

ASCO-ASH CAC NETWORK MEETING

JULY 24, 2009

ASCO Headquarters

Alexandria, va

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Community Hospice of Northeast Florida, Inc.

Hospice Care Background

- Community Hospice of Northeast Florida
 - Serves five-county North Florida area with over 1 million population
 - One of the oldest hospices in the US-organized in 1978
 - Serves approximately 6,000 patients plus estimated 24,000 family members each year making it one of the largest programs in the US
 - Is a freestanding not-for-profit corporation focused solely on hospice care
 - Has revenues of over \$62 million annually and patient census of approximately 1,000 per day and 750 employees

Hospice Care Overview

- History
 - In the United States since 1974
 - Is a holistic, team-based, patient-centered approach to care
 - Focuses on comfort or “palliation” of symptoms and pain, *without attempting to treat or cure the underlying illness itself*
 - Philosophically based in belief that death is a natural part of the life cycle, rather than an adverse outcome
 - Has changed from a movement to an industry

Hospice length of stay, by diagnosis, 2006
(MedPAC Data)

| | Diagnosis share of total cases | Percent of cases with length of stay greater than 180 days |
|------------------------------------|--------------------------------|--|
| Cancer (except lung cancer) | 24% | 9% |
| Circulatory, except heart failure | 11 | 19 |
| Lung cancer | 10 | 8 |
| Heart failure | 8 | 20 |
| Debility, NOS | 8 | 21 |
| Alzheimer's and similar disease | 6 | 31 |
| Chronic airway obstruction, NOS | 6 | 24 |
| Unspecific symptoms/signs | 6 | 21 |
| Dementia | 5 | 26 |
| Organic psychoses | 4 | 25 |
| Genitourinary disease | 3 | 5 |
| Nervous system, except Alzheimer's | 3 | 28 |
| Respiratory diseases | 3 | 12 |
| Other | 2 | 13 |
| Digestive diseases | 2 | 9 |
| All | 100 | 17 |

Hospice Care Overview

- How the MHB Works:
 - Patients make a special election, including signing a statement acknowledging the terminal state of their illness and agreeing to forgo curative treatment
- Community Hospice Northeast Patient/Family Election Statement
 - *I/We understand that I will be receiving comfort/palliative care only and that I/We waive the right to receive services that are for curative purposes related to my terminal illness.* Care for all illnesses other than the primary diagnosis for which Community Hospice is treating me can be billed to Medicare in the traditional manner.

Hospice Care Overview

- How the MHB Works (cont'd):
 - Hospices receive set per diem for each day the patient is enrolled in the program and must accept that as full payment, regardless of cost of caring for patient
 - Hospice providers assume financial risk for 100% of costs associated with care, including all care by professionals, drugs, medical equipment, supplies, therapies, transportation, and bereavement for survivors for up to 13 months

