

July 15, 2013

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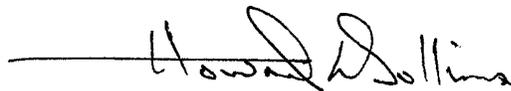
Ms. Ruby Potter
Health Facilities Coordination Office
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: Seasons Hospice and Palliative Care of Maryland, Inc.
Docket No. 11-03-2318

Dear Ms. Potter:

Pursuant to guidance provided by Reverend Robert L. Conway, Commissioner|Reviewer, in his June 28, 2013 Memorandum accompanying his Recommended Decision in the above-referenced matter, enclosed are 30 copies of the Response to Exceptions being filed on behalf of Seasons Hospice & Palliative Care of Maryland, Inc.

Sincerely,



Howard L. Sollins

/tjr

cc: Ben Steffen, Executive Director, Maryland Health Care Commission
Paul Parker, Director, Center for Hospital Services
Joel Riklin, Acting Chief, Certificate of Need
Suellen Wideman, Esq., Assistant Attorney General
Gregory Branch, M.D., Baltimore County Health Department
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Philip F. Diamond, Esq.
Thomas C. Dame, Esq.
Mr. Andrew L. Solberg
Mr. Todd A. Stern
Mr. Dean H. Forman
John J. Eller, Esq

IN THE MATTER OF	*	BEFORE THE
SEASONS HOSPICE AND	*	MARYLAND HEALTH
PALLIATIVE CARE	*	CARE COMMISSION
OF MARYLAND, INC.	*	
DOCKET NO. 11-03-2318	*	
* * * * *		

RESPONSE TO EXCEPTIONS

Seasons Hospice and Palliative Care of Maryland, Inc. (“Seasons”), the applicant in the above-captioned certificate of need (“CON”) proceedings, through undersigned counsel, hereby replies to the exceptions filed by Gilchrist Hospice Care, Inc. (“Gilchrist”) and Stella Maris, Inc. (“Stella Maris”) (collectively, the “Interested Parties”), urging rejection of the well-reasoned analysis, findings and recommended decision (the “Recommended Decision”) by Reverend Robert L. Conway, the Commissioner appointed to act as the Reviewer (the “Commissioner | Reviewer”). Seasons supports and urges the Commission to ratify the Recommended Decision. It is the product of a lengthy CON review, including full and fair consideration of an extensive record. In that regard, the Recommended Decision reflects full consideration of (a) the needs of individuals with terminal conditions and their families for access to hospice care in the best environment and from a provider of their choice, and (b) the legal obligation of general hospices to provide a full spectrum of services of which inpatient hospice care is an essential part.

This is best illustrated by Reverend Conway's finding, on page 25:

"... I believe it is reasonable, as a general proposition, that the MHCC be open to allowing general hospices to develop and operate their own inpatient facilities when such facilities can be feasibly established and operated and when there is no evidence indicating that such development and operation will alter the provision of inpatient hospice care in ways that may diminish quality or patient safety, or result in inappropriate delivery of hospice services."

Indeed, inpatient hospice services are part of a continuum of services that some, but certainly not all, individuals with a terminal prognosis of six months or less may require for brief periods. As Seasons explained on page 7 of its Application, in addition to the overall requirement that individuals covered under the Medicare hospice benefit have a prognosis of six months or less, additional Medicare criteria for *inpatient* hospice care include, among others:

- Agitation requiring medication change
- Uncontrolled pain requiring dosage changes
- Blood transfusions
- Intractable seizures requiring observation and/or medication titration
- Weaning from a ventilator
- Wound care needing frequent dressing changes
- Respiratory distress
- Cardiac failure requiring frequent medication administration

- Intractable bleeding

The Seasons Open Access program, described on pages 9 and 10 of its application, distinguishes its hospital-located inpatient hospice units from those the Interested Parties provide in freestanding facilities. As Seasons explained, there are some individuals who, as part of a comfortable dying process, continue to need some additional services such as IV antibiotics, total parenteral nutrition, ventilator support, cardiac drips, chest tubes, hemo/peritoneal dialysis for non-hospice conditions, palliative radiation, biological response modifiers or other support before they are discharged for home hospice care. The Seasons inpatient hospice unit at MSFSMC is not limited to individuals with these additional needs, but their availability makes hospice care available to a greater number of individuals with complex medical needs. The availability of a dedicated inpatient hospice unit on-site in the hospital means that individuals who otherwise would refuse hospice care can be more comfortable making the hospice election.

