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Core Roles and Responsibilities of Physicians in Hospice Care: A Statement by and for U.S. Hospice and Palliative Care Physicians

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Abstract

Physicians are integral members of hospice interdisciplinary teams (IDTs). This statement delineates the core roles and responsibilities of hospice medical directors (HMDs) and hospice physicians who are designated by the hospice program to fulfill core HMD responsibilities. In addition, we describe the basic elements of hospice programs' structure and function required for hospice physicians to fulfill their roles and responsibilities. Finally, we call attention to hospice program characteristics and circumstances of the work environment that should raise a hospice physician's concerns that hospice patients and families are at risk of receiving low-quality care. Such factors include lack of a functioning IDT, minimal physician involvement in direct patient care and clinical IDT meetings, inadequate responses to symptom emergencies in patients' homes, and no or limited access to general inpatient and continuous home hospice care. We write as individual physicians who are concerned about troubling variability in access to and quality of U.S. hospice care. This statement arises from the need to protect the safety and well-being of vulnerable seriously ill people with their families from low-quality hospice care. This statement is primarily intended to be a resource to hospice physicians in negotiating employment agreements and justifying staffing and programmatic resources necessary to perform their jobs well. This statement may also serve as a resource and reference for patient advocacy groups, hospice industry leaders, health services oversight organizations, accountability agencies, and legislatures in efforts to ensure the safety, quality, and reliability of hospice care in the United States.

Keywords: clinical standards; ethical standards; hospice care; hospice medical director; roles and responsibilities

Introduction

Hospice care in the United States is an interdisciplinary model of caring for people with incurable medical conditions who are approaching the end of life. In this country, hospice care is recognized as a best practice in caring for dying people and their families, primarily at home. Organizations providing hospice care are paid per diem by Medicare, Medicaid, and most insurance and health plans. Physicians are integral members of the hospice interdisciplinary team (IDT).[1,2] Although the majority of direct hospice care is delivered by nurses, hospice physicians have indispensable clinical roles and administrative responsibilities in hospice teams and programs. This statement reviews the core roles and responsibilities of hospice medical directors (HMDs) and hospice physicians, whether employed, contracted, or volunteering, who are designated by a hospice program's medical director to fulfill core responsibilities.

We write as individual hospice and palliative medicine (HPM) physician specialists. We are clinicians, some who have retired from practice; many of us have served as HMDs, palliative care program directors, HPM fellowship directors

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and faculty, and have contributed to development of clinical standards, best practices, and curricula for our field. Several of us have held leadership positions within the American Academy of Hospice and Palliative Medicine.

In recent years, we have observed an increasing prevalence of serious deficiencies in hospice care and high variability in quality of care from one region and one hospice program to another. Our observations are reinforced by government oversight reports,[3–6] peer-reviewed research,[7–10] journalistic investigations,[11–13] and the industry's own data.[14]

Shortages of qualified clinical staff, unsafe and unsustainably high hospice nurse caseloads, and the diminishing scope and roles of HMDs figure prominently among trends that contribute to variability in quality and increasingly common instances of poor care.

We are moved to write, first and foremost, to protect the safety and well-being of vulnerable seriously ill people and their families who are at risk of receiving substandard and unsafe hospice care. We are also motivated to issue this statement out of concern for physician colleagues who may be asked to participate in hospice programs that are staffed, structured, and operated in ways that put patients and families at risk of poor care, and concomitantly expose physicians to violations of clinical and ethical standards.

In this statement, we delineate basic expectations and requirements of hospice physician practice. This statement is intended to serve as a resource to hospice physicians in negotiating employment agreements and justifying resources required to accomplish their clinical and administrative responsibilities to provide consistently high-quality patient and family care.

Roles and Responsibilities of Hospice Physicians

The need for physicians to actively participate in the care of hospice patients is self-evident. People receiving hospice care are, by definition, among the sickest patients in any health care system. Hospice patients often have multiple comorbidities, and many have complex symptoms and care needs. Physicians bring a high level of training and licensed scope of practice to hospice IDTs and programs, contributing to an environment in which other clinicians are able to perform to the full extent of their license and scope of practice.

HPM is a medical subspecialty; however, there are not enough physician specialists certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) nor sufficient fellowship positions to meet the need for hospice physicians in the United States. Nevertheless, physicians working in hospice care must have special knowledge and skills in symptom management, communication, shared decision making, team-based practice, and hospice regulatory compliance.

Writing in *The Hospice Medical Director Manual* of the American Academy of Hospice and Palliative Medicine, Drs. Robert Friedman and Joel Policzer succinctly summarize the overall role that physicians play in the hospice IDT.

