Talking Points for Public Hearing – Hospice & Palliative Care of Iredell County, Inc
Terri Phillips, President and CEO

Greensboro, NC
July 16, 2010

1. Introduction –
   1.1. My name is Terri Phillips. I am President and CEO of Hospice of Iredell County, Inc,
   1.2. We have offices in Statesville and Mooresville, NC and a 9-bed hospice inpatient facility, Gordon Hospice House, in Statesville.
   1.3. I have been with the agency since 2007, having previously been a hospice COO in Palm Beach County, Florida
   1.4. With me is: Margaret Johnson, V Chair of the Board and a volunteer for 7 years.
   1.5. Thank you for taking time to listen to our petition today

2. Hospice of Iredell County, Inc has served Iredell and surrounding counties for 26 years.
   2.1. Last year we served 831 patients and we are still growing.
   2.2. Gordon Hospice House opened with three inpatient (GIP) beds and 6 residential beds in September 2005.
   2.3. In 2008 we received a CON to convert the six residential beds to GIP and to build replacement residential beds, which are currently under construction. Those will be complete by January 2011.
   2.4. Today we are requesting that the State Health Coordinating Council add a special need to the 2011 State Medical Facilities Plan to permit us to convert those six residential beds to GIP beds.
   2.5. I will explain, and I think you will agree that Iredell County has a very compelling case for this request.

3. Our nine GIP beds are most often full and we have a waiting list.
   3.1. Yet the Proposed 2011 Plan shows no need for more GIP beds in Iredell County.
   3.2. This is not consistent with reality.
   3.3. Today, we are using all 9 beds, often times discharge and admit on the same day, exceeding capacity.
   3.4. The GIP beds filled almost as quickly as we opened them in 2008.
   3.5. In 2009, the first full year with 9 GIP beds, we averaged 77 percent full. Year to date for 10 months we are averaging GIP occupancy is 89 percent.

3.6. When The Gordon Hospice House has more than 9 patients, and there is a waiting list for patients needing GIP care; many die before we can admit them.

3.6.1. 2011 Plan forecasts assume that residents of Iredell County are the only users of the Gordon House GIP beds.

3.6.2. Reality is that Other counties use 14% of Gordon Hospice House days—several of the counties we serve do not have an inpt unit—Wilkes, Davie, Rowan and Alexander

3.6.3. Plan forecasts assume that demand for beds will increase at **4** percent a year—the state average for admission growth

3.6.4. Iredell County demand has increased almost four times that fast **-- 15.7** percent increase in admissions a year over the past two years.

3.6.4.1. 2011Plan forecasts assume that only **6 percent** of days will be used at the inpatient level. At Hospice of Iredell, **9 percent** of days are inpatient. Here are the reasons for higher inpt %:

3.6.4.2. Hospice of Iredell County is unique in many ways. We serve three hospitals and they refer patients who are actively dying and have two weeks or less to live to Gordon Hospice House. This is unique among hospice inpatient units. Two other hospices with high use are hospital based, Presbyterian and Southeastern

3.6.4.3. The median length of stay for patients at Hospice of Iredell County was **13 days**. This is about one-third of the state average of **33 days**.

3.6.4.4. Iredell County has responded well to the hospice option. **44 percent** of 2009 Iredell County deaths occurred in hospice care.- compared to **34 percent** in 2007, a 30% increase in serving deaths in Iredell Co in 2 years.

3.6.4.5. The Plan forecasts no need for Iredell County GIP beds in 2013 because it uses state averages which are very conservative assumptions.

3.6.4.6. In reality, Iredell County alone needs four more beds today and at least six by 2013.

3.6.4.7. We are prepared to submit a formal petition showing you how we calculate the need, using local Iredell County numbers, rather than state numbers.

3.6.4.8. Today, I would like to acquaint you with highlights of the differences between the Plan's metrics and Iredell's.

Measure	Plan Metric	Iredell County	Source
2-year trailing Rate Of Growth In Hospice Admissions	4%	15.7%	*Licensure Supplements 2008-2010*
Hospice Program Length of Stay 2009 (whichever is lower 75.4)	64.8	64.8	*Licensure Supplements 2010*
Hospice Program Median Length of Stay 2009	33.1	13	*HOIC records*
Percent of days at GIP level 2009	6%	9%	*Licensure Supplements 2010*
GIP bed occupancy	77.23% from FYE 2009	89% YTD	*Gordon Hospice House records*
2-year trailing Rate of Growth in Deaths Served	5%	13.35%	*Licensure Supplements 2008-2010*

4. Gordon Hospice House has no waiting list for Residential beds
    - 4.1.1. Last year we used about half a bed/day for residential care.
    - 4.1.2. Serenity House, a new residential care provider, opened late in 2007 and seeks residential hospice patients.
    - 4.1.3. Fourteen local adult care homes and nursing homes seek our residential patient referrals.
    - 4.1.4. We provide home hospice care in those institutions.