It is these terminally ill individuals -- with acute, fragile conditions requiring a short stay in a specialized inpatient setting -- who Seasons serves in a dedicated, specialized setting with trained hospice staff. Attached as Exhibit A to this Response is a published article already in the record as Exhibit 5 to the August 16, 2011 completeness response Seasons submitted to the Commission. It describes the manner in which inpatient hospice services were established by Seasons in 2007 at Northwest Hospital Center, in a unit that is similar to the proposed for MSFSMC in this CON application.

It is this inpatient hospice care that the Interested Parties wish to prevent Seasons from providing a dedicated, specially designed, accessible setting, based on the hope that if Seasons is denied this service, the hospice patients would instead leave the hospital and go to the Interested Parties' freestanding inpatient facilities. Acceptance of the Exceptions would deny terminally ill patients and their families access and choice. As the Recommended Decision finds, the effect would not be that these patients would go elsewhere to receive hospice care. Rather, it means that terminally ill patients in hospitals continue to refrain from making the election to receive hospice care, as Seasons demonstrated that they have done historically. It means that terminally ill patients who wish to receive palliative care in a manner that recognizes the dying process, would instead remain in intensive care units, coronary care units, medical/surgical units and elsewhere in the midst of a care environment that is, instead, fully focused on providing a full array of medical and surgical costly and futile interventions for the patient. Not only would these individuals not have an available, accessible choice for hospice care, by not making the hospice election their families would be deprived of the 13 months of bereavement support that the hospice benefit provides.

As the Recommended Decision correctly finds, on page 2:

"... every licensed general hospice is obligated to make provisions for inpatient care."

Under the certificate of need, licensing and Medicare rules, there is no finite limitation on the number of inpatient hospice relationships and settings, but there is an

overall legal restraint that ensures there is no overutilization of inpatient hospice services in relation to overall general hospice services. See, Recommended Decision, p. page 27. This is a reference to the federal Centers for Medicare and Medicaid Services hospice regulations.¹ This regulation acts as a firm financial ceiling and protection against overutilization of this part of the continuum of hospice care.

The Commission now requires general hospices to obtain certificate of need approval to establish, or increase beyond certain thresholds, dedicated inpatient hospice units designed to meet the special needs of these short-stay, acutely symptomatic, terminally ill patients.

As for the settings in which inpatient hospice care may be provided, there are several options. First, general hospices may have dedicated freestanding hospice facilities. The Interested Parties use this approach, locating their facilities in specific locations even though they have approval to offer hospice services in a significant number of counties and are among the largest hospices in Maryland. In fact, both of the Interested Parties affirmatively chose to develop such facilities during a longstanding period when there was no requirement limiting the number or locations of dedicated inpatient hospice locations. Both are among Maryland's largest hospice providers, are authorized to operate in multiple counties, and are affiliates of larger hospital and health systems. Moreover, for many years since the inception of CON regulation over hospices, until 2010, it was the policy of the Commission to exempt from CON review

¹ Federal hospice regulations 42 C.F.R., §418.108(d) state: "*Standard: Inpatient care limitation.* The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries."

any development of dedicated inpatient hospice bed capacity by a general hospice. Thus, neither Stella Maris nor and Gilchrist ever received a CON for their facilities and Gilchrist was permitted to complete a second freestanding hospice location in Howard County (without a CON) even after the change in Commission policy. They developed their freestanding hospice facilities during a period when there was no ability to use the CON process to challenge other hospices seeking to offer the same service.

Second, inpatient hospice services may be provided on an unlimited basis under hospice/hospital contractual arrangements based on where a hospital may have an ad hoc, available empty bed in the institution. See Recommended Decision, p. 3. While this offers access to inpatient hospice care on a “available bed” basis, it also means, however, that if a terminally ill individual with a complex condition needs inpatient hospice services, those services are not provided in a dedicated, specialized environment with an atmosphere and setting that is geared to support of the individual and family. Rather, that the terminally ill patient who wishes or needs to remain in the hospital would only have available the choice whether to receive inpatient hospice care in whichever empty hospital bed happens to be available, i.e., to seek hospice care in the midst of an overall clinical atmosphere in which patients and staff are otherwise focused on a curative process and return to home. As the Recommended Decision finds, Seasons, as an active hospice serving individuals throughout the jurisdictions it serves, should not be relegated to having only this kind of ad hoc inpatient hospice resource available in the hospital, while the Interested Parties have developed and operate their own freestanding inpatient hospice facilities.

