A COMPARISON OF QUALITY OF HOSPICE CARE FOR RURAL AND URBAN RESIDENTS

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Purposes/Aims: Rural communities have less access to hospice care. Once rural patients are in enrolled in a hospice program it is not known if they receive similar quality care as their urban counterparts. This study examined whether patient and families’ perceptions of quality of hospice care differ in rural and urban areas.

Rationale/Conceptual Basis/Background: In 2011 1.65 million people received care from one of the 5300 hospice programs in the United States (US) and 44.6% were under the care of a hospice provider at time of death. 57.5% were freestanding hospice programs. Whether these patients and their families receive the care they need and have subsequent good hospice outcomes has been understudied. Guided by the Quality Health Outcomes Model (QHOM) we examined the interrelationships between system (geographic and care location), 3 hospice interventions (explanation of plan of care, information about patient’s condition, and emotional support), patient characteristics (race/ethnicity, primary diagnosis, and relationship to patient), and 3 hospice outcomes (overall satisfaction, satisfaction with pain management, and satisfaction with other symptom management).

Methods: Using a cross sectional design, the study used survey data from 743 patients and their families who were admitted to one large hospice program (in-patient or at home) in the Southeastern US during September 1, 2009 – April 30th, 2010. As part of their quality assessment, the hospice organization called all adult patients and/or family/significant other 4-10 days after admission to assure they had received the care they needed. Patients were divided into rural and urban areas using the Area Resource File (ARF) county codes: 1-3 were designated urban and 4-9 rural. Descriptive summaries were compared using Chi-square and logistic regressions were used for initial univariate and final models.

Results: About 67% of patients received hospice care at home. Compared to patients in urban areas, rural patients were significantly more likely to be White and less likely to be African American (7.9% versus 14.6%). Most patients had a non-cancer diagnosis (46.8 and 45.6%) and the respondent was least likely to be the patient (16.3% for both areas) and most likely to be an adult child (35.6% and 41.5%) followed by spouse (27.5% and 23.5%) and other (20.5% and 18.7%). The three hospice interventions had been provided in 89.8% to 94.9% of the cases with information about patient’s condition scoring lowest in urban areas and emotional support scoring highest in rural areas. In general satisfaction was rated higher in rural areas compared to urban areas but only overall satisfaction reached significance (99.4% versus 93.9%). In the regressions we found patients and families in rural areas were significantly more likely to be satisfied with hospice care. Except for one association, satisfaction with patient management and explanation of plan of care, the 3 hospice outcomes were more likely to be rated higher if one of the 3 hospice interventions were in place.

Implications for research, rural health and/or rural practice: This is one of the first studies that assess patients and families perception of quality during the period of Hospice care. Most studies use post mortem surveys of family members. It is encouraging that there was no difference in quality ratings between patients and other respondents. In both rural and urban areas the high satisfaction scores were attributed to high scores of hospice care interventions. In general rural patients and families were more satisfied with hospice than their urban counterpart suggesting there are factors not included in this study explaining the higher rural ratings. The community connectedness between providers and patients described in other studies may explain this finding.

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