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.	Below benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on rating hospice 9 or 10	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.	Below benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on providing help for pain and symptoms	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.	Below benchmark may indicate need for additional staffing
Survey Deficiencies (Subpart C)	Review survey deficiencies related to missed visits, plan of care, comprehensive assessment, etc. Higher numbers of patient care deficiencies may indicate that patient and family needs are not being met due to staffing constraints.	Higher numbers may indicate need for additional staffing
Financial		
SIA (Service Intensity Add-On): Nurse Visits in Last 7 Days of Life	Percentage of days with at least one in-person registered nurse visit in the last 7 days of life	Below benchmark may indicate need for additional staffing
SIA (Service Intensity Add-On): Social Worker Visits in Last 7 Days of Life	Percentage of days with at least one in-person social work visit in the last 7 days of life	Below benchmark may indicate need for additional staffing
Staffing		
Staff Satisfaction: My workload is manageable (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.	Below benchmark may indicate need for additional staffing
Staff Satisfaction: The amount of stress in my job is manageable (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.	Below benchmark may indicate need for additional staffing
Staff Satisfaction: I rarely think about looking for a new job with another company (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.	Below benchmark may indicate need for additional staffing

NHPCO Hospice Staffing Framework Tool

VARIABLE METRICS

Variable	Description	Organizational Metric	Benchmark Metric (Where Available)	Significance
Acuity				
Median Length of Stay (LOS)	Shorter median LOS often indicates higher patient acuity		17 days[1]	Below benchmark may indicate need for additional staffing
% of patients with LOS <5 days	Higher percentage of patients with short length of stay often indicates higher acuity		25%[2]	Above benchmark may indicate need for additional staffing
Patient Mix				
% Hospital Referrals	Higher percentage of hospital referrals often indicates higher patient acuity		Not Available*	Higher percentages may indicate need for additional staffing
% Cancer patients	Higher percentage of cancer patients often indicates higher patient acuity		7.5%[2]	Above benchmark may indicate need for additional staffing
% patients residing in Nursing Facilities, Skilled Nursing Facilities, and Long-Term Care Facilities	Higher percentage of facility patients may indicate less travel time between patients, and often facility patients have longer length of stay and lower acuity		17.4%[6]	Below benchmark may indicate need for additional staffing
% patients receiving Open Access/ Complex palliative treatments and services	Higher percentage of Open Access patients often indicates higher patient acuity		N/A	Higher percentages may indicate need for additional staffing.
% total days General Inpatient (GIP) level of care	Higher percentage of GIP patients often indicates higher acuity, more transitions in care, and additional administrative/ professional management		0.9%[3]	Above benchmark may indicate need for additional staffing
% total days Continuous Home Care (CHC) level of care	Higher percentage of CHC patients often indicates higher acuity, more transitions in care, and additional administrative/ professional management		0.1%[3]	Above benchmark may indicate need for additional staffing

VARIABLE METRICS

Variable	Description	Organizational Metric	Benchmark Metric (Where Available)	Significance
Organizational Characteristics				
ADC	Organizations with a smaller census may have fewer staffing resources and less ability for staff to flex to cover increased patient care needs		Utilize internal historical and planned ADC	Rapid increases or decreases in ADC may indicate need for reevaluation of staffing needs
Turnover % (annual)	Higher turnover rates may indicate increased staffing resources dedicated to orientation and precepting and reduced ability make patient visits		Utilize internal or vendor benchmarks as available	Higher percentages may indicate need for additional staffing.
Referral/Admission Conversion Rate	Lower conversion rates may indicate inadequate staffing resources dedicated to admitting and supporting new patients		Utilize internal or vendor benchmarks as available	Below benchmark may indicate need for additional staffing
Staffing Characteristics				
% Full Time Employees	Higher percentage of full-time employees may indicate more stable staffing, better coordination of care, and less stress on staff		86.7%[4]	Below benchmark may indicate need for additional staffing
% Part Time or PRN Employees	Higher percentage of full-time employees may indicate more flexibility but limited coordination of care and additional stress of staff		10.65%[4]	Above benchmark may indicate need for additional staffing
% Salaried Employees	Higher percentage of salaried employees may indicate fewer labor costs attributable to overtime		46.14%[4]	Below benchmark may indicate need for additional staffing
% Hourly Employees	Higher percentage of hourly employees may indicate additional labor costs attributable to overtime		53.14%[4]	Above benchmark may indicate need for additional staffing
Length of employment: Less than 1 year	Higher percentage of new employees may indicate high turnover, staffing resources dedicated to orientation and precepting, and reduced ability to make patient visits		20.17%[4]	Above benchmark may indicate need for additional staffing
Hospice-certified staff	Higher percentage of certified hospice staff may indicate more experience and improved ability to manage caseloads		Utilize internal or vendor benchmarks as available	Lower percentages may indicate need for additional staffing

