

Hospitalists and Hospices: Opportunities for Collaboration at the Fulcrum of End-of-Life Care

Hospitalists are practicing physicians who devote some or all of their professional lives to caring for patients in an acute hospital setting. This new and growing field, also known as hospital or inpatient medicine, occupies a pivotal position for connecting hospitalized, seriously ill patients to hospice and palliative care services and thus is an obvious target for hospices' educational outreach and efforts to build constructive working relationships.

Hospitalists accept responsibility for patients admitted to the hospital, typically on referral from outpatient clinic-based primary physicians, who increasingly are too busy to visit the hospital themselves to directly manage the inpatient treatment of their patients. The hospitalist, as the attending's surrogate, assumes medical management while the patient is in the hospital and helps to plan for discharge, after which the patient's care reverts back to the community physician and the hospitalist's role ends—unless the patient returns to the hospital.

The professional association for hospitalists and recent journal articles have emphasized the field's responsibility for end-of-life care. Given that patients are increasingly ill when admitted to, and even when discharged from, the acute

care setting, the inpatient-based hospitalist plays a central role in the care of patients nearing the end of life. That role includes identifying those who have palliative care needs and helping to connect them with appropriate end-of-life services post-discharge.

For many chronically ill patients, hospitalization signals a crisis and a change in status that is also a logical opportunity to reconsider treatment approaches and care goals. When this crisis, frequently accompanied by fears, emotional turmoil and caregiver exhaustion, opens the door to end-of-life discussions, patients may be willing to consider other treatment options, such as hospice care, that hadn't been offered previously. The hospitalist's role in end-of-life care thus suggests an opening for collaborative relationships with hospice programs in the community, as well as the importance of making certain that the hospitalist knows when and how to introduce hospice referrals to eligible patients. Some hospices have capitalized on this interface to involve hospitalists more directly in end-of-life care.

The purpose of this report is to call attention to the hospitalist's growing role and pivotal position in end-of-life care, as well as to highlight opportunities

for hospice programs to build on that role in developing collaborative relationships and give some real-world examples of such collaboration. The National Hospice and Palliative Care Organization believes that enhancing these relationships is an essential component of building the end-of-life care continuum and of positioning the hospice program as the end-of-life care leader in its community. We recommend that NHPCO-member hospices reach out to identify practicing hospitalists in their communities, if any, educate them about hospice and palliative care, and then work collaboratively with them.

The Hospitalist Phenomenon

A hospitalist is a physician whose primary professional orientation is the medical care of hospitalized patients. Although inpatient medicine has been practiced for many years, particularly in Europe, the term “hospitalist” was coined in 1996 in a *New England Journal of Medicine* article by two physicians at the University of California – San Francisco.¹ The field has since grown to at least 7,000 hospitalists practicing today in U.S. hospitals. It is projected to reach 20,000 by the end of this decade, when it will be as large as the specialty of cardiology is today.

Once defined on the basis of dedicating more than 25 percent of one’s job to caring for patients in the hospital, hospital medicine has recently moved toward a definition that emphasizes a primary professional focus on inpatient care. Hospital medicine is described as a subspecialty of internal medicine, and is represented by its own professional

¹ Wachter RM, Goldman L. The emerging role of ‘hospitalists’ in the health care system. *NEJM* 1996; 335: 514-517.

association, the Society of Hospital Medicine, formed in 1997 as the National Association of Inpatient Physicians.

Hospitalists become experts in the management of the inpatient care process and treatment of the common medical disorders of acute inpatient care. They need a different professional mindset than primary care doctors or general internists, along with strong communication and coordination skills and knowledge of health care services and resources in the community. Other common roles for hospitalists include triage in the emergency department and management of “unassigned” patients admitted to the hospital without a primary care doctor. In hospitals that do not use intensivists to manage patients in the ICU, the hospitalist may continue to follow patients transferred to the ICU. Hospitalists also participate in hospital teaching, committees, research, utilization review, protocol development, and other quality or safety activities.

Because the field is so new, most practicing hospitalists come from other medical backgrounds such as general internal medicine (83 percent), general pediatrics (9 percent), family practice (3 percent), and other internal medicine subspecialties,² although the number of residency rotations and fellowships dedicated to hospital medicine is growing. Oncologists are less likely to use hospitalists for their patients because they typically spend more time seeing patients in the hospital and utilize specialized skills in administering and managing chemotherapy.

