GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

State Health Planning and Development Agency





DISTRICT OF COLUMBIA
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY (SHPDA)
Notice of Official Action
Certificate of Need
Number 00-3-5

Hospice of Washington is hereby awarded this Certificate of Need in conformance with the District of Columbia Certificate of Need statute, DC Code § 32-351 et. seq. , to add four hospice beds to its nine-bed facility.

This issuance is based on all specifications contained in the Certificate of Need application and related documents in the record. Deviations from the specifications are allowable pursuant to the statute. The capital expenditure associated with this project is $750,000. The State Health Planning and Development Agency herewith makes all findings applicable to this issuance as required by the statute.

This Certificate of Need is valid until September 20, 2002 unless: (1) its issuance is revoked following a public hearing held for reconsideration of this issuance in accordance with DC Code § 32-362, Section 13, or further proceedings in accordance with DC Code § 32-363, Section 14 or DC Code § 32-364, Section 15; (2) it is withdrawn in accordance with DC Code § 32-359, Sections 12 or DC Code § 32-362, Section 13; or (3) it is terminated because the State Health Planning and Development Agency has certified that operations may begin, in accordance with DC Code § 32-359, Section 10(j).

Unless this Certificate of Need has been revoked, withdrawn, or terminated, quarterly progress reports must be submitted to the State Health Planning and Development Agency on December 20, 2001, March 20, 2002, June 20, 2002 and September 20, 2002.

Notification of the proposed date for the initiation of operation of the facility or service approved here should be provided to the State Health Planning and Development Agency

BZA
Case No. 16836
Exhibit No. 12

Board of Zoning Adjustment
District of Columbia
CASE NO.16836
EXHIBIT NO.12

no later than thirty days prior to the proposed date for the initiation of operation so that the review required by DC Code § 32-359, Section 10(j) may be conducted.

Signed this 20th day of September, 2001.

Sincerely,

Andrew Schamess, M.D.
Acting Director

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

State Health Planning and
Development Agency

DISTRICT OF CLUMBIA
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
CERTIFICATE OF NEED REVIEW
FINDINGS IN THE MATTER OF:
HOSPICE OF WAHINGTON
CERTIFICATE OFNEED REGISTRATION NO. 00-3-5

The findings contained in this document were developed in conformance with Certificate of Need (CON) review criteria required by D.C. code & 32-359, section 10, and contained in regulations, 22 DCMR 4050 et. seq. These findings reflect the SHPDA's assessment of the information in the project record, and its consistency with the applicable considerations, standards and criteria for CON review. These findings are based on all specifications contained in the CON application and all related documents and testimony submitted to the record.

The findings take into account the recommendations of both the Project Review Committee and the Statewide Health Coordinating Council (SHCC) in their respective deliberations on August 9, 2001 and September 6, 2001.

A. Overview of the Applicant and the Proposed Project

According to the Applicant, the Hospice of Washington (HOW) initiated operations in 1978 and serves as the only Medicare/Medicaid approved provider of inpatient hospice care in the District of Columbia. As such, HOW serves as the hospice inpatient referral center for patients from a variety of settings, including but not limited to home hospice programs, hospital-based palliative care programs, hospitals which refer patients directly, as well as form its own

home hospice program. HOW has developed a great deal of expertise since initiating operations in 1978. Its services include a 9-bed inpatient hospice program.

Hospice is the name for a concept of care that provides interdisciplinary management for purposes of palliation (relief of symptoms) as well as emotional, social, and spiritual care to terminally ill persons and their families. Hospice care represents the final six-month phase of a longer period of palliative care, and strives to provide the patient and his/her family with both comfort and an optimal sense of dignity and worth in the final stages of the patient's life.

Hospice care was added as a Medicare benefit in 1983 and as a Medicaid benefit in 1985. To be eligible for hospice care benefits, a patient's physician and a hospice medical director must certify that the person is terminally ill and is expected to live for no longer than six months. At the same item, the beneficiary must sign a statement indicating that he/she is choosing hospice care rather than acute or curative services, if necessary and medically appropriate. Continued certification by the program's medical director allows hospice patients to continue to receive services (and for the provider to receive continued reimbursement) beyond the initial six-month time frame.

The Applicant states that the main focus of hospice care is to provide needed services to patients in their home environment, which may include a private residence or a nursing home setting. However, inpatient beds are an essential adjunct to home care under the following circumstances:

- To provide intensive pain and symptom management;
- To allow for an effective transition from hospital to home care;
- To provide respite care as needed by persons who are caring for the patient in the home setting;

- To serve as a safety net environment when care at home is not going well; and
- To provide services at the end of life (in the final days) if more intensive services than can be offered in the home setting are necessary.