VARIABLE METRICS

Variable	Description	Organizational Metric	Benchmark Metric (Where Available)	Significance
Visit Patterns				
Average number of visits per patient per week: RN and LPN	Average number of visits per patient/per week, by discipline		1.7[1]	Below benchmark may indicate need for additional staffing
Average number of visits per patient per week: Aide	Average number of visits per patient/per week, by discipline		1.8[1]	Below benchmark may indicate need for additional staffing
Average number of visits per patient per week: Social worker	Average number of visits per patient/per week, by discipline		0.3[1]	Below benchmark may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Organiztional Metric	Benchmark Metric (Where Available)	Significance
Quality Metrics				
HCI Indicator 5: Burdensome Transitions Type 1	The percentage of all live discharges from hospice that were followed by hospitalization within two days and followed by hospital readmission within two days of hospital discharge. Higher percentages may indicate poor care coordination.		8.2%[5]	Above benchmark may indicate need for additional staffing
HCI Indicator 6: Burdensome Transitions Type 2	The percentage of all live discharges from hospice that were followed by hospitalization within two days, and where the patient also died during the inpatient hospitalization stay. Higher percentages may indicate poor care coordination.		2.3%[5]	Above benchmark may indicate need for additional staffing
HCI Indicator 8: Skilled Nursing Care Minutes per RHC day	Average total skilled nurse minutes provided by hospices on all Routine Home Care (RHC) service days: the total number of skilled nurse minutes provided by the hospice on all RHC service days divided by the total number of RHC days the hospice serviced.		13.9	Below benchmark may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Organiztional Metric	Benchmark Metric (Where Applicable)	Significance
HCI Indicator 9: Skilled Nursing Visits on Weekends	The percentage of skilled nurse visits minutes that occurred on Saturdays or Sundays out of all skilled nurse visits provided by the hospice during RHC service days.		9.3%	Below benchmark may indicate need for additional staffing
HCI Indicator 10: Visits Near Death	The percentage of beneficiaries receiving at least one visit by a skilled nurse or social worker during the last three days of the patient's life (a visit on the date of death, the date prior to the date of death, or two days prior to the date of death).		90%	Below benchmark may indicate need for additional staffing
HVLDL (Hospice Visits Last Days of Life)	The percentage of patients who received in-person visits from a registered nurse (RN) or medical social worker (MSW) on at least two out of the final three days of the patient's life.		49.2%	Below benchmark may indicate need for additional staffing
Complaints/Concerns per 1000 patient days	Higher rate of complaints/concerns may indicate that patient and family needs are not being met due to staffing constraints.		Utilize internal or vendor benchmarks as available	Above benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on providing timely help	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.		78%[1]	Below benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on rating hospice 9 or 10	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.		81%[1]	Below benchmark may indicate need for additional staffing
CAHPS: Share of respondents giving top rating on providing help for pain and symptoms	Lower percentages may indicate that patient and family needs are not being met due to staffing constraints.		75%[1]	Below benchmark may indicate need for additional staffing
Survey Deficiencies (Subpart C)	Review survey deficiencies related to missed visits, plan of care, comprehensive assessment, etc. Higher numbers of patient care deficiencies may indicate that patient and family needs are not being met due to staffing constraints.		Utilize internal survey data	Higher numbers may indicate need for additional staffing