Hospitalists, typically in practices or services of four to ten physicians, are most often employed by a hospital or

² Society of Hospital Medicine fact sheet: “Hospital Medicine at a Glance.”

hospital-based corporation (54 percent), a multi-specialty medical group (24 percent), or a hospitalist-only medical group (13 percent).³ Most hospitalists are paid a salary roughly equivalent to that of a general internist, although capitated, fee-for-service, or incentivized compensation may be used. Several growing national hospitalist companies employ staffs of physicians and contract with hospitals in different communities for their services. For example, IPC—the Hospitalist Company employs 300 hospitalists in nine regional groups. IPC provides approximately 50 hours of on-the-job training for generalist internists to develop a specialized hospitalist practice.

Generally, hospitalists are not able to cover their costs on fee collection alone, since on a typical day they may see the patient and family several times, order multiple tests, and communicate with the primary physician and other specialists—while qualifying for only a single billable visit. A typical hospitalist caseload might be to manage 12 to 20 active patients on a shift, along with daily admissions and discharges. Because research has shown that hospitalists reduce hospital lengths of stay and treatment costs, enhance patient flow and overall efficiency, and improve outcomes of care and patient/family satisfaction, a growing number of hospitals have found it worthwhile to subsidize or otherwise support their work. Managed care also promotes the use of hospitalists.

When the hospitalist approach was first introduced, some primary care physicians feared that it would erode continuity of care for their long-established patients who were hospitalized. They also feared losing their

³ October 2001 survey by the American College of Healthcare Executives, in “Research Notes.” *Healthcare Executive* Jan.-Feb. 2002, p.40.

patients to the hospitalist and regretted giving up the collegiality they enjoyed while visiting the hospital. However, most physicians today find it costly and time-consuming to visit dwindling inpatient caseloads when they can more efficiently manage their time by staying in their offices. At one time, primary care physicians spent as much as half of their time providing hospital care, but today that role represents on average just 12 percent of their time.⁴

Other forces driving the hospitalist concept include a growing focus on patient safety and medical error reduction, coupled with the belief that doing the same service (in this case, managing the acutely ill patient’s hospital stay and the medical complications of inpatient care) over and over again would tend to improve quality. A growing body of research has supported this thesis by documenting improved clinical and financial outcomes from the use of hospitalists.

Other advantages of the hospitalist approach include continuous availability onsite to patients, families and other doctors; more frequent communication; easier end-of-shift handoffs; enhanced expertise in both clinical and logistical aspects of increasingly complex inpatient care; and overall management of patients with multi-system conditions and multiple specialists. The hospitalist’s Achilles heel is the intentional discontinuity between medical office and hospital created by the physician handover on admission and discharge. Unfamiliarity with a patient’s history and milieu or incomplete transmission of critical information between attending and hospitalist could lead to negative outcomes.

⁴ Chesanow N. How doctors spend their working hours. *Medical Economics* 1997; 74: 116-130.

However, according to a recent journal article, the more effective hospitalist systems have attempted to overcome the negative effects of discontinuity through frequent communications with the attending by making phone calls at admission and discharge, sending daily progress notes, and encouraging the attending to visit or call the patient.⁵ The authors suggest that many hospitalized patients are willing to trade familiarity with their primary physician for the hospitalist's increased availability. Barriers to this new model of treatment in some settings have included low inpatient volume, inability or unwillingness of the hospital to support the service, and opposition by other physicians.

What Do Hospices Need to Know About Hospitalists?

First of all, hospices need to appreciate the magnitude of the change in hospital care represented by the emergence of hospital medicine in the past few years to fill a role previously belonging to primary care physicians. At least 1,200 U.S. hospitals have instituted hospitalist programs, with the greatest concentration in California, New York and Texas. Hospitals are where patients with serious illness tend to end up—and where many will die—while the hospitalist, increasingly, is the doctor in charge of their treatment while they are in the hospital. This role gives hospices an opportunity to focus on a small number of key referring physicians. Also, it is the rare patient who gets referred to hospice care without having undergone a recent inpatient stay.

⁵ Baudendistel TE, Wachter RM. The evolution of the hospitalist movement in the USA. *Clinical Medicine* July/Aug. 2002, 2: 327-330.

