Hospice & Palliative CareCenter
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Public Comment
To the State Health Coordinating Council
In support of
The 2010 State Medical Facilities Plan's
New Hospice Methodology

Good afternoon, members of the State Health Coordinating Council and members of the public. My name is Kathy Cecil VP, Finance & Administration. I am here today to make a public comment in support of the new hospice methodology in the proposed 2010 State Medical Facilities Plan. At the same time, I would like to highlight some planning concerns we have in our service area as the awareness for hospice and resulting demand for additional inpatient services increases.

As many of you may know, Hospice & Palliative CareCenter in Winston-Salem, was one of the first hospice agencies in North Carolina. Throughout our 30-year history, we have led the way by developing additional services to better serve our members.

We were very pleased to see the Hospice Methodologies Task Force convene to update and improve the Hospice Home Care Office and Hospice Inpatient Bed methodologies. Hospice & Palliative CareCenter attended some of the Task Force meetings and was impressed with the openness in which they were conducted and the genuine progress toward consensus. We support the new changes in the underlying assumptions to improve the basis of the methodology.

All of the new assumptions in the methodology are improvements such as:

In the Hospice Home Care Office methodology: Utilized the two-year trailing average growth rate, added a need cap at three hospice home care offices per 100,000 population, and setting the threshold and placeholder for new hospice offices at 90 patients per year.

In the Hospice Inpatient methodology: Utilized the two-year trailing average growth rate, projecting hospice admissions by the two year trailing average growth rate and using the 6% inpatient days as percent of total days.

We also agree with some of the statements made in the first meeting of the task force that the access issue does not appear to be in home care, as all of the counties in North Carolina are well served. However, we believe the access challenges will increasingly be seen in the Hospice inpatient arena.

The new methodology has the effect of reducing the projected inpatient bed need by three beds in our core service area counties. We are providing the details of the reduction in need in our comment. At the moment, we anticipate that the additional ten beds that we have recently received a CON for will satisfy the immediate need for inpatient beds in our immediate service area in Winston-Salem. However, we are concerned that in future years,

the surrounding counties will have a need and demand for more inpatient beds in their own communities.

While we support the methodology as designed, we were somewhat surprised at the conservative nature of the new methodology's projected need, which results in a reduction in projected total inpatient beds in our service area. As Table 1 indicates, there are 3 fewer hospice inpatient beds projected in the 2010 SMFP. While in the short-term the additional 10 beds we are developing in Winston-Salem may answer the need, we will be monitoring the impact in surrounding counties for the future.

Table 1
Projected Inpatient Bed Need in Hospice & Palliative CareCenter Core Counties

County	2009 SMFP Projected Total Inpatient Beds Column H	2010 SMFP Projected Total Inpatient Beds Column J	Difference
Forsyth	22	23	Increased by 1 bed
Davidson	9	9	Unchanged
Davie	3	3	Unchanged
Rowan	10	9	Reduced by 1 bed
Stokes	7	4	Reduced by 3 beds
Yadkin	3	3	Unchanged
Total	54	51	Reduced by 3 beds

Source: 2009 SMFP and May 27, 2009 Task Force Notes to the SHCC
Note: Projected Total Inpatient Beds were chosen for this analysis rather than adjusted projected beds to show the application of the actual forecasting of bed need.

As we work to increase the awareness, we anticipate additional demand for hospice services and hospice inpatient beds that may be difficult to reflect in a timely fashion in any methodology. In Forsyth County, we have long been in the top 25% of counties for % deaths served by hospice. In the recent past we have been in the top 10, and have only moved to 23 as other counties have increased their awareness. We continue to recognize additional opportunities for awareness. A review of our core service area counties (Reference Table 2) shows additional opportunity as four of the six counties are below the statewide average. Because the methodology is retrospective, if dramatic improvements are made in the % of deaths served, it may take a few years to project demand.

Table 2
Percent of Deaths Served by Hospice and Rank in the State in Hospice & Palliative CareCenter Core Counties

County	% Deaths Served by Hospice	Rank
Forsyth	35.96%	23
Davidson	24.54%	71
Davie	31.55%	39
Rowan	24.85%	69
Stokes	34.69%	27
Yadkin	28.08%	52
NC Average	32.75%	

Source: The Carolinas Center, Percent of Deaths Served by County Report, FFY 2007 Data

Hospice Inpatient beds will continue to be the most cost-effective setting for inpatient end-of-life care. As awareness of hospice & palliative care continues to grow, and hospitals, nursing homes, and the health system are increasingly pressured to reduce costs, we anticipate further demand for hospice inpatient beds.

There are elements of future concern in our service area that cannot be addressed by a statewide methodology. These include but are not limited to: sustained high demand for services at our KBR facility in Winston-Salem, the challenges in access in rural counties and the potential need to develop a facility with less than 6 beds in a rural area, the regional aspect of health care delivery where regional referral medical centers are present, the increasing pressures on hospitals and nursing homes to seek alternative settings for end-of-life patients, and the impact of the growing awareness of hospice.

For 2010, we support the projected changes to the methodology as an improvement over the current methodology and we support its inclusion in the 2010 SMFP. We will remain focused on the impact of the methodology to our service area counties, particularly the rural and suburban counties. We appreciate the conservativeness on the part of the SHCC and the Task Force. Further, we recognize that any need projection methodology will have limitations in how it projects need in individual counties across the entire state. Our hope is that with future years, we will all have the opportunity to monitor the application of the methodology to ensure that it recognizes additional need in a timely fashion. In the event that we see a need before the SMFP recognizes it, we will be pleased to come back with a petition.

Thank you again for your diligent work and for your time today. Please do not hesitate to contact me with further questions as the 2010 State Medical Facilities Plan is finalized.