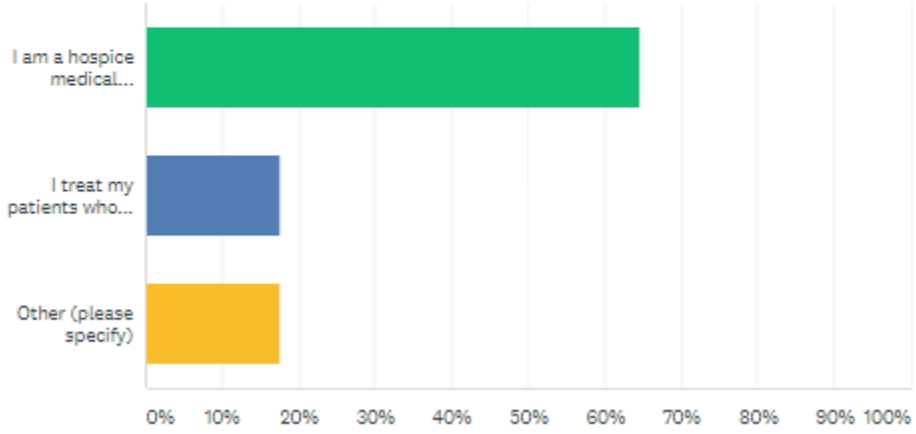
MAFP Hospice Physicians Survey – August 2019

Q1

Customi

In your practice, what is your area of hospice treatment?

Answered: 17 Skipped: 1



I am both a hospice medical director and I have followed my own patients with other hopices as well the hospice I am director of. I have an aging population and I would like to offer them hospice care to the hospice I am medical director of, when appropriate, because I have a lot better contact and follow up with the hospice I am director of, than with the other hospices who give me just lip service.

8/26/2019 12:59 PM View respondent's answers Add tags

Hospice assistant medical director. I will also treat my patients who are on hospice.

8/23/2019 12:42 PM View respondent's answers Add tags

I have previously been a hospice medical director and will likely do so again in the future.

8/22/2019 11:59 AM View respondent's answers Add tags

Question 2: The MSBML has laid out new requirements of a 'proper physician-patient relationship' in its proposed new hospice regulation, including the following:

1. **The medical director must receive an order from the treating/referring physician requesting the patient be admitted for hospice care;**
2. **That the treating hospice physician or medical director has thoroughly reviewed the medical records of the patient, as provided by the referring physician, has documented the review, and has determined just cause exists for hospice admission (expected death in six months or less), with documented follow-up review at every certification period thereafter;**
3. **That the actions of the physician are otherwise deemed within the course of legitimate professional practice, as defined by the Centers for Medicare and Medicaid Services (CMS);**

Please comment below with any feedback on the 3 factors above.

Pt as to meet criteria to be admitted and will not be admitted if they do not meet it. This always done. Pt are reviewed every two weeks in our hospice. The PCP is encouraged to continue to care for the pt . They are all reviewed on a regular basis. 9/3/2019

1. The medical director works for the Hospice company. I think the order needs to be directed toward Hospice care as this is definitely a team approach. 2. MANY times, the full records are NOT available at the time of admission, but based on a diagnosis of say "widely metastatic cancer, refusing treatment" on a patient that has had a recent 60 lb weight loss, the MSBML should defer to the judgment of the medical director rather than insisting that all medical records be thoroughly reviewed prior to admission. The physician that is treating the patient knows that patient the best and should have some say in whether their patient is hospice appropriate or not. 9/2/2019

WE are doing this now 9/2/2019 11:20 AM

Agree. I work in a physician shortage area and I am often both the attending referring physician and the accepting Hospice Medical director. So I am referring to myself. I ask my patients if they have a particular hospice preference. As attending I refer my patients to the hospice of their choice. If they have ties to other hospices, I honor their preferences. 9/1/2019

all appropriate 8/28/2019 3:26 PM

I do numbers 1-3 already. 8/28/2019 2:17 PM

These 3 factors seem reasonable. 8/26/2019 3:39 PM

I have no objections 8/26/2019 12:59 PM

More physicians should not relegate total care to a hospice medical director who has no relationship with the patient. They refer them and then take no further hand in care, possibly fearing having to write controlled substances, so they put the onus of that on the medical director. Also, because they will no longer be being paid for managing their patient they have no qualms about handing them off to someone else. I think that is a travesty. 8/25/2019 4:29 PM

