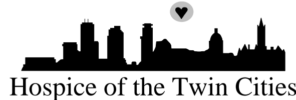
Hospice of the Twin Cities

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Hospitalists and Hospices: Opportunities for Collaboration at the Fulcrum of End-of-Life Care (A Review of a NHPCO Issue Brief)

"To make a prairie it takes a clover and one bee. One clover, and a bee, and revery. The revery alone will do, if bees are few."
-Emily Dickenson

Hospitalists are physicians who manage the care of patients who have been referred to an inpatient hospital setting by their primary care physician or by an outpatient clinic. They work with individuals who are acutely, or seriously ill. Because the primary care physicians do not have the time to visit patients that are hospitalized, hospitalists become the surrogate primary physician while patients are in the inpatient setting. The hospitalist is also the physician who then helps plan the discharge of the patient from the hospital back to the community. Recently, it has been noted that many people who are seriously ill, and in an inpatient setting, are also at "end-of-life". Therefore, it becomes apparent that Hospitalists will have a lot of responsibility in caring for patients who are at "end-of-life". As such, it is up to the Hospitalist to refer patients to appropriate palliative care or hospice care when discharging their patients back to the community.

Hospital medicine is a subspecialty under Internal Medicine and has its own professional association, the Society of Hospital Medicine, formed in 1997 as the National Association of Inpatient Physicians (p.2). The definition of a hospitalist emphasizes a focus on inpatient care and was first used in 1996 in a *New England Journal of Medicine* article. The specialty now has at least 7000 practicing hospitalists and a projected growth of up to 20,000 by the end of this decade, which will equal the number of cardiologists currently practicing.

Hospitalists not only become experts in inpatient care, but must also develop excellent skills in communication and coordination of care, expanding their expertise into community resources, as well. In the hospital setting they may see patients in the ER, unassigned patients, and may even see patients in the ICU. They also participate in many other areas, including: "Hospital teaching, committees, research, utilization review, protocol development, and other quality or safety activities." (p.2)

This is a relatively new specialty and therefore, most hospitalists come from other specialty areas (internal medicine 83%, general pediatrics 9%, family practice 3%-p.2). "The use of these specialty physicians has done much to improve the continuity of care; reduce the cost of treatments; reduce the average length of care in the inpatient setting; enhance efficiency; improve the outcomes of care and patient/family satisfaction; reduce medical errors and increase patient safety, thus increasing the quality of care; provide 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." (p.3). The downfall is that the hospitalist does

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not usually have a history with the patient and therefore there is a learning curve regarding the patient's history and lack of continuity of care when the office physician hands off care to the hospitalist and vice versa when the patient is discharged from the hospital. The positives, however, greatly outweigh the negatives. Also, it is easy to decrease the negative outcomes when there are increased phone communications between the hospitalist and the office physician at the time of admission to the hospital and discharge from the hospital; the sending of daily progress notes and encouraging the attending physician to call the patient and keep informed in that manner.

"Key issues in the hospitalist-hospice relationship, according to a recent article in the Society for Hospital Medicine's (SHM) professional journal, *The Hospitalist,* include:

- Identifying eligible patients;
- Introducing the hospice concept and services;
- Medical management of the hospice patient; and
- Ensuring continuity of care." (p.5)

There are many factors which may make the hospitalist➔hospice referral very complex. If an individual enters the hospital and is in the end of life, it means they have not been offered hospice by their primary physician or they have been offered hospice and have declined the offer. This means the hospitalist must be very diplomatic about making hospice referrals, and a three way relationship must be developed between the hospitalist, the primary physician and the hospice's medical director. This all means the hospitalist must receive extensive education in end-of-life care.

Developing a Collaborative Relationship

1. Identify key contacts: Find out who the hospitalists are and how their position is structured (salaried position with the hospital or an external medical group).
2. Care planning and educational meetings: The hospice can present in-services on end-of-life care; discuss its admission policies and practices; share helpful tools such as NHPCO's non-cancer guidelines for determining eligibility for hospice referral; offer EPEC (Educating Physicians on End-of-Life Care) courses and CEU credits. The EPEC training includes education on sharing bad news; advance care planning; and provisions of the Medicare Hospice Benefit. The hospice can also offer a liaison to be available for the hospitalist care planning team to help with end-of-life care planning.
3. Offering solutions for the hospitalist: The hospice can be a solution to care management for those patients who are seriously ill and considered at the end-of-life. The hospice must be responsive to the needs of the hospitalist and his/her team and available when they need to consult with the hospice.
4. Other kinds of relationships: Regular meetings between the hospitalist and the hospice to maintain the relationship and discuss issues, solutions, care planning, etc.; protocols to govern the direct hospice enrollment of terminally ill patients while they are still in the hospital; direct referrals of appropriate patients; develop a palliative care consultation service; provide additional training for the hospitalist; and/or having a role for the hospitalist as an associate medical director.
5. Billing issues: If the hospitalist sees a patient after they have been admitted to the hospice program, they must bill as a consultant. This differs from their normal billing practice and may be a barrier to direct admissions to the hospice program.

Hospitalists and hospices can be successful partners in providing end-of-life care for individuals who, otherwise, may not be referred to a hospice program. It will be interesting to watch these relationships develop and witness the positive impact it will have on end-of-life care.

Reference: NHPCO Issue Brief, Beresford, Larry

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Mission Statement

Hospice of the Twin Cities' mission is to enhance the quality of the lives of our patients and their families by providing respectful care based on maintaining dignity, alleviating physical, psychosocial, and spiritual suffering, advocating for fundamental rights, and affirming the sacred value of life.