

HOME-BASED PALLIATIVE CARE (HbPC) STAFFING MODELS SUMMARY

Palliative care programs that successfully operate under fixed payment rely on new staffing models that rely less heavily on billable clinicians. This document reviews the three main types, to help others understand the pros and cons and consider what might work for their own patient population and circumstances.

NP-SW Team with MD Oversight Model

Interdisciplinary field teams are led by NPs practicing at the full scope of their license, with support from social workers to address psychosocial needs and family support. Office-based RNs may provide telephone-based case management and triage support. Multiple teams report to a lead MD for oversight.

Benefits

- NPs can meet most patient clinical needs immediately: prescribing, conduct of the history and physical exam, comprehensive assessment, care plan revisions, conduct of advance care planning conversations over time.
- NPs can bill fee-for-service for visits.
- This model is flexible and can assume primary care of the patient when needed, though most programs use a co-management model in collaboration with the patient's primary physician.

Costs and Disadvantages:

- The NP-led model has higher staffing costs relative to RN-led programs. Costs are mitigated by investing in office-based administrative and case management support, enabling NPs to handle larger caseloads.
- Some treating physicians may be less receptive to coordinating care with an NP, rather than MD.

Staffing and Caseloads

Field teams are groups of clinicians making visits in the field and serving patients in home settings. Based on surveys of existing NP-led programs, staffing ratios for all disciplines are suggested:

Field team = NP + SW

Number of patients per field team: 250-300

Patients per NP: 50-60

Patients per SW: 300-500 (caseloads will differ according to the socioeconomic profile of patient population)

Patients per MD (in oversight role): 500-700

*Consider an RN in a telephonic support role for every 250-500 patients

*Consider community health workers in non-clinical support roles.

The NP-SW Team Model in Action: Aspire Health

Field team = NP + SW

Number of patients per field team: 275

Number of staff per field team: 5 NP, 0.5 SW, 0.5 RN (office), 0.3 MD (oversight), 0.3 MD (clinical director)

number of patients per NP: 55

Number of patients per SW: 500

Number of patients per RN (office coordinator): 500

Number of patients per lead MD/clinical director: 825

Three IDTs roll up to two MDs: a lead MD and a clinical director. Aspire also employs community health workers to support field teams by phone, conducting check-in calls, scheduling, and troubleshooting with pharmacies and private duty caregivers. Aspire patients receive a home visit from an NP on average 1.3 times per month and a phone call from an NP twice a month, with more frequent visits and calls as clinically appropriate.

RN-SW Team with MD/NP Oversight Model

Interdisciplinary field teams are led by RNs to monitor and address clinical needs with support from social workers to address psychosocial and family support. Multiple teams report to a lead MD and/or NP for oversight.

Benefits

- The RN-led model has the lowest staffing costs, though it may require investment in other areas (see costs and disadvantages).
- With clinical oversight from both an MD and/or NP, RN-SW programs can assume primary care of the patient when needed, though most programs use a co-management model in collaboration with the patient's primary physician.

Costs and Disadvantages

- RNs cannot prescribe. Additional patient care hand-offs are necessary if medication changes are needed.
- Additional supervision from an MD or NP may require investment in telehealth to support virtual visits for patients with acute needs, especially if the program aims to scale.

Staffing and Caseloads

Field teams are groups of clinicians making visits in the field and serving patients in home settings. Based on surveys of existing RN-led programs, staffing ratios for all disciplines are suggested:

Field team = RN + SW

Number of patients per field team: 200-300

Patients per RN: 50-80

Patients per SW: 100-600 (caseloads differ according to socioeconomic profile of patient population)

Patients per MD (in oversight role): 500-700

*Consider an RN in a telephonic support role for every 250-500 patients

*Consider community health workers in non-clinical support roles.

The RN-SW Model in Action: ProHEALTH Care Support

Field team = RN + SW

Number of patients per field team: 320

Number of staff per field team: 4 RN, 0.5 SW, 0.5 MD

Patients per RN: 80

Patients per SW: 640 (caseloads differ according to patient population)

Patients per MD (in oversight role): 640

ProHEALTH assigns patients to one of three risk tiers. (1) High risk patients receive two in-person RN visits and two telehealth visits per month, and more if needed. Social workers visit monthly until the situation is stable then are available by phone. (2) Medium risk patients receive one in-person RN visit and one telehealth visit per month. Social workers make two monthly visits, then telehealth calls as needed. (3) Low risk patients receive an in-person RN visit every two months and a telehealth visit every month. Social workers make one visit and then telehealth calls as needed. RNs make between 4-5 visits per day, geo-mapped to keep them in a tight radius.

ProHEALTH also has "friendly visitor" volunteers who visit the home and can report concerns.

The Mixed Model:

Interdisciplinary field teams include NPs, RNs and social workers deployed in several ways:

Model A: NPs conduct initial visits with patients to complete assessments, conduct goals of care conversations and develop patient-centered care plans; RNs then take over for follow-up clinical monitoring and care; social workers visit/call as needed to address psychosocial needs. (see Arizona Palliative Home Care example)

Model B: Patients are assessed and stratified into risk tiers. NPs focus on the most complex, high-risk patients, while RNs lead clinical care for patients at lower levels of risk; social workers visit/call as needed. (see Hospice Buffalo example)

In both models, multiple field teams report to an MD for oversight.

