Health Workforce Policy Brief

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Few Hospital Palliative Care Programs Meet National Staffing Recommendations

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I. Introduction/Background

The predominant model for palliative care delivery, outside of hospice care, is the hospital-based consultative team. Although a majority of US hospitals offer palliative care services, there has been little research on program team staffing and whether those teams meet national guidelines, such as the Joint Commission's standard of including at least one physician, an advanced practice or other registered nurse, a social worker, and a chaplain. We analyzed national data on staffing in hospital-based palliative care programs and assessed whether there are important staffing differences by program characteristics, hospital characteristics, or region. Spetz, J., Dudley, N, Trupin, L., et al. Few Hospital Palliative Care Programs Meet National Staffing Recommendations. *Health Aff*, Sept 2016:35(9):1690-1697.

II. Methods

We analyzed self-reported operational data on hospital-based palliative care programs from the 2012–13 annual voluntary surveys of the National Palliative Care Registry, a project of the Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center. Data included size and nature of the program, size and type of the hospital, scope of services, patient profile, staffing levels, and certification. Staffing information included both funded and unfunded (in-kind, which includes time paid by another department of the hospital, and volunteer) positions. We computed the percentage of programs with a complete team, according to the Joint Commission's standards, whether programs included a paid physician per recommendation of the CAPC consensus panel and, if not, whether they included an advanced practice or other registered nurse. We assessed whether programs complied with recommendations for on-site staffing coverage during normal business hours and for telephone coverage at all times. Comparisons were made by program size, measured as the number of consultations per year; hospital size, measured as the number of beds; the types of palliative services offered; staffing coverage; program penetration; and region, using the ten regions developed by the Health Resources and Services Administration. Following previous research, we divided hospitals into two groups: those with <300 beds and those with ≥300 beds.

Conclusions and Policy Implications

1) The Institute of Medicine has recommended that all Americans with advanced illness have access to palliative care services provided by well-trained transprofessional teams.

2) One-third of palliative care programs do not have recommended coverage—personnel available on-site during weekday business hours and by telephone at all times.

3) Only 25% of programs have a complete team for palliative care services.

4) Rapid and sustained efforts in education, financing, and health systems management will be required to prepare the US health workforce to meet the palliative care needs of a growing and aging population living with serious and complex chronic illnesses.

III. Findings

Of the 410 palliative care programs analyzed, 95% offered consulting services only, in which palliative care team members serve patients across all hospital units, and the remaining 5% offered consultation as well as a dedicated palliative care unit. Sixty of the programs (14.6%) were certified by the Joint Commission, and an additional seventy-five (18.3%) had applied for certification or were planning to do so within the next year. Hospitals with >300 beds accounted for 59% of programs; 31% had an outpatient clinic, 17% had a home-based program, and 95% had a relationship with a hospice program. Only 25% of hospitals had a complete team of funded staff members, according to Joint Commission standards; if unfunded positions were included, the share rose to 39%. Mean number of funded staff members was 6.8, which produced 4.9 full-time equivalent positions (FTEs). Forty-five percent of programs reported having in-kind or volunteer staff members. More than half reported that they had funded positions for physicians, nurses, and social workers, but only 38% had funded chaplains. Administrators or medical directors were unfunded in 13% of the programs. The median annual consultations per FTE (funded and unfunded) was 144. Programs whose consultation volume was in the top quartile (above the seventy-fifth percentile) reported median FTEs per 10,000 admissions of 2.53, as compared with 1.80 FTEs for programs with consultation volumes at or below the median. Programs with complete teams were more likely to have greater consultation volumes: only 14% of hospitals with volumes below the median had a complete funded team, compared with 36% of programs with volumes in the top quartile. Programs reported medians of 531 consultations/year and 336 per 10,000 admissions. The programs reached a median of 3.4% percent of hospital patients (IQ: 2.1–4.9%). Patients aged >65 years made up a median of 71% of all patients receiving palliative consultations.

IV. Conclusion

Palliative care programs reached only a median of 3.4% of hospital patients, likely below the need for consultation among hospital patients. Fully one-third of palliative care programs did not have recommended coverage—personnel available on-site during weekday business hours and by telephone at all times, and because the survey data were voluntarily reported and overrepresented programs in larger hospitals, it is likely that they have higher staffing levels than the average among all US hospitals, leading us to overestimate the adequacy of palliative care program staffing. Palliative care physicians are in short supply, and it has been estimated that 18,000 more of them would be needed to staff current programs at recommended levels. Current education programs do not provide adequate training in palliative care, which should incorporate training in interprofessional teamwork skills, and include social work as well as the health professions.

V. Policy Implications

Palliative Care and Hospice Education and Training Act, now pending in Congress, would amend the Public Health Service Act to increase the number of palliative care faculty members in medical schools, nursing schools, social work schools, and other programs. The Bureau of Health Workforce within the Health Resources and Services Administration can play a role in supporting palliative care education through its grants programs. Additionally, the Centers for Medicare and Medicaid Services (CMS) has established programs that may support reimbursement policies that help encourage palliative care, such as separate payment for advance care planning and provisions to allow hospices in the Medicare Care Choices Model to offer patients supportive services while continuing to receive curative treatment. Rapid and sustained efforts in education, financing, and health systems management will be required to prepare the US health workforce to meet the palliative care needs of a growing and aging population living with serious and complex chronic illnesses.

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Charts/Tables

Funded staffing in palliative care programs by program characteristics, 2012–13.

	Per 10,000 admissions:		Percent with funded:			
Characteristic	**Median staff**	**Median FTEs**	**Physician**	**RN**	**Social worker**	**Chaplain**
All programs	3.14	2.17	66	52	51	38
Number of annual consultations (percentile)						
At or below 50th	2.93	1.80***	53***	51	40***	29***
51st–75th	3.31	2.27***	73***	50	60***	49***
Above 75th	3.32	2.53***	86***	57	65***	46***
Number of beds						
Less than 300	4.24***	2.56***	56***	55	45**	31**
300 or more	2.72***	1.88***	73***	50	56**	43**
Services						
Outpatient clinic	3.94***	2.68***	66***	47	53	43
Home-based program	4.01***	2.61***	75	49	55	49**
Recommended coverage	3.61***	2.39***	62***	54	53	44***
Above median penetration	4.13***	2.77***	67	57**	54	40

**p ≤ 0.05

***p ≤ 0.01

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