#1 does not seem necessary since there are already guidelines from CMS on what criteria need to be met to qualify for hospice. #2 & 3 seem redundant since we already do this as part of cms requirements 8/23/2019 5:00 PM

Factor 1 is not entirely unreasonable. Factor 2 May proved to be a bit cumbersome if someone is needing hospice admission in their final hours or days. Also, Medicare does not require that a patient passed away or be discharged from hospice within 6 months of enrollment. Medicare allows for recertification periods. I would rather see this language track the language of Medicare rules or guidelines. The language of "expected death in 6 months or less" seems like a bit of a trap to me. Factor 3 seems fine to me. 8/23/2019 12:42 PM

New regulations don’t giveA timeline for initial review of the medical records 8/23/2019 8:15 AM

certification followups now done by NP--that should suffice since they will allow them such free reign 8/22/2019 1:20 PM

I am thought these factors were already in place 8/22/2019 1:19 PM

What if the treating/referring clinician is an NP? Often it is a primary care provider who refers a patient even if the patient is seeing specialist such is oncology, pulmonology, cardiology, etc. With the exception of oncology, specialists seldom make a hospice referral. What documentation is acceptable for confirming that medical records have been "thoroughly reviewed"? 8/22/2019 12:48 PM

We already comply with those three criteria. One exception being the hospice referral does not always come from a pcp. Some patients do not have a pcp. The referral can come from other sources. 8/22/2019 12:45 PM

I strongly agree with those factors, although I am not sure they are sufficient. As I see it they are trying to deal with the current reality, that hospice directors typically don't see the patients, but need to prescribe for them. Although

hospice status in some ways simplifies the patient issues, I'm not convinced it is fair to hospice patients to be treated by someone who has never seen them. 8/22/2019 12:42 PM

I believe this is completely appropriate. As a physician that sometimes finds my patients enrolled with hospice without my knowledge beforehand, I think this will help cut back on inappropriate hospice recruitment. 8/22/2019 11:59 AM

I am already doing all of these. 8/22/2019 11:41 AM

Question 3

The MSBML's 4th requirement of a 'proper physician-patient relationship' is "that the physician's live-discharge rate for hospice patients does not exceed 20 percent." Do you know your discharge rate? Is it difficult to find out this percentage? Please comment below:

I do not know. Pt's are discharged if they go in to the hospital even for unrelated problems. We have little control over this and I do not see how we can be held responsible for this. We do truly discharge pts when they no longer meet criteria or if they go to the hospital for admission more than 3 times because we feel they are not committed to being a hospice pt. 9/3/2019 10:31 AM

Mine is higher than 20%. Wonder why they picked this threshold? If a patient has a very close family, the entire family may be in agreement as to the procedure as a person approaches end of life. If a patient has no close family or is strongly influenced by their church or their neighbors or the one child in California, they may choose to revoke hospice near the end of life. Then the hospice director gets penalized? Medicare is fussing about keeping people on hospice and MSBML is fussing about people getting off of hospice..... 9/2/2019 7:06 PM

I would say it does not exceed 20 % - don't know exact numbers 9/2/2019 11:20 AM

Very Very difficult to determine. I usually have about 40 to 50 patients on hospice. I discharge one about every 4 to 6 months. Some patients die in 2 days , 2 weeks or 2 years. There would have to be a time limit to obtain the percentage of live discharges, one or two years , six months, three months? I'm not sure there would be any relevant , value based information from that statistic. 9/1/2019 10:32 AM

My life discharge rate is less than 5 %. I work with a very reputable hospice. BUT I do know of a couple of hospices that have much higher rates because they do not follow the rule of less than 6 mo life expectancy. 8/28/2019 3:26 PM

That sounds like a reasonable figure but there are extenuating circumstances to consider in that many hospice discharges are due to the family and/or patient becoming scared, and going to the ER and/or hospital to die, in which case these patients were indeed hospice appropriate. 8/28/2019 2:17 PM

Dont know rate. Dont think it should be difficult to find out rate. 8/28/2019 2:31 AM