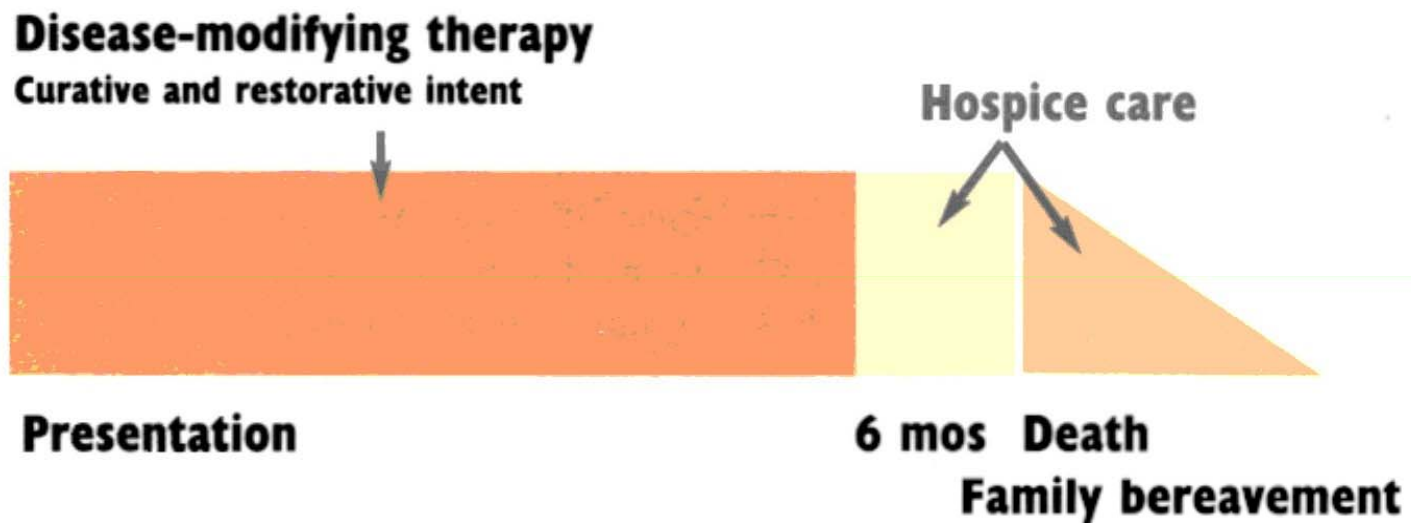
Hospice Care Overview

- How the MHB Works (cont'd):
 - Levels of care include Routine Home Care (RHC), General Inpatient (GIP), Respite, and Continuous Home Care (CHC) all reimbursed at different rates
 - There is no limit on the number of days patients can be under hospice care, but providers must have ongoing documentation that patient's prognosis remains terminal.

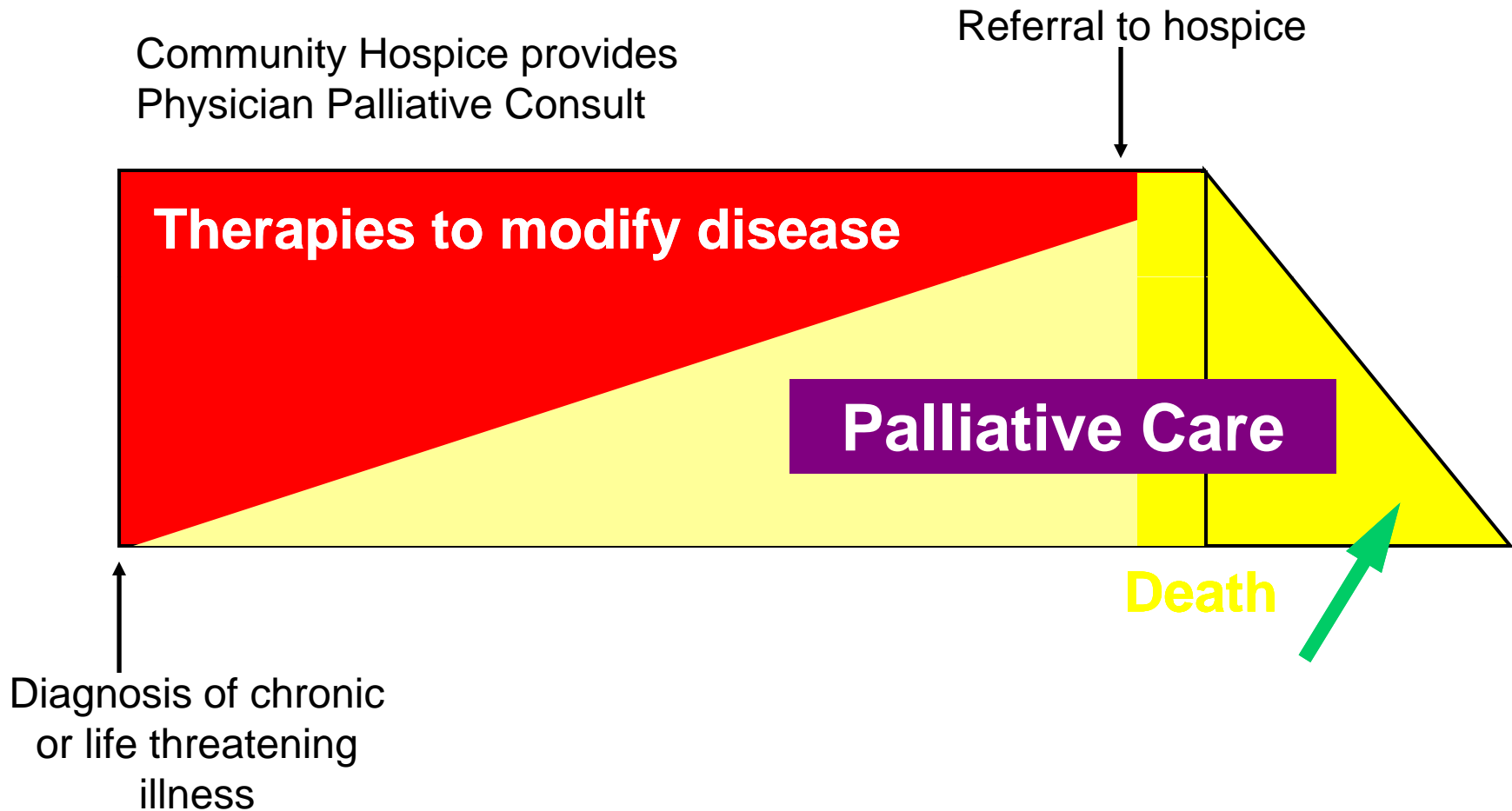
Hospice Care Overview

- Although Medicare has supported the growth of hospice, there are some barriers to access that exist as well:
 - Election statement requiring patients to acknowledge they are foregoing the chance for cure is a “deal breaker” for many.
 - The “Either/Or” paradigm reflecting Dying/Not Dying does not represent how most patients move through their illness