A major part of the hospitalist's responsibility, often working closely with the hospital's discharge planners and case managers, is to connect patients to community resources, including hospice care, in developing a workable plan for discharge as soon as their condition permits. In fact, hospital conditions of participation specify a responsibility for discharge planning, one that the hospice can offer to help with—so long as it does not risk regulatory scrutiny by taking over the hospital's mandated responsibility in this area.

The emphasis on moving the patient along to the next level of care as quickly as possible gives the hospice an opening to offer itself as a solution for the needs of the most complex, seriously ill patients. Hospitalists are challenged to manage patients with advanced life-limiting illnesses for whom conventional treatment may no longer offer much benefit while time-consuming symptom management, emotional and social complications are multiplying—and occupancy pressures are demanding prompt disposition. These are the very issues that hospices and palliative care programs are designed to address.

In fact, say experts interviewed for this report, hospices should not find it difficult to make their case for expanded relationships with hospitalists. However, they should not assume that hospitalists already understand hospice and end-of-life care. In fact, lack of training in end-of-life care has been identified as a serious shortcoming for the field. For many working hospitalists, hospice and palliative care referrals may not be on their radar screens yet, unless they have received specialized training in this area.

The importance of the end of life to hospitalists can be seen in a recent journal article identifying “10 issues to

consider” for the field’s future, one of which is end-of-life care.⁶ “If the hospitalist model becomes the dominant model for hospital care, the hospitalist will *de facto* become the major provider of end-of-life care. In fact, putting the care of dying patients into the hands of a relatively small number of practitioners opens the way to improved palliative care and better decision-making about resuscitation,” the authors note. End-of-life care as a core skill of hospitalists has also been recognized by the Society for Hospital Medicine (SHM), which includes the topic in its educational programs and written resources.

Key issues in the hospitalist-hospice relationship, according to a recent article in SHM’s professional journal, *The Hospitalist*,⁷ include:

- Identifying eligible patients;
- Introducing the hospice concept and services;
- Medical management of the hospice patient; and
- Ensuring continuity of care.

However, the dynamics of the referral process can be complex. First of all, the hospitalization of a patient who is hospice-eligible at the time of admission already suggests that the patient either was not offered the hospice option by the primary care physician—or else declined it. Hospitalists need to preserve a cordial referral relationship with primary care physicians and may be reluctant to push a hospice referral onto an attending who is uncertain about eligibility or

⁶ Wachter, RM. The hospitalist movement: ten issues to consider. *Hospital Practice (Off ED)* 1999 Feb. 15; 34 (2): 95-111.

⁷ Pantilat S, Ryndes, T, Beresford L. Enhancing collaboration between hospitalists and hospice, Part 1: what is hospice care and how is it used. *The Hospitalist* March/April 2003; 7 (2): 24-27.

appropriateness. If the attending has not seen the patient during the current hospitalization, he or she may not be aware of the patient’s deteriorating condition or terminal status. Whether the hospitalist refers unilaterally to hospice care, confers with the attending on care planning, or simply advises the attending about the patient’s eligibility for hospice care will depend in part on the local setting and its medical politics.

Hospitalists who are not trained in the art of delivering bad news may be uncomfortable telling patients that they are dying or that no further curative treatment is available—especially if they have only a few days in which to develop rapport. Such discussions may also involve explorations of advance care planning, code status, the patient’s expectations and goals for treatment, and family caregivers’ concerns and coping abilities. These factors point to the need for hospices to educate hospitalists about end-of-life care—and to find ways to foster flexible, comfortable, three-way working relationships between the hospitalist, the primary care physician, and the hospice medical director.

Developing a Collaborative Relationship

1) Identifying key contacts: The first challenge for hospices in advancing the hospitalist interface is to identify the existence of practicing hospitalists in their community and how their position is structured—e.g., salaried positions with the hospital or an external medical group. What is the practice’s relationship with the hospital’s central administration, and what are the incentives that guide the hospitalist practice? Does the hospital have occupancy pressures? Does its reimbursement emphasize fee-for-service (and thus maximizing admissions) or

capitation (and thus minimizing hospital days)?

The hospital's administration may be able to encourage collaboration between the hospice and hospitalists. If the hospitalists already feel tension in their relationship with attending physicians or are likely to encounter political issues over hospice referrals, it may be advisable for the hospice to pursue preliminary contacts with the hospital's administration or chief of medical staff. Such discussions can also take place at a health system level.