I have no idea what my number is. I can't predict the future. If you are going to allow non cancer diagnosis on hospice, this is not realistic. 8/27/2019 9:23 PM

I do not know my discharge rate but think it would not be difficult to obtain. 8/26/2019 3:39 PM

No, My hospice has a record of it. In my work with them I believe the live-discharge rate is below 10% 8/26/2019 12:59 PM

How would anyone know this.It is ridiculous to make the assumption that people know their live discharge rate. In fact prior to seeing this proposed document....I never heard the term!!! Also medical directors have no control over patients and families who become apprehensive when the patient reaches a more terminal state, and "revoke" or leave hospice AMA. That results in a "live discharge." 8/25/2019 4:29 PM

This is very difficult to determine, it would be better to have a rule about length of time someone can be in hospice before they have to be discharged and then criteria for admission to hospice again. 8/23/2019 5:00 PM

Factor 4 is be on the control of the physician. Many patients in Mississippi self discharge by going to the emergency department or getting themselves admitted to a hospital or nursing home that does not have a contract with the hospice provider they have been admitted to. Some people choose to terminate hospice services and therefore would be considered a live discharge. I think the assumption is that a high discharge rate indicates fraud and that is not necessarily true. this factor is a definite trap for physicians when this factor is outside the control of a physician. It also supports the assumption that, if a patient is not dad within the first 180 days after admission then they did not need hospice in the first place. 8/23/2019 12:42 PM

Yes we can find out our live discharge rate, but this should not be a factor, as long as the initial admission criteria are met. 8/23/2019 8:15 AM

Yes and it's not difficult to find out. Provided by Medicare annually. Has many complex factors including revoking hospice due to further care or not wanting to die in home as well as fraudulent hospices that exhaust days for patients who are not truly hospice. Our hospice live discharge rate is 2 %. 8/23/2019 7:54 AM

Company can provide that and we are below. Problem is too many factors that we can't control. This should only measure patients discharged due to expired benefits and not patients who changed mind and opted out(maybe to die at home or changed mind about ttreatment options) 8/22/2019 1:20 PM

Don't know live discharge rate Does this include patients who are recertified ? 8/22/2019 1:19 PM

I do not know my live discharge rate. It would not be difficulty to obtain it. However, this is something that is very difficult to control. We often admit patients who refuse to sign a DNR order. Patients in extended/long term care facilities are often sent out to the ER before hospice is notified of an issue. Many of these patients get admitted for acute treatment, and this would constitute a live discharge. A patient may decide to seek aggressive treatment again, and this is the patient's right. A study in the NEJM of a NY City NON-PROFIT hospice showed a 21% live discharge rate. If a threshold must be set, it should be much higher than 20%. 8/22/2019 12:48 PM

I do not know my discharge rate and do not know how to obtain that but it is no where close to 20%. Limiting a doctor's prescriptive authority in hospice based on a percentage of live discharge will create undue hardship on that physician. You cannot be a hospice medical director nor hospice provider if you cannot prescribe comfort meds for dying patients and patients needing palliative care. If your prescriptive authority is limited that will have an effect on hospital priveleges and licensing. This is absurd. 8/22/2019 12:45 PM

I don't know it, and given my volume of hospice patients I don't know that it would be statistically meaningful. However, I am not a Hospice Med Director 8/22/2019 12:42 PM

No this is not hard to determine, and is a hallmark of a well run hospice. However, I think that putting a hard number (the 20 percent) is dangerous and arbitrary. When many things involving the live discharge rate, such as the family taking a patient to the ER without calling the hospice first or not heeding advice and going anyway, are out of the physicians control. I would favor a tiered system where physicians that rise above a 20 percent are put under review until they get their discharge rate below 20 percent, or some similarly determined number. 8/22/2019 11:59 AM

Yes. My question is what is consider a discharge? Is it those who are deemed not hospice appropriate or those who revoke hospice services considered this too? My 8/22/2019 11:41 AM