> ''The hospice medical director (HMD) plays an integral role in, and is ultimately responsible for, the medical care of the hospice patient. This role normally involves direct patient care, collaboration with other team members, provider oversight, and related clinical-administrative functions.''[15]

These basic clinical roles and responsibilities of HMDs, as well as additional administrative responsibilities, whether practicing directly or discharged through delegation to other hospice physicians, are formalized in Medicare's hospice conditions of participation regulations.[16]

In the Foreword to *The Hospice Medical Director Manual*, Dr. Edward Martin emphasized the hands-on nature of the physician's role in contemporary hospice care.

> ''The role of the HMD has greatly expanded due to new regulatory requirements and the expectation that the HMD will be involved in the initial decision to admit, writing the narrative, face-to-face visits, and determining what is related and what will be covered.''[17]

Active participation by physicians is essential to well-functioning interdisciplinary hospice teams. Hospice physicians' expertise is invaluable in developing comprehensive individualized patient plans of care. Whether or not they convene or manage meetings of the hospice IDT, hospice physicians must consider themselves medical leaders of the clinical team.

Hospice nurses provide the majority of direct patient care and generally take a leading role in developing each patient's individualized plan of care. Working closely with each patient's nurse case manager and other members of the clinical team, hospice physicians bear ultimate responsibility for each patient's overall medical care.

At the time of election of hospice care, a hospice physician is needed to review the available medical records and preliminary assessments of each patient referred for admission. The primary purpose of this physician review is to confirm and certify eligibility for hospice under Medicare (or other insurance). It is important to note that during the review of a patient's records or during direct clinical evaluation of a patient, hospice physicians occasionally identify treatment options for the patient's primary diagnosis or general medical condition that might meaningfully prolong the patient's life and have not been previously considered or discussed with the patient.

Examples include patients with end-stage heart failure who have not had a trial of optimal medical therapy or patients with advanced cancer who, with tumor genotyping, might benefit from targeted immunotherapy. In bringing treatment options to the attention of the primary, attending, or referring physicians, hospice physicians contribute to the quality of care of patients with serious illnesses who are referred to hospice beyond those who are admitted to hospice services.

Medication review is another critical component of the clinical evaluation of prospective and recently admitted hospice patients that requires a physician's knowledge and skill set. Patients with serious medical conditions are commonly taking numerous medications, often prescribed by multiple providers, and may require additional prescription medications to alleviate pain and other symptoms. Although polypharmacy cannot always be avoided, it should be reduced to the extent possible, and careful management is required to avoid drug–drug interactions and adverse drug effects.

Patients with life-limiting medical conditions are at risk for acute deterioration of their health and sudden worsening of pain or other sources of suffering. Physicians' knowledge, clinical experience, and perspective are invaluable for

developing an individualized crisis prevention and management plan. Hospice physicians should create a team culture in which nurses seek and receive active physician consultation for difficult clinical situations. Importantly, hospice physicians, individually or through a shared call system, must quickly respond to time-sensitive questions or requests for assistance from hospice nurses in managing symptoms including prescribing new medications when necessary.

Furthermore, Medicare conditions of participation specify that, ''if the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.''[16]

Additional duties of hospice physicians include communicating with patients' primary, attending, and referring physicians, and serving as liaison between the hospice program and the general medical community. When patients' primary physicians are unavailable, hospice physicians ensure that death certificates are completed in a timely and accurate manner. Physicians should participate in team-building and continuing education of clinical members of the interdisciplinary hospice team.

Hospice physicians are charged with deciding which diagnoses and related treatments will be covered by the patient's Medicare Hospice Benefit (or similar insurance plan).

Hospice physicians are obliged to participate—directly or in a delegated manner—in their hospice program's quality assurance and performance improvement process. By virtue of their roles in delivery of clinical care, oversight, education, and quality improvement, hospice physicians must participate in their hospice program's response to concerns raised during quality surveys and by governmental accountability agencies (Fig. 1).

What Hospice Physicians Need to Do Their Jobs

In comparison with many other clinical specialties, hospice physicians require relatively few highly technical tools and expensive medical resources to do their jobs well. However, hospice physicians do require adequate professional time to fulfill their responsibilities, including (1) preparing for and participating in interdisciplinary hospice team meetings, (2) reviewing patient records, (3) visiting patients in their homes, hospitals, and other facilities as clinically needed, and making face-to-face visits required for certification and recertification, (4) communicating with hospice nurses and other team members, (5) communicating with patients' primary, attending, or referring physicians, (6) taking part in the hospice's quality improvement program, (7) participating in IDT development and education activities, as well as (8) participating in general medical community and public education.