Next, the hospice should identify the hospitalist practice's leadership structure and a key contact—e.g., head of the service, practice manager, or even just a member with an interest in end-of-life care. Can the hospice schedule a meeting in that key individual's busy schedule to explain its desire for closer collaboration and then a follow-up meeting with the full practice? Such contacts should emphasize end-of-life care as a core competency for hospitalists, hospice's ability to help them manage this competency, and the logic of a closer relationship as an extension of the hospitalist's role in managing community resources. The emotional rewards of end-of-life care can also be stressed.

2) Care planning and educational meetings: There may be periodic business or educational meetings for the group, and the hospice could use this time to present in-services on end-of-life care, discuss its admission policies and practices, or share helpful tools such as NHPCO's non-cancer guidelines for determining eligibility for hospice referral. Offering EPEC (Educating Physicians on End-of-Life Care) courses and CEU credits may be effective entrees. Preliminary education can also emphasize basic techniques of sharing bad news, advance care planning, and provisions of the Medicare Hospice Benefit.

Depending on the practice and setting, the hospice can also offer to send a liaison to the hospitalists' daily care planning meeting, typically held at the start of morning shift, to help identify patients with end-of-life care needs. One or more members of the hospitalist group may want to develop closer relationships with the hospice and, in turn, may prefer working with a designated contact person at the hospice. Relationships are also advanced informally by the physical presence of the hospice's medical director and other staff in the hospital and their availability for "curbside consults."

3) Offering solutions for the hospitalist: The hospice can emphasize its ability to be a solution to care management and discharge planning needs for seriously ill patients and its commitment to respond promptly to referrals or consultation requests—ideally within 24 hours. Hospitalists often feel starved for information about what happens to their patients post-discharge. They should be asked how and how much of this information they would like to have communicated back to them about patients referred to hospice. Overall, hospitalists should be managed the same as any other key referral source.

Hospices need to understand the hospitalist's role and what is likely to attract the hospitalist's attention in order to offer themselves as solutions to the hospitalist's needs. Critical data may include rates of rehospitalization and total days of inpatient care, both for dying patients not enrolled in hospice and for those referred to hospice. Because these data often belong to the hospital, the hospice may want to propose a joint research project to capture and analyze key hospitalization data and develop a statistical profile of terminally ill patients in the hospital. The hospice also can explain the interface between hospital

DRG payments and coverage under the Medicare Hospice Benefit, including the opportunity for direct hospice enrollment of eligible patients who are still in the hospital—transferring their coverage from the DRG to the hospice benefit while they remain in place.

4) Other kinds of relationships:

More specific opportunities for collaboration include:

- Regular meetings between hospice staff and hospitalists to explore end-of-life care challenges, unmet needs, solutions, care protocols, algorithms for palliative referrals, and new program development;
- Protocols to govern the direct hospice enrollment of terminally ill patients while they are still in the hospital;
- Direct referrals of appropriate terminally ill patients to hospice care by hospitalists practicing triage in the emergency department;
- Development of a palliative care consultation service or an inpatient hospice unit by the hospice, the hospitalist group or both working together;
- Additional training, including palliative medicine certification, for hospitalists wishing to become experts in palliative care for their own patients or to assume a greater role as a primary end-of-life resource, contact, or hospice liaison for the hospital; and
- A formal role for a hospitalist as part-time medical director or physician for the hospice program or as medical director of a hospice unit or palliative care program.

5) Billing issues: One final concern

for hospices and hospitalists is billing. The patient's enrollment on the Medicare Hospice Benefit immediately alters the hospitalist's usual way of billing for services, and this information must be communicated to hospitalists and their billing staff. Generally, hospitalists do not wish to become the designated attendings for patients enrolled in hospice care, while after hospice enrollment there can be only one designated attending physician. Any other physicians—including a hospitalist who is seeing the patient in the acute care setting following a direct hospice admit or during a subsequent rehospitalization for hospice general inpatient care—must bill as consultants through the hospice. Consultant billing and other intricacies of physician billing under the Medicare Hospice Benefit are discussed in a recent NHPCO monograph on this subject.⁸

In some cases, a hospitalist may become a part-time employee of the hospice as medical director or hospice physician, and this, too, must be taken into account in preparing physician billing. It is essential that hospitalists and their billing staff understand the rules for billing under the hospice benefit, in order to avoid unanticipated interruptions in their billing streams. The hospice should take pains to clarify who is the designated attending at the time of referral, rather than assuming that the referring physician is also the attending. It is also worth clarifying medical management roles and responsibilities for when a patient enrolled on the hospice benefit and in need of general inpatient care is admitted to a hospital that utilizes hospitalists for inpatient medical management.