Q4

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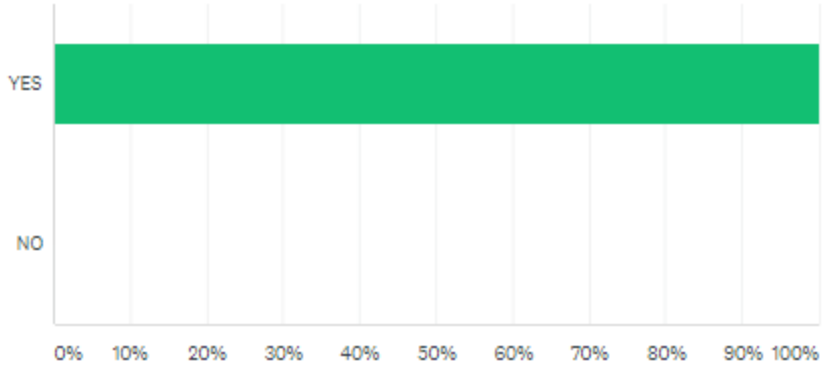
Does a requirement to see a hospice patient in person or via telemedicine in order to be able to write prescriptions hinder your ability to effectively practice and treat hospice patients?

Answered: 22 Skipped: 0



ANSWER CHOICES	RESPONSES	
YES	100.00%	22
NO	0.00%	0
TOTAL		22

Comments (17)

I simply won't be able to do this and maintain a full time practice. 9/2/2019 7:06 PM

I cant argue with this requirement - but it would require more time and problably make it harder to recruit physicians to do Hospice care 9/2/2019 11:20 AM

That requirement would severely impair my ability to provide palliative medications to patients who wanted to die at home. 8/28/2019 2:17 PM

Sometimes patients are actively dying and need comfort meds rapidly and difficult to stop everything in practice to reassess patients in a moment's notice 8/28/2019 2:31 AM

Hospice patients located in scattered rural areas would hinder my ability to practice and treat hospice patients effectively. 8/26/2019 3:39 PM

I have a busy Family Practice. I do not have the time to see every hospice patient. We have a nurse practioner that sees many of the patients for recertifications. I see some hospice patients as needed as well. 8/26/2019 12:59 PM

It does if they live an hour away, no telemedicine available. That would help. 8/25/2019 4:29 PM

It would make the job almost full time and prevent a lot of family physicians from doing it part time. It would be better to require the patients pcp remain on the case (which I feel they should) and not abandon the patient to hospice. The hospice / medical director should be a consultant to help the pcp with guidance on narcotic/morphine dosing and not take over total care of the patient. 8/23/2019 5:00 PM

The prescriptions that the Medical Board are concerned about are opiates and benzodiazepines. If a patient is suffering significantly, that suffering needs to be relieved even if it physician is unable to see the patient immediately. There should be an expectation that the physician see the patient in a reasonable amount of time after controlled substances are ordered. 8/23/2019 12:42 PM

Some patients are truly bedbound and others live in an area that has poor cell phone/internet capabilities. 8/23/2019 7:54 AM

Coordinating telemed can lead to time delays which leaves patients untreated 8/22/2019 1:20 PM

No telemedicine available and some of these patients can only be transported by ambulance which no one will pay for 8/22/2019 1:19 PM

My agency covers 12 counties, and at least 50% of those counties are very rural with limited to no cellular data or phone service. We also often get admissions for patients who are actively dying and need comfort medications such as morphine immediately. There may not be enough time to see an actively dying patient in person. 8/22/2019 12:48 PM

This will create a shortage of hospice medical directors. 8/22/2019 12:45 PM

Certainly it would make it more difficult, but I think every hospice patient deserves to have at least one prescriber who has met with him or her personally. Other team members should be able to prescribe if that one isn't available. 8/22/2019 12:42 PM

I live and practice in the Delta. My patients come from as far away as 60 miles. If it were your grandmother suffering from intractable pain at 8 AM, would you want to have to wait until the physician finished their days work and then depend on them to drive the hour to see you and THEN go to the pharmacy (which may by then be closed) in order to address their pain in a manner consistent with the very purpose for hospice? No, you wouldn't. Plus, telemedicine in this setting is not a substantial improvement for a variety of reasons. If you cannot trust the hospice nurse to accurately reflect what is going on with the patient, then viewing them via teleconference would not substantially improve your perception of the patient's status. Plus, with coverage issues for cell phone and internet services, this will preclude some patients from receiving care. 8/22/2019 11:59 AM