OUTCOME METRICS

Outcome	Description	Organiztional Metric	Benchmark Metric (Where Applicable)	Significance
Financial				
SIA (Service Intensity Add-On): Nurse Visits in Last 7 Days of Life	Percentage of days with at least one in-person registered nurse visit in the last 7 days of life		63%[1]	Below benchmark may indicate need for additional staffing
SIA (Service Intensity Add-On): Social Worker Visits in Last 7 Days of Life	Percentage of days with at least one in-person social work visit in the last 7 days of life		9%[1]	Below benchmark may indicate need for additional staffing
Staff Satisfaction				
Staff Satisfaction: My workload is manageable (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.		24.24%[4]	Below benchmark may indicate need for additional staffing
Staff Satisfaction: The amount of stress in my job is manageable (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.		20.27%[4]	Below benchmark may indicate need for additional staffing
Staff Satisfaction: I rarely think about looking for a new job with another company (Strongly Agree)	Higher percentages may indicate that staff needs are being met, which may positively impact turnover, patient care, and quality measures.		35.95[4]	Below benchmark may indicate need for additional staffing

NHPCO Hospice Staffing Framework Tool References

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Section 4: Staffing Models Reference Library

This section includes a list of staffing models for organizations to explore, including circumstances in which each model may be appropriate to consider.

The Staffing Models Reference Library was developed by members of the NHPCO Quality and Standards and Regulatory Committees as a partial list of staffing models employed by hospice organizations around the country. The intent of the Reference Library is to show examples of creative solutions to staffing challenges that may be feasible for organizations with varying size, geography, and scope of services.

Organizations are encouraged to use this Reference Library as inspiration to consider possible means of organizing their teams to best meet the needs of patients and families. Example staffing models are organized by the discipline primarily impacted, but organizations should ensure that all disciplines are represented in their staffing plans. In addition, many of these models could be combined to create a unique staffing plan.

Nursing Models

- **Admission Nurse**
  - Designated Admissions RN completes Initial Assessment
  - RN Case Manager assume responsibility for patient going forward
- **RN/LPN Team**
  - RN Case Manager completes comprehensive assessments and manages plan of care
  - LPN makes supplemental visits as needed
- **Visit Nurses**
  - RN Case Manager completes comprehensive assessments and manages plan of care
  - A support team of Visit Nurses make symptom-management, routine reassessment, death verification, and additional visits as needed in between
- **Administrative Support Nursing**
  - Designated nurses provide administrative support in office, such as managing DME, pharmacy, and physician's orders
  - RN Case Managers and additional nursing staff make patient visits
- **On-Call Nursing Team**
  - Dedicated nursing team for on-call/after-hours patient care
- **Hybrid RN**
  - Dedicated RN to facilitate admissions and transfers between community and hospice inpatient unit

Physician Models

- **Medical Director**
  - » Patient Visits, including Face-to-Face Encounters
    - Patient visits (can be done by an NP, who may bill for the visit if selected by the patient/representative as the Hospice Attending, or a physician, who may bill for the visit regardless of status as the Hospice Attending)
  - » **Administrative**
    - the Face-to-Face encounter (can be done by a W2 employed NP or a physician)
    - Certification of Terminal Illness completion (can only be done by a physician)
    - presence at Interdisciplinary Group Meetings (can only be done by a physician)
- **NP models:**
  - » Dedicated to all agency face to face encounters
  - » Shared teams with the Medical Director
    - Performing patient visits and face to face encounters
- **Medical Director with team physicians and/or nurse practitioners**
  - » Teams based on geographical locations, care settings, etc.
  - » NPs for Face-to-Face and other patient care needs