Figure 1.
The Medicare Hospice Benefit



Position in Palliative Care



Palliative Care Overview

- New form of care that is still developing.
- Goal is to address symptoms and pain just like hospice care, but unlike hospice, does not require that patients be at least six (6) months of life or cease curative treatment.
- Has some definition by organizations such as the World Health Organization, but goals of treatment, standards of care, and practices, are still evolving.

Public Policy Issues

- Growing recognition that much of our end of life spending goes into things that produce poor outcomes
- 28% of Medicare dollars spent on any single patient will be invested in delaying death during the last 12 months of life
- 50% of Medicare spending in the last year of life occurs **IN THE LAST 30 DAYS**
- 23% of Medicare beneficiaries with five (5) or more chronic illnesses account for almost 68% of Medicare's spending, with much of that taking place in the last year of life

Public Policy Issues

- National groups like the American Academy of Hospice and Palliative Medicine (AAHPM) have identified Palliative and End of Life Care as one of six (6) national reform priorities
- Recommendations include increasing the number of specialists in this area, increasing research on issues related to end of life care and improving access to care for all patients with life-threatening illnesses
- There are emerging legislative proposals to address barriers and support development of palliative models of care such as the “Compassionate Care Act”

Public Policy Issues

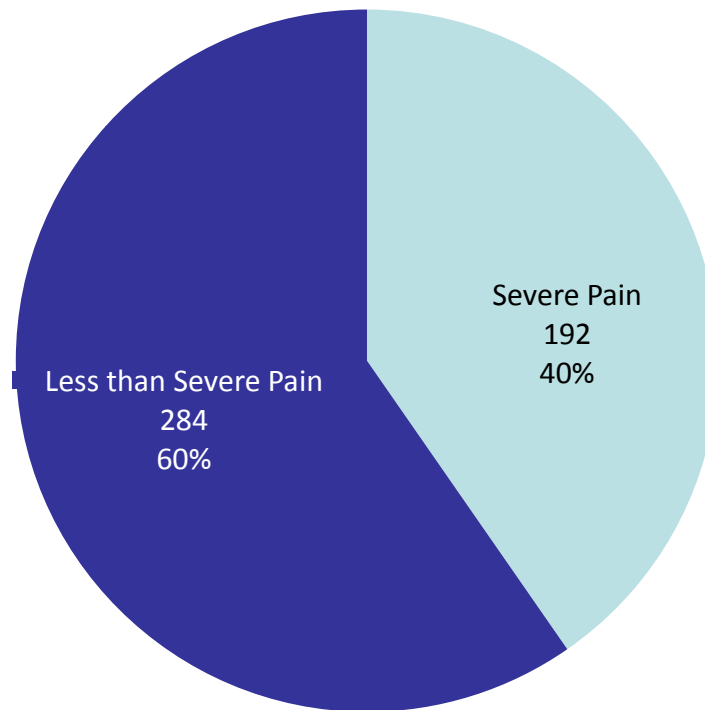
- Regulatory Impacts on Hospice and End of Life Care
 - Revised Medicare Hospice Conditions of Participation (CoPs) became effective in 2008-first major revision in over a decade
 - New CoPs provided more guidance on:
 - Patient-directed care and best practices
 - Tying activities to outcomes and focusing on measurable quality results
 - Patient rights
 - Admission process
- New CoPs also increased providers' risks, especially in admitting patients and determining appropriateness for care

General Trends in Hospice Include

- Greater documentation, reporting and other administrative requirements by Federal and State regulators, and Fiscal Intermediaries
- Increased emphasis on quality, transparency and outcomes, which majority of providers welcome
- Florida has voluntarily reported outcomes so consumers can have better information
- Increased emphasis on partnership between physicians, hospice staff, and patients/families that works toward measurable goals and results that are meaningful to patients' quality of life
- Focus on pain and symptom management and answering question: "What was different because hospice was involved?"

