Later this month, NHPCO will be releasing the eagerly awaited update to its staffing ratio recommendations — but it is far more than just an ‘update.’ The new document, “Staffing Guidelines for Hospice Home Care Teams,” will help each hospice determine its unique staffing requirements, based on its model of delivery, patient characteristics and environmental considerations.

In this article, Tara Brodbeck, the president/CEO of Hospice of the Miami Valley and the co-chair of the Task Force charged with developing the new Guidelines, talks about the tool, including why a new approach was taken, the member feedback from field testing, and suggestions on using it.

NHPCO’s New Staffing Guidelines:
No Longer a One-Size-Fits-All Approach

By Tara Brodbeck, MS, RN, CHPN

In 2008, as the NHPCO Quality and Standards Committee began revising the Standards of Practice for Hospice Care to incorporate the new Hospice CoPs, we knew it was also time to take on the challenging task of revising the staffing ratio recommendations in NHPCO’s “Hospice Services Guidelines and Definitions” (which had been produced back in 1994!).

As soon as the project was added to our committee agenda, questions and comments began pouring in from members across the country. It seemed that many had strong ideas about the topic and what the revision should address. Here’s a sampling of the initial feedback we received:

“The current staffing ratios are outdated and not useful—staff are complaining if we ask them to take more patients.”
“What is the correct number of patients per discipline?”
“My CFO/director wants to know how many positions per census to budget.”
“How will we find the “correct” number that all programs could use [when] our hospice is different from other hospices?”

Some Background About Development

As a committee, we had to approach this important project in a thoughtful, organized and very thorough manner. So first, we held an all-day, onsite appreciative inquiry in January 2009 to elicit the entire committee’s feedback concerning the ratios. It was a very exciting and lively meeting, with an open, free-form discussion so all ideas and comments could be heard.

By the end of the day, committee members felt the task was critical enough to require more input from the entire
group as well as further in-depth discussions, so we made the decision not to delegate the project to a smaller work group at that time. Throughout the year, the committee developed structure for the project’s discussions and a framework for the new guidelines. In January 2010, a smaller Staffing Guidelines Task Force (see sidebar) was then formed, with the goal of completing the project by the end of the year.

In response to the concerns of hospice providers, the Task Force made a concerted effort to be as inclusive as possible. This included the presentation of revised drafts at the Ohio Hospice and Palliative Care 2009 annual conference and NHPCO’s 2010 Management and Leadership Conference. In total, we were pleased that more than 200 hospice managers and staff provided input over the course of its two-year development.

**Why a New Approach**

While information concerning staffing ratios was only one small section of the 1994 “Hospice Services Guidelines,” it had become one of the most controversial topics among providers as the hospice industry matured.

Given the sparse data available, the ratios had been developed from a small sample of hospice programs at that time, and consensus could only be based on what was “thought to be” good practice. In the mid-90s, hospice service models were also more basic and uniform, and the patient populations were vastly different from those of today. For example, 57 percent of patients admitted to hospice in 1994 had a primary diagnosis of cancer (National Center for Health Statistics) compared to only the 40 percent who were admitted in 2009 (NHPCO Facts and Figures).

**Key Considerations Addressed**

The Task Force began the process of revision by asking five key questions:

- What was the purpose of providing the staff ratio recommendations?
- What would be the expected outcome from the revision?
- Do ratios and caseloads directly relate to quality of care? If so, how?
- How do different hospice models of care fit into these guidelines?
- What characteristics of a hospice program affect ratios and caseloads?

Exploring these questions evolved into discussion of hospice best practices. We explored different processes of care, such as admission, specialty teams, on-call processes, and how different hospice programs structured their teams. We then compared these processes to best practices known to date, and looked at current outcomes, tools and industry benchmarks (such as NHPCO’s Family Evaluation of Hospice Care and Family Evaluation of Bereavement Services).

While engaging in these discussions was both helpful and useful, Task Force members realized that we must bring more clarity to the discussion by focusing specifically on the staffing ratios and caseloads. That said, during these best-practices discussions, we heard about the many interesting ways in which hospices were structuring their resources and utilizing their staff, which led us to the final path of developing new guidelines that would help each hospice arrive at numbers that took its situation into account.

**Staffing Guidelines Task Force**

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<tr>
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The Many Factors Affecting Ratios and Caseloads
As hospices have evolved, they have created diverse models and processes of care to serve their patients and families. These models and processes have been driven by a variety of factors in each particular hospice program.

The Task Force started to list the different models and processes of care, including admission teams, care specialty teams (e.g., disease-specific teams, nursing home teams), primary care models of care, on-call teams, RN-LPN partner teams and, of course, many others. We also had a rich discussion concerning “caseloads” versus case mix/intensity of care and decided it was best to integrate acuity/intensity of care into the factors we thought could be reason to support a lower or higher caseload. We wound up with 90 different factors to consider when determining staffing ratios and caseloads! Recognizing that this number was unworkable, we reviewed each factor and, if it didn’t directly influence a caseload, we discarded it.

During these discussions, the term “staffing ratios” evolved into “caseloads.” We also made the decision to not be prescriptive by using a definitive number for a particular discipline’s caseload — for two reasons:

1. It was seen as too restrictive and didn’t allow for creative staffing approaches in our hospice industry, and
2. There was a lack of research data on staffing caseloads.

As a result of our discussions, the 90 initial factors were ultimately reduced to 11 factors under three categories. These factors are listed and discussed on page 4 of this article.

Feedback from the Field

As the Task Force co-chair, I was very pleased the Quality and Standards Committee gave me permission to present the initial draft of the new guidelines at the Ohio Hospice and Palliative Care Organization annual conference in 2009. Because Task Force members had worked so closely on the project for such a long time, we were very anxious to get feedback from our fellow providers in the field—especially since the new guidelines had taken this new approach. The timing of the Ohio conference was quite fortuitous.