Third, as reflected in its application, Seasons seeks to provide accessible inpatient hospice care in smaller, specially designed and expertly staffed, dedicated, efficient settings that bring hospice and palliative care closer to the patients in the hospital, thus offering a choice and alternative to patients. This means that, rather than moving to a so-called “scattered” available bed somewhere in the hospital or remaining in ICUs, CCUs and other units with a curative clinical focus, the patient has the option to receive inpatient hospice care in an optimal setting. It is this choice the Interested Parties seek to deny hospice patients.

At the outset, it is relevant to note what the Interested Parties concede. There are six CON review criteria under COMAR 10.24.01.08G(3)(a)-(f). Gilchrist’s and Stella Maris’ Exceptions only cite to two of them: “need” under Regulation .08G(3)(b) and “impact” under Regulation .08G(3)(f). There were no challenges to the Recommended Decision’s favorable findings that Seasons complied with the State Health Plan, offered a cost-effective alternative, demonstrated the viability of its proposal, and established there were no compliance issues under prior CONs, under Regulations .08(G)(a), (c), (d) and (e).

Need: Regulation .08G(3)(b)

Both Gilchrist and Stella Maris challenge Reverend Conway’s finding that Seasons demonstrated a need for its unit.

Plainly, Reverend Conway did not confuse “demand” with “need,” as Gilchrist claims. After careful consideration of the positions of all parties, he rightly noted, on page 26, that the “demonstration of need for a project of this type is, of necessity, of a

different order than that applicable to many of the projects regulated under CON.” (Neither the current State Health Plan nor the draft revision to the State Health Plan relating to hospice services that the Commission voted to publish as a proposed regulation imposes a formulaic approach that identifies a specific pool of inpatient hospice bed need.) As the Recommended Decision notes on page 27, applications that, since 2010, are required to establish new dedicated inpatient hospice units “can be viewed as primarily proposing to change the manner in which [the hospice] delivers one of the services it is already required to make available to patients.” (emphasis added).

In essence, Seasons is obligated to make inpatient hospice care available to its patients and has demonstrated a need for it to be able to do so in a dedicated, specially designed, cost-effective and staffed setting it operates. The Commissioner | Reviewer was convinced that Seasons demonstrated that its unit will, as it has done in the past, generate a substantial portion of its patients from terminally ill individuals in hospital beds who are not now electing hospice care but who otherwise would wish to do so if this access and choice were available. He also identified the growth in the population likely to need hospice care.

Gilchrist wrongly claims, on page 2 and 3 of its Exceptions, that Reverend Conway, a very experienced Reviewer, does not understand the difference between “need” and “demand.” However, it is evident from the Recommended Decision that the Commissioner | Reviewer clearly understood the settings in which general hospices provide inpatient care and made a valid finding, supported by the evidence, that

Seasons demonstrated an unmet need among individuals who are in hospitals and are not electing a hospice election. This was demonstrated, for example, by the history of the comparable unit at Northwest Hospital Center, as well as an out-of-state example Seasons provided, where hospital mortality rates in acute care beds declined after an on-site hospice unit was established. This validates that patients wish to have the choice to receive this kind of care in a more accessible setting. Gilchrist seems more concerned, on page 3, about what "future applicants" would need to show, than what Seasons convincingly demonstrated in this CON review.

Likewise, Stella Maris suggests, on page 3, that while the Interested Parties are permitted to maintain operation of their own, CON-exempt, freestanding, inpatient hospice facilities, Seasons should be required to demonstrate why it cannot be satisfied with only one option in meeting its obligation to provide inpatient hospice care, by providing inpatient hospice care on an ad hoc basis, and in randomly available hospital beds scattered throughout area hospitals. As the Recommended Decision determines and as Seasons experience demonstrates, many patients faced with this choice prefer not to make a hospice election, and to remain in the hospital in an ICU, CCU or other acute care bed.

On page 4, Stella Maris continues to assert, as it did in its comments and oral argument, that it is sufficient for extremely ill and vulnerable patients at MedStar Franklin Square Medical Center to be advised that their only options for receiving inpatient hospice care are in an empty hospital bed (not on a designated hospice unit) as a hospital bed becomes available on a traditional hospital unit or instead to change from

Seasons as their hospice provider of choice and transfer out of the hospital to a different hospice's freestanding facility. Indeed, the Recommended Decision rejects such disparate treatment and denial of patient choice and access, validating that Seasons has demonstrated a valid basis for meeting the needs of these extremely ill and vulnerable individuals in need of inpatient hospice care.