Patient Comfort

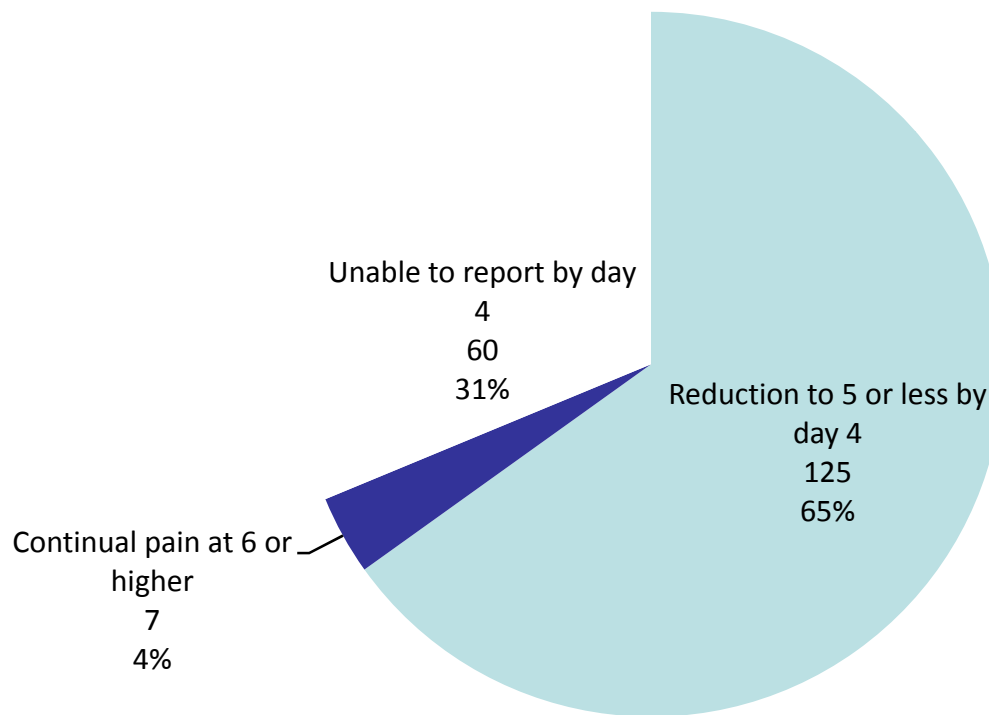
Patients Reporting Pain on Admission



January-March, 2009

Patient Comfort

Severe Pain Outcomes by End of Day 4



January-March, 2009

Outcomes at the Last Place of Care

| Provided Desired Physical Comfort and Emotional Support to Patients | | | | |
|--|------------------|----------------|-------------------------|-----------------|
| Outcome | Home Care | Hospice | Nursing Facility | Hospital |
| Patient did not receive any or enough help with: | | | | |
| Pain | 42.6 % | 18.3 % | 31.8 % | 19.3 % |
| Dyspnea | 38.0 % | 25.6 % | 23.7 % | 18.9 % |
| Emotional Support | 70.0 % | 34.6 % | 56.2 % | 51.7 % |

Public Policy Issues

- Reimbursement Issues:
 - All medical providers are facing cuts in reimbursement. Hospice estimated to be cut by almost \$10 billion over the next decade in current reform proposal
 - Proposals for changes in how hospice is paid are being considered but availability and reliability of data are of concern
 - Decreases in reimbursement and resources for “upstream” providers will likely place more demand and pressure on hospices when taking patients under their care
 - Hospice providers will continue to advocate for adequate payment well supported by documentable results at the bedside

Roles for Palliative Care during Active Treatment

- There is growing evidence that core principles of hospice care that focus on palliation can improve care provided to patients beyond the traditional six-month MHB threshold
 - Regulatory barriers, including fraud and abuse concerns, can make it difficult to provide what the patient really needs
 - Current system places hospice in silo at the very end of life
 - Goal would be to integrate hospice and palliative care principles in general into mainstream care system so patient has seamless experience
 - Benefit/burden of treatment changes along the course of illness

Roles for Palliative Care during Active Treatment

- Can support shared decision-making, clarity of goals for care and treatment and care planning
- Specific clinical expertise with pain and symptom management can improve patient's quality of life throughout illness and improve outcomes, increase and patient satisfaction, and reduce unnecessary hospitalizations

Roles for Palliative Care during Active Treatment

- Palliative Care Programs-Some Approaches Include:
 - Sponsoring or participating in palliative medicine fellowships, and educational programs that include research on best practices, improving clinical outcomes, sustainable models of care
 - Development of models and research on how treatment and palliation can co-exist, including evaluation of financial and clinical impacts
 - Palliative care consultative services offered in both acute and long term care settings including Grand Rounds
 - Shared models of care in acute care settings
 - For the future, hospice and palliative care and its defined body of practice should be an integral part of how we deliver end of life care in the United States

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