To be effective in their clinical role, hospice physicians require hospice programs to maintain adequately staffed full IDTs, as specified by the Medicare hospice conditions of participation, which function in case review and care planning. Physicians should expect that their hospice programs provide access to the four levels of hospice care—routine home care, respite care, continuous home care (CHC), and general inpatient care (GIP)—required by the Medicare hospice conditions of participation. Out of concern for patients with high acuity and complex needs, hospice physicians should expect that they or hospice physician colleagues will visit patients receiving general inpatient hospice care. As part of the continuum of care for seriously ill patients and their families, physicians should be able to rely on their hospice programs to offer bereavement services to families, also as required by Medicare.[16]

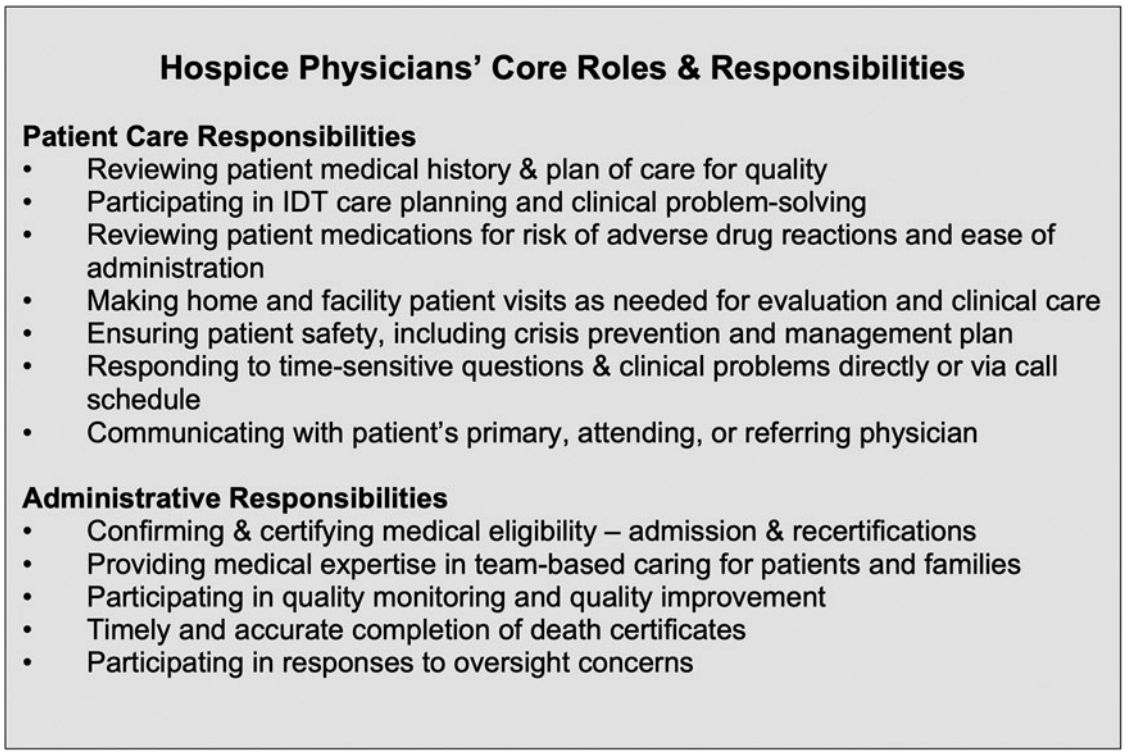

FIG. 1. Hospice physicians' core roles and responsibilities. IDT, interdisciplinary team.

All hospice physicians, particularly those who do not have subspecialty HPM certification through the ABMS or AOA, should be supported by their hospice programs to pursue training and skill-building that leads to Hospice Medical Director Certification through the Hospice Medical Director Certification Board[18] (Fig. 2).

Circumstances That Should Raise Physician Concerns

Employment agreements between hospice programs and physicians vary widely in structure, compensation models, and scopes of service. Current hospice physician employment agreements may specify discrete roles of physicians, such as certification and recertification of patients, without encompassing or compensating essential clinical and administrative responsibilities previously outlined. Some agreements may explicitly exclude direct patient visits from the scope of physician services or tacitly discourage physicians from making patient visits.

Physicians employed or contracted primarily to provide administrative functions may assume that other physicians are responsible for direct patient care. Similarly, physicians employed or contracted primarily to provide direct patient care may assume that other physicians are responsible for IDT support, clinical supervision, and required quality improvement functions.