⁸ *Providing Direct Billable Physician Services to Hospice Patients: An Opportunity to Upgrade the Medical Component of Hospice Care.* Alexandria, Va.: National Hospice and Palliative Care Organization.

Examples of Successful Relationships

Covenant Hospice in Pensacola, FL, collaborates with hospitalist practices at three Pensacola hospitals and plans to do the same with hospitalist programs under development at other hospitals in its service area.⁹ The hospice contacted the three hospitals' administrators and chiefs of medical staff as their programs were being launched to discuss the role of hospitalists and their relationship to hospice care. Then it sent a community education nurse to meet with each hospitalist in person to explain hospice care and the hospice's relationship with the hospital.

Those wanting more information were contacted for follow-up by the hospice's medical director. Based on the established relationships, hospitalists now identify patients admitted to these hospitals as hospice-appropriate and refer them to Covenant, reports the hospice's president and CEO, Dale Knee. They also triage patients in the emergency department and may refer them directly to hospice.

The hospice program of **VNA of Erie County** (Erie, PA) tries to include referring hospitalists in its referral visits to patients at the hospital and also uses these joint visits to arrange for post-discharge prescription needs while informing the physicians about hospice philosophy and care management.

Hospice of the Bluegrass in Lexington, KY, works closely with the three acute care hospitals in Lexington

⁹ Pantilat S, Ryndes T, Beresford, L. Enhancing collaboration between hospitalists and hospice, Part 2: beyond the hospice referral; expanded opportunities. *The Hospitalist* May/June 2003; 7 (3): 22-24.

and has established jointly staffed palliative care consultation services at each, led by its medical director, Dr. Terry Gutsell. At one of the hospitals, St. Joseph, the hospice also operates a leased, 17-bed inpatient unit for hospice-enrolled patients who need inpatient care and for the direct admission of hospitalized patients onto the hospice benefit while they are still in the facility. The physical presence of the hospice unit has helped to advance the relationship with St. Joseph's three hospitalist medical groups by offering a constant reminder of end-of-life issues and an illustration of how the hospice manages terminally ill patients.

Hospitalists at St. Joseph have learned when to refer patients for hospice care and have become the hospital's major referrers to the hospice unit. Thanks to the relationships that have been developed, they are even learning to appreciate the subtle distinctions between hospice and palliative care, says Marsha Sherman, director of the Hospice Care Center at St. Joseph. A hospitalist may briefly introduce the palliative care concept to the patient and family and then call in the palliative care team for a more intensive conversation to explore care options and a possible hospice referral.

Pike's Peak Hospice in Colorado Springs, CO, hired its first full-time medical director, Dr. Jonathan Weston, in 2000 in response to a management consultant's recommendation, and he has since spearheaded a dramatic rise in its patient census. Weston previously established hospitalist programs at two local acute care hospitals, and those connections have facilitated collaborative relationships with the hospitalists at those facilities. The hospice now provides a palliative care consultation service at one hospital and a floating liaison nurse at the other. Weston has encouraged the hospice's staff to learn

the culture and speak the language of physicians.

One of the Colorado Springs hospitalists, Dr. Gil Porat, received hospice training when he was a medical resident, and he recommends such training for other hospitalists to be able to appropriately manage patients nearing the end of life. Porat confidently refers appropriate hospitalized patients directly to hospice and says he has never received a complaint for doing so from a patient's attending physician. One of his cues to consider a hospice referral is seeing the same patient rehospitalized again and again.

Hospice of Metro Denver in Denver, CO, first encountered this topic when it began receiving referrals from doctors who were neither primary care physician nor consulting specialist, reports Beth Courville, the agency's vice president for access. So Courville went directly to those physicians and asked them to explain their role and how they preferred to work with the hospice. Sometimes hospitalists will refer directly to the hospice; other times they contact the patient's attending physician to coordinate the referral. In most cases, they are not interested in being the designated attending physician after the hospice patient goes home from the hospital.