Team Design Models

- **Facility Team**
  - » Dedicated teams focused specifically on caring for facility-based patients
  - » May apply to one or all disciplines
- **CHC Team**
  - » Dedicated teams focused specifically on caring for patients using Continuous Home Care
  - » May apply to one or all disciplines
- **Triage Team**
  - » Dedicated triage team to facilitate appropriate IDG support to patients during the day and/or after-hours
  - » Consider outsourced on-call services
- **Geographic Teams**
  - » Dedicated teams focused specifically on certain geographic regions of the service area
- **Administrator On-Call**
  - » Dedicated clinical leader on-call after hours to support after-hours staff in managing complex patient care needs
- **Dedicated Pediatric Team**
  - » Dedicated pediatric nurse
    - Completes admission patient visits
  - » Dedicated medical social worker
    - Provides social work support and bereavement care to surviving family members of pediatric hospice patients
    - Follows pediatric grievers (both internal and external/community bereavement referrals).
  - » Dedicated spiritual counselor
- **Hybrid/Blended Pediatric team**
  - » IDG members care for pediatric and adult patients
  - » Dedicated IDG members dependent on organization's current pediatric caseload
- **Non-Patient Facing Clinical Support**
  - » Utilize administrative or other staff to support clinical needs such as triaging patient calls, facilitating medication and supply orders, coordinating transportation needs

NHPCO Hospice Staffing Framework At-A-Glance

What is the NHPCO Hospice Staffing Framework?

The NHPCO Hospice Staffing Framework is a tool intended to help hospice providers assess a number of factors with the potential to impact staffing in order to better determine whether their current staffing framework is appropriate to their organizational needs. The framework utilizes an assessment process to help determine 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 quality and financial outcomes.

How is this Framework different from past NHPCO Hospice Staffing Guidelines?

Although NHPCO has provided staffing guidance to member organizations for many years, no one "best standard" in the literature regarding hospice staffing caseloads currently exists. This framework differs from the previously published staffing ratios and guidelines in that recommended ranges for caseloads are not provided. Instead, using the analysis process delineated in the framework, each hospice may assess a number of variables and outcomes measures to identify whether there are opportunities to better tailor staffing to meet the needs of their organization.

Why should my hospice organization utilize this framework?

Around the nation, hospices have evolved in various directions, creating diverse models of care to serve hospice patients and families. The NHPCO Hospice Staffing Framework 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. This resource provides a framework that utilizes outcomes to help determine the organization's needs and improve the hospice model of care, in a transparent manner that allows staff to remain informed and provide valuable input.

How does my organization use the framework?

The NHPCO Staffing Framework for Hospice includes several organizational variables and outcome measures for hospice leaders to consider when determining whether staffing adjustments need to be made. While there is no existing validated instrument capable of capturing the complexity of hospice care and determining staffing minimums by discipline, this tool is intended to highlight the multiple factors that organizations should assess when considering their staffing models.

What data sources does the framework reference?

The NHPCO Hospice Staffing Framework is reviewed annually and references up-to-date clinical and operational data from the following sources to identify comparative benchmarks.

- MedPac Report to Congress
- Hospice Wage Index and Quality Reporting Proposed Rule
- NHPCO Facts and Figures Report
- NHPCO National STAR Report
- CMS Hospice National Data Set
- CMS Hospice Quality Reporting Program User's Manual

For more information, please visit NHPCO Quality Resources or reach out to quality@nhpco.org.

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4. NHPCO National STAR Report 2022 https://www.nhpco.org/wp-content/uploads/2022_STAR_National_Report.pdf
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7. HQRP User's Manual V1.01 Aug 2022 https://www.cms.gov/files/document/hqrp-qm-users-manual-v101aug2022.pdf

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NHPCO Hospice Staffing Framework

NHPCO
Leading Person-Centered Care

1731 KING STREET
ALEXANDRIA, VA 22314

nhpco.org