Matters of safety, quality, and regulatory compliance require explicit delineation within employment agreements or program policies describing with specificity how the full complement of hospice physician responsibilities will be met by the physician, hospice medical staff, or company medical director. Physicians should be concerned if their contract, service employment agreement, or performance expectations do not ensure that the full scope of HMD and affiliated hospice physician responsibilities can reliably be met by themselves or their colleagues.

There are reasonable limits to the clinical caseload that any physician can responsibly maintain. Variability in the acuity and complexity of a program's patient population, geography and patient density, and in the design of medical practices challenge development of numerical guidelines for hospice physician caseload. For instance, some hospice programs have one or more physicians who dedicate their efforts to the care of patients receiving GIP level care either full time or on a rotating basis; other programs have collaborative arrangements in which GIP level of care is delegated to an external hospice program that maintains a specialized hospice care facility.

That said, it is the considered opinion of senior HMDs consulted in the development of this statement that an average daily census of 75 to 100 patients is at the high end of the range of caseloads that a single IDT and hospice physician can safely and effectively manage. This range is intended to apply to practice arrangements and periods of service in which individual hospice physicians are carrying minimal to modest GIP care responsibilities. Physicians who are required to assume sole responsibility for >100 patients at a time, even if those responsibilities are primarily to determine initial eligibility and recertification of eligibility for hospice care, should be concerned that patients may not be receiving optimal quality care.

Hospice nurses make the majority of patient visits and each patient's nurse case manager is the operational linchpin of their care. A national nursing shortage has impacted hospice care, challenged hiring and retention, and required recruitment of less experienced nurses. Hospice physicians practice in close collaboration with hospice nurses in managing patients' symptoms and medical needs, while bearing ultimate responsibility for hospice patients' clinical care. Physicians should be concerned about quality of care if nurse case managers are carrying caseloads that limit their visits, inhibit their responsiveness to calls, questions and urgent problems, or cause nurse strain and moral distress.

Reasonable numerical caseloads for a hospice nurse manager will vary by patient acuity, geographic density (travel time), program staffing structure, as well as each nurse's skill set. Hospice nurses we have consulted with years of clinical and supervisory experience state that an average caseload of 10 to 12 hospice patients per nurse is reasonable and sustainable. If patients reside in a single facility or proximity, a caseload of 12 to 15 may be reasonable. A reliable way for a hospice physician to assess the safety and sustainability of nursing caseloads in their program is to ask their nurse colleagues how often they are able to accomplish their clinical

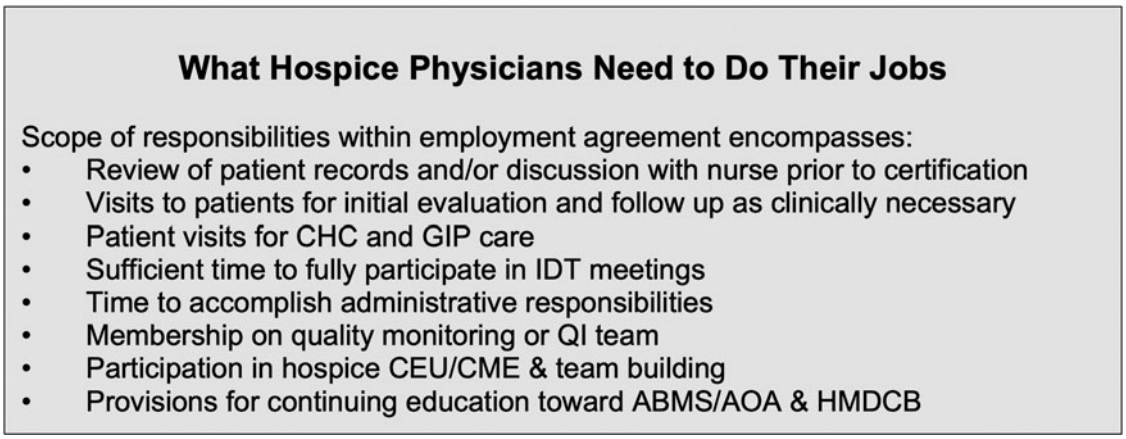

FIG. 2. What hospice physicians need to do their jobs. ABMS, American Board of Medical Specialties; AOA, American Osteopathic Association; CEU, continuing education units; CHC, continuous home care; CME, continuing medical education; GIP, general inpatient care; HMDCB, Hospice Medical Director Certification Board.