HOW provides services to its patients and their families through an interdisciplinary approach, which involves physicians, nurses, social workers, other allied professionals, clergy, and volunteers. The clergy and volunteers are vital components of the care team. Other support services include nutrition management, physical therapy, and behavioral therapy, as appropriate.

In addition to serving patients who are residents of the District of Columbia (who comprise 66% of inpatient hospice admissions), the HOW inpatient unit also serves patients form the close-in suburbs of Montgomery County, Prince Georges County, and Northern Virginia.

According to the Applicant, its patient populations comprise of persons with a host of chronic, terminal illnesses, chief among them being cancer and AIDS which account for approximately 75% of patient admissions. Other diagnostic categories of persons admitted include chronic heart and respiratory disorders, renal failure, and CVA/dementia.

According to the Applicant, the inpatient unit has averaged 334 admissions per year over the past three years, while the unit's ALOS has averaged 7.8 days. This has resulted in an average occupancy for the 9-bed unit of approximately 87% during the past two years. The Applicant further states that the occupancy rate has reached 95% in two of the last six months, and the census reaches or exceeds 100% at least two days per week (occupancy exceeds 100% when beds are full and one or more patients are discharged and replaced with another patient during a 24-hour time period).

This high occupancy rate is expected to continue to increase as a result of several factors, which include:

- increased visibility and acceptability of hospice care, with an emphasis on home care, by the population;
- the aging of the population;
- the increased recognition of the use of both home care and complementary inpatient hospice care as an alternative to end of life acute care by managed care payers; and
- an expected increase in the use of palliative care, which will lead to increased numbers of chronic patients being exposed to hospice care earlier in the end of life process.

In order to address this additional and growing demand for in patient care for terminally ill persons, as well as the constraint of the current capacity, HOW is now proposing to increase its Medicare/Medicaid designated beds form nine (9) to thirteen (13) beds. The applicant maintains that expanding Medicare/Medicaid certification by four beds will allow it to ensure timely availability of services of the inpatient hospice unit.

The project will be accomplished by adding four rooms onto the building, as well as by utilizing several contiguous support spaces to create a large patient/family lounge as well as kitchen area. The proposed capital expenditure for the project is $750,000.

B. Review Findings of Fact and Conclusion

1. Need for the Proposed Project

The Applicant maintains that the high occupancy rate of the existing beds, projected increases in the population cohorts that are likely to utilize hospice

beds and the prevalence of the primary illnesses that result in hospice care indicate the need for more beds. Specifically, the Applicant maintains that;

- the 55-64 and 65+ populations experience higher rates of terminal illness than the rest of the populations; 1998 estimates for the District of Columbia population, by age cohort, indicate that the greatest proportion of persons in the age cohorts reside in sections of the City closest to HOW (Wards 3, 4, and 5); and

- Population estimates for the year 2000 and projections for five-year intervals form 2005 through 2025 indicate that the 65+ population, which contains the majority of hospice service users, will remain relatively stable through 2005 and then experience growth for the foreseeable future thereafter. The 55-64 year age cohort (which account for approximately 20% of hospice patients) will consistently increase over the next 20 years.

The Applicant further states that the four primary types of illnesses, which trigger the use of hospice/palliative care services are cancer, chronic heart disease, chronic respiratory disease, and HIV/AIDS, all of which are very prevalent in the District.

The Hospice of Washington reports that it contracted with the Corridor Group in the spring of 2000 to research the need for hospice services in the District of Columbia. Data collected by the Corridor Group regarding the number of deaths associated with these diagnoses indicated that there were 3824 such deaths in HOW's service area population in 2000 (includes both the primary and secondary service area). The Applicant maintains that hospice experts indicate that approximately 50% of persons in the process of dying from these diagnoses are potential hospice patients (1,912 patients), while 22% of these potential hospice patients may be appropriately considered to be candidates for use of inpatient hospice services (420 admissions). If all of the 420 patients were admitted to an

inpatient unit, the unit would have to be greater than a 9-bed unit. As education and awareness continues to grow within the service area, the Applicant reports that Corridor estimates the need for 660 admissions by the year 2005.

Further, the above estimates do not include potential additional volumes of patients (an additional 10%-20% of caseloads) with other life-ending illnesses who will use hospice care.

The Applicant maintains that the proposed expansion will allow HOW to better serve the needs/demand generated by area HMOs, which currently account for 15% of patients admitted to its inpatient unit. The referring HMOs recognize the cost-effective nature of hospice services when compared with alternative approaches such as having terminally ill patients use expensive acute and special care units in acute inpatient facilities in their final days of life (which is too often the case). The Applicant argues that providing such a cost-effective alternative will serve to allow HMOs to achieve cost savings, which will inturn impact positively on their rate structures.