Benefits:

- Mixed models are flexible to meet patients' unique clinical needs and are especially effective when combined with the use of risk stratification.
- Mixed models can adapt to the contracting preferences of multiple payers, which may ask for an MD or NP to conduct initial patient assessments or have a more direct patient care role.

Costs and Disadvantages:

- Programs using the mixed models run the risk of trying to be all things to all payers, resulting in multiple contracts with differing protocols for patient care. Program directors warn that managing this complexity is challenging and can add additional communication hand-offs.

Staffing and Caseloads

Field teams are groups of clinicians making visits in the field and serving patients in home settings. Based on surveys of existing mixed model programs, staffing ratios for all disciplines are suggested:

Field team = NP, RN, SW

Patients per field team: 250-280

Patients per NP (mixed model A): ~150

Patients per NP (mixed model B): ~50

Patients per RN: 40-60

Patients per SW: 60-300 (caseloads differ according to patient population.)

Patients per MD (in oversight role): 500

*Consider an RN in a telephonic support role for every 250-500 patients

*Consider community health workers in non-clinical support roles.

The Mixed Model (A) in Action: Arizona Palliative Home Care

Field team = NP, RN, SW, MD

Patients per field team: 250

Number of staff per field team: 1 MD, 1 NP, 6.5 RN (field), 1 RN (office), 5 SW

Patients per NP: 150

Patients per RN: 40

Patients per SW: 60 (caseloads differ according to patient population)

Patients per MD (in oversight role): 250

Patients per RN (in a telephone role): 250

Each patient receives an initial visit from an MD or NP, and 1-2 RN visits per month thereafter. Nurses make follow-up telephone calls to patients 2-3 days after medical appointments, new medications or tests. Social workers make 1-2 visits in the first month.

The Mixed Model (B) in Action: Hospice Buffalo

Field team = NP, RN, SW, MD

Patients per field team: 260

Number of staff per field team: 0.5 NP, 7 RN, 1.5 SW, 0.25 MD

Patients per NP: ~50
Patients per RN: 40
Patients per SW: 90 (caseloads differ according to patient population)
Patients per MD (in oversight role): 500
Patients are formally triaged into three risk tiers. All visits are made by RNs, with support from the NP for the highest risk patients. High-risk patients receive 4 visits per month, medium-risk receive 2 visits per month, and low-risk patients receive one visit a month, all with phone support as needed. Social workers are deployed as needed.

Additional Considerations

Risk stratification can help determine the frequency of patient touchpoints: Growing numbers of home-based palliative care programs are using “risk stratification” - sorting patients into groups according to their level of need, and “dosing” visits accordingly. Programs commonly use three risk levels – high, medium and low – with criteria for each, supplemented by clinical judgement.

See the Accelerator’s “Patient Stratification Tool” for suggested criteria and tips on using stratification.

24/7 telephone/telehealth support: Almost all programs provide 24/7 telephone support, citing it as a crucial aspect of quality care, consistent with NCP Clinical Practice Guidelines. After-hours calls can be managed directly or contracted through a third party. Aspire Health reported that around 30% of its patients use the after-hours call service, while other programs reported lower usage in the 5-10% range. Most programs provide a visit in response when warranted, and telehealth can be used for rapid response as well.

See the Accelerator’s “Telehealth Guide” for more information on how to establish and use video-conferencing.

Scheduling and other support functions: There is no single approach to scheduling and other support functions. While some home-based palliative care programs have additional support staff to conduct scheduling, check-in calls and trouble-shooting, others still rely heavily on their field teams to manage those functions. However, as programs grow, reducing administrative burden reserves the time and skill of clinicians for patient care, and allows for increased caseloads.

Structured team communications support quality care: Weekly interdisciplinary team meetings are essential for field teams to remain connected and coordinated. They can be in-person or virtual, but at least some in-person team meetings should be regularly scheduled. These team meetings should be structured to focus on coordination and decisions and changes in care plans should be well-documented. For example, at Hospice Buffalo’s team meetings, they discuss (i) all new admissions, (ii) patients that have had an on-call visit or telephone call, (iii) patients that are currently hospitalized, (iv) patients that have died in the program, to conduct a case review, (v) patients that are hospice eligible, (vi) any live discharges from the program. Program directors should also be explicit about how they expect teams to conduct and document their daily interactions when they are out in the field, whether by phone, EHR messaging, or group chat software.

Adjust the staffing model to meet special needs: Caseloads for social workers need adjustment based on underlying patient population, ranging from 35 patients per social worker for patients and families with high psychosocial needs, to up to 600 patients per social worker in more well-resourced populations. Programs operating in rural areas typically adjust their caseloads to account for travel time. For example, Transitions LifeCare, based in Raleigh, NC, has a mixed model home palliative care program in which NPs and nurses serving urban and suburban areas have standard caseloads of between 50-60 patients. NPs and nurses in rural areas see on average 20 fewer patients.

Further guidance for planning and starting a home-based palliative care program can be found in CAPC’s [“Palliative Care in the Home: A Guide to Program Design.”](#) The guide contains program startup and staffing examples from 10 well-established home-based programs, demonstrating the impact that geography and other factors have on staffing design.