Hospice of Metro Denver has emphasized a "champion" approach to marketing and outreach to the hospitalists in its community, Courville says. It identified one hospitalist opinion leader at each of nine area hospitals willing to become more involved in end-of-life care and then brought this group together for an educational forum on palliative care and discussion of the models of palliative care and hospital-hospice relationships. The nine hospice champions have been encouraged to become end-of-life trainers

within their hospitals, with honorarium support from the hospice.

San Diego Hospice operates a celebrated pediatric program in collaboration with San Diego Children's Hospital.¹⁰ Until recently, its part-time pediatric medical director, Dr. David Sine, also practiced part-time as a pediatric hospitalist at the hospital. Because both roles were combined in a single person, it was easy for Sine to facilitate a working relationship with the pediatric hospitalists. Having a circulating generalist skilled in pediatric hospice and palliative care also had a positive impact throughout the hospital by raising awareness about quality-of-life and bereavement concerns for all hospitalized patients and their families.

Sine's roles for the hospice have included co-managing patients, assuming overall medical management when requested by the attending or for general hospice inpatient care, consulting on pain and symptom management, conferring with community pediatricians on care management at home, participating in "breaking bad news" consults, serving as hospice liaison to primary care physicians, and providing palliative care training to hospital staff and community physicians.

Regions Hospital in St. Paul, MN, part of the HealthPartners managed care organization and integrated health system, is now exploring a "hospitalist-based model of hospice and palliative care services," reports Dr. Howard Epstein, a hospitalist practicing at Regions. Epstein was recently hired part-time as assistant medical director by **Hospice of the Lakes**, HealthPartners' system-wide

¹⁰ Pantilat S, Ryndes T, Beresford, L. Enhancing collaboration between hospitalists and hospice, Part 2: beyond the hospice referral; expanded opportunities. *The Hospitalist* May/June 2003; 7 (3): 22-24.

hospice program serving multiple hospitals in the Twin Cities. When Hospice of the Lakes admits its patients to Regions Hospital for general inpatient or respite care, they are generally followed by one of the hospital's seven hospitalist medical services, which manages their inpatient care in tandem with the hospice team until they return home. The hospitalists also make direct admissions to hospice.

Epstein is now developing a proposal for a more advanced approach to hospitalist involvement in end-of-life care, which soon will be submitted to the hospital and health plan for consideration. Although the details, business plan, and buy-in from key parties were still being worked out as this report was written, the basic approach is for one of the hospitalist groups at Regions to dedicate its time 50 percent to hospice and palliative care.

Five or six of the hospitalists in the group would participate in the new inpatient hospice and palliative care service. Other hospitalists and fellows at Regions receive end-of-life training, but this smaller group would seek additional training in palliative care and certification in hospice and palliative medicine. It would follow all Hospice of the Lakes patients admitted to Regions Hospital, and would establish a palliative care consultation service within the hospital, initially offered to patients on medical units and the medical ICU. Eventually it would expand to other parts of the hospital and incorporate resident and fellowship training.

Epstein does not expect the palliative care service to pay for itself on consultation billing alone (which reflects the experience of other palliative care services nationwide). But benefits to the hospital and health system, including the hospice, may justify their financial support

for the program. It won't require additional staffing, he explains, only a redeployment of existing hospitalist staff.

Resources for More Information

- The Society of Hospital Medicine, 190 N. Independence Mall West, Philadelphia, PA 19106, 800/843-3360 or 215/351-2746, www.HospitalMedicine.org.
- SHM's professional journal, *The Hospitalist*, included a two-part series on hospice care in its March/April and May/June 2003 issues, which can be accessed at <http://www.hospitalmedicine.org/presentation/apps/publications/Hospitalist-Mar03.pdf> and <http://www.hospitalmedicine.org/hospitalist/article.asp?IssueID=135&SectionID=150&ArticleID=195>.
- For more information on the proposed hospitalist palliative care service at Regions Hospital in St. Paul, MN, contact Dr. Howard Epstein at: Howard.R.Epstein@HealthPartners.com.
- Dr. Steven Pantilat, associate professor of clinical medicine at the University of California – San Francisco, is a leading national authority on hospitalists and end-of-life care. He has also developed a full-length curriculum on inpatient end-of-life care. For a copy or more information, contact him at: stevep@medicine.ucsf.edu.

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