In addition, the Applicant maintains that the four (4) beds added as a result of this approval will allow HOW to continue its role as a regional resource by providing additional capacity to accommodate patient needs in a timely manner. As referrals for services are generated not only from the District but also from the metropolitan area, it states that the proposed option is the most cost-efficient and conservative approach to moderately increase the availability of needed impatient beds by terminally ill residents in need of hospice.

The Applicant also maintains that operating an additional four (4) beds will allow it to spread its overhead cost among these beds thus allowing it to get closer to payers' per diem reimbursement limits. The inpatient services can also be provided more cost efficiently since HOW can operate an additional 4 beds through the use of one additional RN per shift.

The Applicant states that all major studies point out that the primary reason for cost savings associated with hospice relate to its ability to substitute relatively expensive care at home for more expensive institutional care typically provided to terminally ill patients who are not hospice patients. The hospice inpatient unit serves to support and supplement care provided to hospice patient as intermittently necessary and thereby allows hospice care as an appropriate alternative to more traditional treatment for terminally ill persons.

According to the Applicant, a 1988 study conducted by the Health Care Financing Administration showed savings to $1.26 for every Medicare dollar spent on hospice. A follow-up study commissioned by the National Hospice and Palliative Care Organization (NHPCO) and conducted by Lewin-VHI, the Applicant reports, showed that for every dollar spent on hospice, Medicare saved $1.52 in Part A and Part B expenditures. Further, non-hospice patients account for 28% of all Medicare cost in the last two months of life.

The Applicant further reports that the use of the additional hospice beds at 90.0% occupancy would result in 1348 inpatient hospice days. At a current all-inclusive reimbursement rate of 439 per day and a 7.1 day LOS, this would yield inpatient fees of $3,117 for an inpatient hospice care episode at HOW and total inpatient fees of $591,772 for this caseload. Conversely, inpatient care costs in an acute ICU care setting at an average cost of $2,000 per day in the District of Columbia would cost $2,696,000 per year for Medicare and Medicaid. In addition, non-hospice terminally ill patients tend to spend multiple episodes in an acute care bed during the last several months of their lives while hospice patients are typically managed in the home setting with infrequent use of inpatient care.

After a careful review of the application, the SHPDA has concluded that the Applicant has demonstrated the need for the increase in beds. Given the reported high utilization rate at HOW and given the prevalence in the District of

the diseases that are likely to lead to hospice care, the proposal to add four beds is reasonable. Expanding services at the existing facility is also a prudent way to add capacity to the system.

2. Accessibility

Hospice of Washington is located at 3720 Upton Street in NW Washington. As such, it is accessible by car, as well as by a number of bus routes. Patients and visitors can also take the metro to either of two stops located at Tenley Street and Wisconsin Avenue or at Connecticut Avenue and Van Ness Street. According to the Applicant, each of these stops is a short walk, bus, or cab ride away from HOW. Inpatient hospice patients most often arrive for inpatient care by ambulance.

HOW's inpatient and home care services are available 24 hours per day, 7 days per week. The Applicant maintains that any person with an appropriate diagnosis and prognosis is given access to the services. HOW welcomes admissions from any physician practicing in the community. Once admitted to the inpatient hospice unit, the patient receives care directed by the patient's primary physician or the Medical Director. The care is provided based on a plan of care developed by an interdisciplinary team, with input by the patient and his/her family. The Medical Director maintains contact with private physicians about the status of their patient as appropriate or requested.

The Applicant maintains that HOW is a non-profit provider of care and accepts all persons who are referred for admissions from either its own home care hospice program or those of other area providers, regardless of payer status, race, gender or ethnicity.

According to the Applicant, approximately 6% of HOW patients are charity patients well exceeding standards for provision of care to non-insured persons.

With respect to other categories, which are typically used to identify under-served populations, 50% of its patients are African-American; 10% are of Hispanic, Far eastern, or Asian ethnicity; and 60% are women.

HOW patients gain access to the services through a variety of means, including referral from private physicians, referral from HMOs, referral form hospital discharge planning departments, or referral by religious organizations. The Applicant states that no person is denied access to HOW based on ability or inability to pay for services.

The Applicant maintains that the proposed expansion will allow the HOW inpatient hospice unit to accommodate referrals form a wide range of community providers, including clergy, physicians, hospitals, and home care hospices.

Based on the above, the SHPDA has determined that the Applicant is consistent with the criteria and standards for accessibility.