5. The Key Factors as to why It makes better economic sense to operate the new beds as GIP beds
    - 5.1. Licensure permits us to use a GIP bed for either GIP or Residential care. It does not permit the reverse—Our physician rounds on these pts and may change level of care based on symptom control
    - 5.2. It costs about $567 a day to operate a residential bed at Gordon Hospice House
    - 5.3. Patients pay, at most $100 a day for the room and board, based on a sliding fee scale, and the average is __$40_; in addition , Medicare and Medicaid pay __$134____ for Residential care
    - 5.4. Thus, we receive about $174 a day for most Residential patients.
    - 5.5. We must subsidize each residential day at a cost of about $393; we subsidize the GIP beds as well, but the subsidy cost is about $17 a day.
    - 5.6. At today's rates, <u>if</u> we operate the six residential beds at 85% occupancy, Gordon Hospice House will have to raise about **<u>$732,000</u>** a year to break even.

5.7. When we filed the original CON we projected that surpluses from GIP would covered the loss from the residential care. This is no longer true. We now subsidize the GIP beds.

5.7.1. This year, Charity care has increased 6 fold in the organization; patients will represent more than $100,000 in unreimbursed care at GHH and bad debt will represent another $185,000.

5.7.2. We are experiencing reductions in Medicare and Medicaid payments . FY 2010 is the first year of 7 yr phase out of BNAF—daily rates reduced by 0.4%. FY 2011-2016 will have increased reduction, with the end result of 4.2% decrease in hospice rates over the 7 year period.

5.7.3. Second series of cuts will begin in 2013. Productivity adjustment reductions are projected to change the market basket from 2.4% increase to 0.8%

5.8. On the other hand, we are way under the Medicare limitations on inpatient days. At the number of days we expect to provide this year, Medicare would cover 24 full beds. We are requesting that you permit us to have only 15 beds.

6. Alternatives

6.1. Waiting until State Plan formulas generate a need will deny care to persons who need it and are entitled to the benefit through their community donations and / or their third party coverage.

6.2. So, having the new beds as Residential only, when we have little or no need for Residential beds, will increase our costs;

6.2.1. Operating the beds such that they are restricted to Residential care will put a tremendous financial burden on our total hospice program at a time of a down economy.

6.2.2. It would jeopardize other programs like Rainbow Kidz, Palliative Care and Helping Hands for our home based patients.

6.3. We have pent up demand more than adequate to fill the new beds with GIP patients;

6.3.1. we can show you calculations that support between six and 15 more GIP beds by 2013 depending on how much you substitute local for state metrics.

6.4. The most prudent alternative is a special need for six GIP beds with a restriction limiting them to beds that can be developed with no additional capital cost.

7. Unfortunately Bill Brater, a former board member, volunteer and family member, who was scheduled to speak, was unable to attend. I spoke on his behalf regarding the care and services his brother received, including residential placement for 6 months and GIP care during the final two weeks of his brother's life provided at GHH.

8. I am happy to respond to any questions you may have.

9. My Board member will share with you the commitment and investment we have made to keep Gordon Hospice debt free and financially stable.

Handouts Public Hearing – Hospice of Iredell County, Inc

Terri Phillips, President and CEO

Reasons to Convert 6 Residential Beds to 6 GIP Beds

Comparison of Metrics for Hospice of Iredell County , Inc to North Carolina Averages

Measure	Plan Metric	Iredell County	Source
2-year trailing Rate Of Growth In Hospice Admissions	4%	15.7%	*Licensure Supplements 2008-2010*
Hospice Program Length of Stay 2009	64.8	64.8	*Licensure Supplements 2010*
Hospice Program Median Length of Stay 2009	33.1	13	*HOIC records*
Percent of days at GIP level 2009	6%	9%	*Licensure Supplements 2010*
GIP bed occupancy	77.23% (FYE 2009)	89% current	*Gordon Hospice House records*
2-year trailing Rate of Growth in Deaths Served	5%	13.35%	*Licensure Supplements 2008-2010*
Unmet GIP Bed Need 2014	0	6 to 15	

Economic Metrics GIP versus Residential

Measure	GIP	Residential	Total
Cost Per Day	$697	$567	
Payment Per day* includes physician billing	*$680	$174	
Subsidy Required per Occupied Day	$17	$393	
Annual Subsidy Required at 85% occupancy 9 GIP + 6 Residential	$47,500	$731,570	$779,070
Annual subsidy for 15 GIP	$79,100	$0	$79,100