I have patients that leave the hospital and were not prescribed pain medications that I will prescribe for...on evenings and weekends, etc... 8/22/2019 11:41

Question 5

The MSBML's new regulation states "it shall be considered unprofessional conduct for a medical director to participate in active recruitment for patient admission to hospice."What behavior do you believe DOES or DOES NOT constitute 'recruitment'? Please let us know your experience and your input:

I have pts admitted to other hospices . I only suggest hospice care if the pt meets criteria and I think they are ready. I do not understand this issue when the board is not reviewing self referrals for heart caths, surgeries, unnecessary wt loss programs and meds and also lithotripsy for non- obstructive stones etc. 9/3/2019 10:31 AM

I have worked in hospice for years and I have no idea what the MSBML is talking about here. Don't do radio ads? Don't tell a colleague that you do hospice care? Don't tell my own patients that I can still manage their care through hospice? 9/2/2019 7:06 PM

I tell pts what hospice co I work for because I have more control on pt care- However family choice is the first line and I hve pts with all Hospice in town 9/2/2019 11:20 AM

I will send separate letter. 9/1/2019 10:32 AM

I do not feel that recommending a hospice serves as recruitment. Pts are always given a choice. 8/28/2019 3:26 PM

That is vague wording. I mention hospice services to my patients whenever I think they need it and will continue to do so. I actively recruit patients for colonoscopies and cardiac treadmill test every day as well. The term "active recruitment" doesn't mean anything to me.
8/28/2019 2:17 PM

Active recruitment would involve admitting a patient who is not your regular patient and not checking with primary provider
8/28/2019 2:31 AM

This is why I am no longer a medical director. There is pressure to find them patients.
8/27/2019 9:23 PM

I have always depended on referrals from patients' personal physicians.
8/26/2019 3:39 PM

Will it be considered unprofessional conduct for a home health agency/hospice to move their home health patient to their hospice without speaking with the patient's doctor and not allowing him to place his patient in his hospice of choice? Likewise for a doctor's hospitalized patient, when hospice is deemed appropriate, will the patient's family doctor be notified to allow him to choose the best hospice for that patient? I think this "new regulation" is absurd and cannot be enforced. Sure if a doctor goes around the hospital and asks all the patients that they need hospice, this is unprofessional conduct.
8/26/2019 12:59

I have never heard tell of a physician recruiting hospirce patients. This would be unethical, It may have happened but I have never experienced that. I know of several hospice companies who are guilty of that though. Competition is fierce. 8/25/2019 4:29 PM

I think that is reasonable, of course if the patient is a member of the medical directors practice and doctor feels patient could benefit from hospice he should be able to refer to his or the hospice of choice by patient or family.
8/23/2019 5:00 PM

I guess this depends on what would be considered "active recruitment" but generally I think this is an acceptable regulation. 8/23/2019 12:42 PM

Active recruitment to me should constitute more than 50% of his hospice referral to his own particular hospice organization 8/23/2019 8:15 AM

Not sure. It is a very vague statement. I refer my patients to the hospice I am medical director for because I know the quality of their care. I do not think this is active recruitment. 8/23/2019 7:54 AM

community recruitment such as churches, civic clubs,etc. Sending one of your own or partner's patients to a hospice that you work at is not recruitment 8/22/2019 1:20 PM

Not t sure 8/22/2019 1:19 PM

That statement leaves a gargantuan amount of room for interpretation! My position as an associate hospice medical director is not my full time job. If I advocate to a patient's family that hospice care would be the best course of therapy for a patient, could this be considered "recruitment"? I do not think it is, but a disgruntled family member who is not the POA could fill a complaint with the MSBML alleging such. I would then be subjected to responding to a needles complaint unnecessarily. A complaint could be lodged by a disgruntled employee or a representative from a competing hospice agency out of spite. Of course I think MY agency provides the best care to terminally ill patients! Why would I not be an advocate for patients to choose my agency? Could that then be construed as "recruitment"? Hospice care is an entirely different practice as opposed to the care of a non-terminally ill patient. With these regulations, I fear there will

be a lack of physicians willing to serve as a hospice medical director, and the terminally ill patients will be the ones who suffer as a result. 8/22/2019 12:48 PM