Approximately 50 hospice staff attended the presentation in Ohio, and were asked to complete a survey. Overall, feedback was very positive, with 86 percent of the attendees indicating that the guidelines’ instructions were clear and the tables were easy to understand. The majority also believed their agencies would use the new tool.

We reviewed every suggestion and comment the attendees had shared and incorporated many of them into a second draft, which was then presented to 100 attendees at the NHPCO Management and Leadership Conference in April 2010. These attendees, who were asked to complete a longer, three-page survey, were even more positive about the tool than the Ohio conference attendees.

In addition to field testing at both conferences, a number of Task Force members conducted similar surveys at their own hospice programs.
Using the Guidelines

The new Staffing Guidelines is organized into four sections:

**Section 1** contains background about the original 1994 guidelines as well as a key table (“Hospice Homecare Staffing Guidelines Analysis”) that delineates the factors you should use to compare your hospice’s characteristics (e.g., length of stay) with median hospice characteristics from NHPCO’s National Data Set.

**Section II** contains the actual “Staffing Guidelines Analysis Worksheet” that you fill out as you conduct the analysis to determine the staffing caseloads needs for your hospice, based on 11 specific factors. Step-by-step instructions are also provided to help you complete both the Analysis and the Worksheet.

**Section III** provides three different hospice-program “case scenarios” for illustrative purposes.

**Section IV** provides a glossary of the terms used in the document.

As a first step, you should undertake a thoughtful planning process that includes:

- Analysis of your care delivery models, or other models needed
- Characteristics of your patient population
- Environmental considerations
- Unique circumstances of your hospice program

As part of this planning process, take time to review the “National Summary of Hospice Care,” the 25-page report which NHPCO produces annually. The National Summary contains comprehensive national estimates for agency demographics, patient demographics, staffing management and delivery, payer mix, revenue and expenses—estimates that will help as you move on to completion of the guidelines’ Table and Worksheet.

**The Guidelines Analysis Table and List of Factors to Consider**

Reviewing this one-page, three-column table will help you identify the information about your hospice related to the multiple factors that must be considered to determine the optimal staffing caseloads for your particular situation.

The first column lists three major hospice characteristics—and multiple sub-factors—that should be taken into consideration:

1. Length of Stay Characteristics
   - Short Length of Stay

2. Staffing Model Characteristics
   - Admission Model
   - On-call Model
   - RN/LPN Model
   - Shared Team Model
   - Bereavement Model
   - Staff Turnover Rate

3. Organizational Characteristics
   - Percent of Routine Level of Care
Access
Aide/Homemaker Delivery Model
Use of Ancillary Services (e.g., art, music, massage, PT/OT)

For each factor, caseloads are adjusted in the direction indicated in columns two and three of the table (i.e., increase or decrease).

Other factors which may impact staffing caseloads, but which do not have comparison data available, are listed and explained in the narrative section that follows this Table. These factors include pattern of utilization of continuous care and general inpatient care; multiple roles for the IDT; psychosocial issues; travel time issues; and several others.

A Note About 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 which would allow for comparison. Thus, some of the measures in the Table were chosen as surrogates of acuity, such as short length of stay. (The Guidelines elaborate on this issue.)

The Guidelines Analysis Worksheet
This two-part Worksheet walks you through each statistic and factor, and helps you 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 presence of other organizational and environmental factors. For example:

- In Part I of the Worksheet, for each organizational characteristic listed, you first write in your hospice’s information and compare it to the national norm. Then, write in a plus (+), minus (-), or equal (=) symbol according to the guideline for each characteristic as a directional indicator for lower or higher staffing caseloads.

- In Part II, review each of the additional factors listed, write in the qualities of these factors for your hospice, and determine the direction of influence of these factors on your staffing caseloads (i.e., plus, minus or equal) as outlined in the factor explanations.

Once you have completed the Worksheet, review the pluses, minuses, and equal signs. This will provide an indication of whether you should consider utilizing caseloads above or below the national norms.

This analysis allows you to individualize your staffing caseloads according to the organizational and environmental characteristics that are specific to your hospice, much in the same way your staff individualize care plans for the patients they serve.

An Ongoing Process

Keep in mind that this analysis only provides a starting point for determining estimated optimal staffing caseloads for your hospice. Ongoing evaluation must also be part of the process.

Be sure to repeat your staffing guidelines analysis at an appropriate interval after instituting caseload changes, and continuously monitor your hospice’s comparative performance using performance measurement tools (such as the Family Evaluation of Hospice Care (FEHC), the Survey of Team Attitudes and Relationships (STAR), and your other program-quality measures). This will help assure continued high-quality patient care as well as high levels of staff performance and well-being.
The development of these new guidelines is only one step in the NHPCO Quality and Standards Committee’s mission to help providers respond to industry changes in an efficient and effective manner while forever keeping at the forefront of our mind “excellence in patient care service.”

Tara Brodbeck is president/CEO of Hospice of the Miami Valley (Xenia, OH) and currently serves as a national director on the NHPCO board of directors. She has also served as a member of the NHPCO Executive and Governance Committees and as chair of the Quality and Standards Committee (2007-2009). In addition, she served as co-chair of the Staffing Guidelines Task Force. She can be reached at brodbeckt@homy.org.

MLC Session on the New Guidelines
If you are planning to attend this year’s Management and Leadership Conference in Washington, DC, be sure to attend this session: New NHPCO Staffing Guidelines: Implementation Methods and Strategies for Success on Saturday, April 9 (10:30-11:30 a.m.). To learn more about MLC or to register, visit www.nhpco.org/mlc2011.