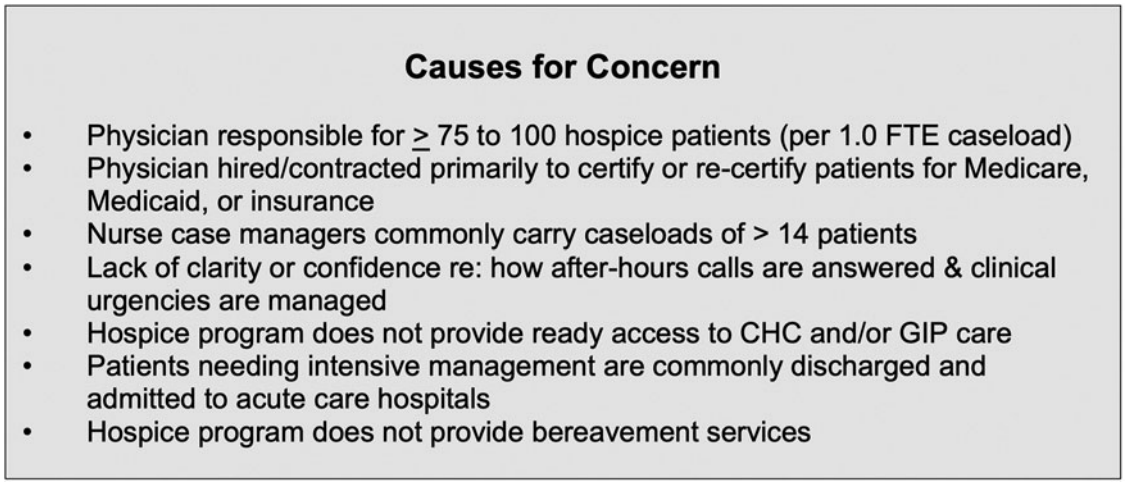

FIG. 3. Causes for concern. FTE, full time equivalent.

tasks and administrative responsibilities within their workdays. Delayed clinical documentation or notes that are frequently entered during personal hours raise concerns about nurse:patient ratios.

Hospice IDT case reviews and collaborative care planning are essential to good quality hospice care. Concerns should be raised if a hospice program's IDT meetings have become perfunctory, are commonly rushed, and do not allow for substantive interdisciplinary discussion of patient and family needs and creative problem-solving.

Physicians should be very concerned if their hospice program does not provide CHC and GIP. The ability to deliver one or both of these intensive levels of hospice care is essential for reliably managing some patients in acute distress or with persistent suffering. Both CHC and GIP levels of care are operationally challenging for hospice programs to provide and, unfortunately, many programs fail to provide either. One result is unmet patient and family needs. Another is inappropriate forced discharge from hospice and admission to acute care facilities. Physicians should note that the capacity to deliver both CHC and GIP are Medicare hospice conditions of participation (Fig. 3).

A Call for Corrective Actions

Physicians are critical to safe and effective medical practice and health care delivery. Physicians' commitment to quality and professional integrity are bulwarks of the U.S. health care system. In the context of recognized problems of high variability in quality of hospice care and the long-standing challenges related to timely and equitable access to hospice services, competent, highly engaged physician leadership is called for within each hospice clinical team, each hospice program and provider organization, as well as collectively within professional associations.

Multifaceted approaches will be required to mitigate and ultimately resolve the problems affecting hospice care in the United States today. Legislatures, regulatory agencies, health care trade organizations, professional associations, as well as patient advocacy and consumer groups all can take actions that contribute to ensuring equitable access to reliably high-quality hospice care.

Physicians alone will not be able to correct the deficiencies and variable quality of hospice care. However, without a commitment by physicians, individually and collectively, to practice and lead in ways that are consistent with clinical and ethical standards, no extent of policy changes, regulations, oversight, accountability, and patient-consumer demands are likely to correct the crisis that surrounds hospice in America today.

The quality parameters and cautions delineated within this statement may inform physicians and hospital discharge planners in making referrals and recommendations for specific hospice programs. By highlighting the critical services hospice physicians are expected to provide, this statement may also inform consumer guidelines and quality score cards and assist prospective hospice patients and families in choosing among available hospice programs.

Finally, we hope that this statement serves as a reference for legislatures, public and private oversight organizations, and accountability agencies in efforts to ensure the safety, quality, and reliability of hospice care in the United States.

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Disclaimers

We have not addressed the roles and responsibilities of advanced practice professionals, including hospice nurse practitioners (NPs) and physician assistants (PAs). Some statutes and regulations relevant to hospice care empower NPs and PAs to perform selected functions of physicians. To the extent that NPs and PAs perform the roles and responsibilities of hospice physicians, content of this statement may apply.

This statement expresses the views of the individual physicians whose names appear as follows. It is not intended to reflect the positions of any institutions, health care organizations, or professional associations.

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