Of course, I refer my own patients to the hospice i am the director of so i can continue to be involved in their care in their final days. It is rude to care for a patient their whole life and at the end turn over care. That would make a patient feel their PCP abandoned them at the end. If they prefer another hospice I do not try to change their mind. Go after the doctors who force a patient onto a hospice and give them no alternative. There are doctors and hospitals that force a hospice on the patient. That is the problem. Fix the problem! 8/22/2019 12:45 PM

My only experience with hospice med directors and recruitment is when they encourage me to consider their company's services. That is clearly NOT unprofessional conduct. For the HMD to contact a patient he does not otherwise have a relationship with and suggest hospice to that patient would clearly be recruitment, and I believe clearly inappropriate. The tougher situation involves patients who get primary care from someone who is also a hospice medical director. His asking that patient to consider hospice certainly brings up concerns of conflict of interest. But not offering appropriate services to his patients would be unethical. 8/22/2019 12:42 PM

Recruitment should be considered interaction with any patient that the physician does not have a previous physician/patient relationship with, especially for the sake of signing up for hospice. This should specifically exclude patients from a physicians clinical practice. If I have seen a patient in clinic and think they are a hospice candidate I should be able to talk about hospice options with them, including a hospice I am involved with. 8/22/2019 11:59 AM

I am really not sure. Discussing hospice with my patients does not constitute recruitment but maybe discussing my specific hospice with someone else's patient's may. 8/22/2019 11:41 AM

Q6

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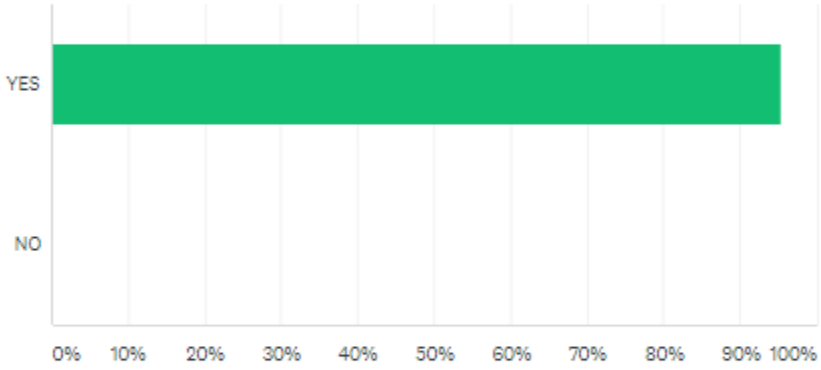
Do you feel the hospice team does what is necessary to prevent drug diversion?

Answered: 22 Skipped: 0



ANSWER CHOICES	RESPONSES	
YES	95.45%	21
NO	0.00%	0
TOTAL		22

Comments (10)

This is a careful and constant reevaluation at each IDG meeting. 9/3/2019 10:31 AM

- We check PMP on patients and review each patient every 2 weeks. We use lock boxes and if there is a suspicion of diversion, the family member is reported to the police. 9/2/2019 7:06 PM

- Diversion is ubiquitous and inevitable everywhere. So of course when you have a dying patient where controlled medications are sometimes the only medication the patient is receiving diversion potential is very high. Also the patient is usually not able to be a credible witness due to their disability. In my 47 years of experience in health care , including lab tech, nursing and physician , hospice narcotic diversions is easier to discover because health workers are exposed to the patients home. 9/1/2019 10:32 AM

Our nurses count pills and keep an eye on every person in the patient's home, etc. 8/28/2019 2:17 PM

- My experience has been good in this regard 8/27/2019 9:23 PM

- What do you mean by drug diversion? 8/26/2019 12:59 PM

- I am willing to give in person test a moaning but, unfortunately, I am working the emergency department on Wednesday, September 18, 2019. 8/23/2019 12:42 PM

- Limited amounts of controlled substances are prescribed (e.g. 2 week supply) for my agency's patients. RN's also monitor the amount of medication in a patient's possession. 8/22/2019 12:48 PM

- I am not in a position to know the answer to that question, especially with specifying which team 8/22/2019 12:42 PM

- This is a hallmark of a well run hospice organization and should be a priority. 8/22/2019 11:59 AM