3. **Quality**

The Applicant states that according to a report prepared for the U.S. Office of Disability, Aging, and Long Term Care of DHHS regarding outcomes and utilization for hospice and non-hospice nursing facility patients, hospice enrollment is associated with a 93% increased likelihood that patients in daily pain have their pain managed through improved pain assessments and appropriate medications. Further, the hospice patients had a much-increased likelihood of receiving management of persistent depression and anxiety. Overall, this study concluded that hospice care improves the quality of life for terminally ill nursing home residents.

The Applicant further maintains that it meets all hospice standards of care set forth by the National Hospice and Palliative Care Organization. In addition HOW

is certified by both Medicare and Medicaid, as well as by the Joint Commission on Accreditation of Health Care Organizations.

The Applicant states that HOW participates in the JCAHO ORYX quality monitoring system, which is applied to ensure that accredited facilities are honoring their commitment to the delivery of high quality patient care. This system provides a wide array of quality indicators to be achieved by providers of service. The list of quality indicators used at HOW, which the facility maintains it meets or exceeds in all instances, includes but is not limited to the following:

- The volume and types of patients who die at home vs. in-facility;
- The level of bereavement services offered to families of hospice patients, as well as to community members whose loved ones die outside of hospice;
- The level of pain comfort achieved within three days of admission; and
- The number of resuscitations, both wanted and unwanted.

The Applicant reports that HOW received the results of its last JCAHO accreditation on June 25, 2001 and was given full 3-year accreditation status. It received an overall rating of 93%, and a patient care/nursing services rating of 97%. As a result, the facility also received full accreditation form the Center for Medicare and Medicaid Services (formerly HCFA).

The Applicant maintains that HOW achieves this level of quality by employing a highly-trained Medical Director and Clinical Program Director who oversee and direct all members of the team in providing services to patients. The facility also maintains extensive Quality Assurance and Continuing Quality Management Systems, which document all phases of the care process as mandated by JCAHO.

The SHPDA is, therefore, satisfied that the application is consistent with the criteria and standards for quality of care.

4. Continuity

The proposed services by their very nature will provide continuity of care to hospice patients who are discharged from hospitals or those who are referred from nursing homes or their residence.

The Applicant states that HOW offers a comprehensive array of services to hospice patients on the unit. Many of these services are operated on its premises, while several others are offered by outside organizations on a fee or consulting basis. Specifically, pharmacy, laboratory, outpatient rehabilitation, ambulance services, radiology services, and home support services are offered to hospice patients through arrangements with at least 20 provider organizations or agencies.

The Applicant also states that the Hospice of Washington is dedicated to professional training. As such, medical residents from the Washington Hospital Center and Prince Georges Medical Center rotate through the inpatient program, and it has also trained medical students, residents and fellows from Georgetown University Medical Center and Providence Hospital.

The Applicant states that is plans on continuing to broaden its "end of life" training initiative through establishing additional collaborative relationships with area professionals/end of life organizations, which will ensure learning opportunities, which emphasize both professional and humane approaches to care of the dying.

Based on the above, the SHPDA finds the application consistent with the criteria and standards for continuity of care.

5. Acceptability

The applicant maintains that it has developed mechanisms to provide for patient rights and to consider consumer grievances. A Client's Rights document details the patient's rights in the care process. This document includes the description of the specific grievance procedure in the event a patient and/or families are dissatisfied with any aspect of the care.

The applicant has stated that it has informed the Advisory Neighborhood Commissions in its service area regarding the proposed project. The SHPDA, however, has not received any letters of support or opposition to the project from the ANCs.

The SHPDA is, therefore, satisfied that the application is consistent with the criteria and standards for acceptability of services.

6. Financial Feasibility

The applicant states that is will finance the project by utilizing retained earnings. A review of the applicant's financial statements shows that it has the funds to finance the project. An analysis of its financial projections also shows that the project will generate more revenues that expenses. SHPDA is, therefore, satisfied that the application is consistent with the criteria and standards for financial feasibility.

C. Compliance with Uncompensated Care Requirements

The Applicant has stated its commitment to provide free care to needy patients. The SHPDA, therefore, is satisfied that the Applicant is consistent with the requirements.

D. Conclusion

After a careful review of all the information, including the staff report as well as the recommendations of the Project Review Committee and the Statewide Health Coordinating Council, the SHPDA has determined that the Applicant has demonstrated the need for the project. Given the high occupancy levels of the existing beds and given the prevalence of the diseases that lead to terminal illness, the Applicant has justified the need for adding four (4) beds. The SHPDA also believes that it is prudent to expand capacity by adding beds to an existing unit. The SHPDA has, therefore, decided that Hospice of Washington be issued a certificate of need to add four (4) beds to its existing nine-bed inpatient hospice program.

9-20-01

Date

Andrew Schamess, M.D.
Acting Director