

Hospice Visit Patterns Across Patient Demographic and Clinical Characteristics

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Background and Aims

Approximately 1.7 million Medicare beneficiaries use hospice care annually, with services primarily delivered through in-person visits from an interdisciplinary team comprising nurses, social workers, home health aides, and other professionals. Despite the centrality of these visits to hospice care, limited evidence on visit patterns hinders efforts to establish or evaluate benchmark visit standards, quality measures, care delivery practices, and workforce planning.

To address this gap, this study examined visit patterns among Medicare beneficiaries aged 65 and older enrolled in hospice (N=7,130,505). Variations in these measures were assessed by demographic characteristics, geographic region, care setting, and admitting diagnosis.

Methods

This study used 100% Medicare assessment and claims data from 2016 to 2021 to analyze hospice visit patterns among beneficiaries aged 65 and older enrolled in hospice care. Researchers calculated total visit frequency and discipline-specific visit measures, including nursing, social work, and home health aide visits. Additional metrics included nurse minutes per day and visits during the last days of life.

The analysis focused on variations in these measures across demographic characteristics (e.g., age, race, ethnicity), geographic regions, admitting diagnoses, and care settings. Descriptive statistics summarized visit patterns across these dimensions, offering insights into the frequency and distribution of hospice care delivery nationwide.

Home health aide visits provided under Medicaid programs were excluded from the analysis unless the aide met hospice-specific training criteria, potentially leading to an underestimation of total visits. Sensitivity analyses excluded data from 2020 and 2021 to account for disruptions caused by the COVID-19 pandemic.

Findings

The study found minimal variation in hospice visit patterns across patient demographics, including age, race, and ethnicity. Visit frequency, however, varied by hospice diagnosis and geographic region. Patients with certain diagnoses, such as cancer, received more frequent visits, while those with other conditions, such as dementia, had fewer visits. These differences may reflect variations in clinical needs or care practices associated with specific diagnoses.

Geographic disparities were notable, with substantial differences in visit frequency across regions of the country. Some areas reported significantly fewer visits, raising questions about workforce shortages, regional staffing practices, or disparities in resource distribution. These findings provide important context for addressing inequities in hospice care delivery.

Limitations and Future Directions

This study is descriptive and does not allow for causal inferences about the observed patterns. Unmeasured confounders, such as differences in hospice organizational policies or patient-specific factors, may have influenced the results.

The analysis focused on visit frequency as a measure of hospice care delivery, providing insights into how often interdisciplinary team members conducted in-person visits. However, this measure did not assess whether the visits were clinically appropriate or met quality standards, leaving room for further exploration of care dimensions. Additionally, the exclusion of home health aide visits furnished through Medicaid programs likely led to an underestimation of total visits.

The study period ended in 2021 and does not capture more recent changes in hospice care delivery. Future research should evaluate whether regional differences reflect clinical needs, staffing challenges, or workforce shortages. Investigating the appropriateness, quality, and frequency of visits will be crucial for informing hospice care standards.

Policy Implications

The findings underscore the need for evidence-informed policies that address regional disparities in hospice visit frequency. Policymakers should consider workforce planning strategies, regulatory standards, and funding mechanisms that ensure uniform access to hospice care across geographic areas. Efforts to enhance quality measurement in hospice care should incorporate both visit frequency and appropriateness to better reflect care quality.

Conclusion

This study provides a valuable national baseline for understanding hospice visit patterns, highlighting minimal variation by patient demographics but notable differences by diagnosis and region. As hospice care delivery continues to evolve, further investigations are needed to ensure standards and workforce planning align with patient needs and address regional disparities. By examining the appropriateness and quality of visits alongside frequency, policymakers and stakeholders can better support high-quality hospice care nationwide.

Full Report

<https://healthworkforce.ucsf.edu/bibcite/reference/2131>