Impact

Both Interested Parties claim negative impact from the Seasons proposed inpatient hospice unit. The starting point for any consideration of the Exceptions is the language of the applicable regulation itself, under .08G(3)(f).

“An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Not only did the Interested Parties fail to address the elements of this CON review criterion; it is also relevant to note what the Interested Parties failed to provide. They only make allegations with respect to lost volumes and revenues, which are partial information at best. They failed to offer any evidence concerning why they would be unable to maintain, and even grow, their services by providing effective services throughout the jurisdictions where they are authorized to operate. They provided no financial statements and no detail on expenses, efficiencies or total sources of financial support. Neither did they consider available growth opportunities, whether

by increasing market share in the Counties where they operate or by growth in the population to be served.

Approving the Seasons application will improve, not diminish, geographic and demographic access to services. The Interested Parties' charges are set by payers and will not change. They presented no evidence on their costs. They did not demonstrate why they could not maintain occupancy or viability. Moreover, the impact of the Seasons inpatient hospice unit on costs to the health care delivery can only be positive. The Interested Parties will remain an available choice hospice for MSFSMC patients. It is only a positive for MSFSMC to be able to identify yet another choice for patients in expensive ICU, CCU and similar acute care units to receive care in an effective, cost-efficient hospice setting.

The Recommended Decision, commencing on page 36, identified the growth in the population and the consistently-experienced growth in the use of hospice services. The Commissioner | Reviewer properly *was convinced*, as reflected on page 37, that the provision of hospice services is not a "zero sum game" and that a Seasons unit would not have an unwarranted negative impact on the Interested Parties. He accepted as valid Seasons' point that, while it effectively seeks to maximize services throughout its authorized service area, the Interested Parties have not yet done so.

Stella Maris tried to identify a potential loss of referrals from MSFSMC as the basis for its claim of negative impact. However, the impact review criterion is not a vehicle for one provider to try to ensure that it will never have competition from any other provider. There simply is no CON review criterion that assures that the

Interested Parties own exclusive rights to referrals from MSFSMC. Neither is the Commission the enforcement tool to ensure a referral relationship with a particular hospital is protected. Rather, the impact criterion under the CON regulations calls for an evaluation of whether overall occupancy at another provider will experience an unwarranted degree of impact from a CON approval. That showing was never asserted, much less made, by the Interested Parties. Allegations of revenue losses without complete financial information cannot support an allegation of negative impact or loss of viability. There was no evidence or detail verifying that overall revenues of the Interested Parties, with their large, multi-jurisdictional hospice programs, would drop. Those hospices, in fact, have an unlimited opportunity to increase their services to home hospice patients and also contract with local hospitals in all of the jurisdictions they serve to provide inpatient hospice care in available hospital beds to augment their hospice service. They too may apply for CON approval to increase their bed capacity at current or new locations. Moreover, the allegations solely related to revenues they claim would be associated from lost referrals at one particular source, i.e. MSFMC. For example, Stella Maris highlights the number of referrals it receives from various hospitals in Table 2, on Page 11 of its Exceptions. Notably, the largest source of referrals is from St. Joseph Medical Center. Stella Maris does not mention that this hospital is part of University of Maryland Medical System, providing a broader opportunity to Stella Maris to develop additional or deeper hospital relationships.² The largest source

² Neither did Stella Maris add to the number referrals on its Table 2 any referrals from Mercy Hospital, which is part of the same health system. In footnote 3 on page 11, Stella Maris acknowledges it does

of referrals is the nursing home with which that hospice is affiliated. There is no discussion of why Stella Maris is barred from developing relationships and receiving referrals wholly separate from MedStar or LifeBridge, where Seasons has competitive relationships. Finally, the asserted potential loss of referrals is speculative, as the Interested Parties are widely known through relationships with health care providers, through the media, and other means so that MSFSMC patients may prefer to be transferred to their facilities.

The Seasons proposal meets the unmet need of persons not now making a hospice election, the population likely to use hospice care is growing, all of the hospices that are parties to this review have been growing, and there are market share growth opportunities for the Interested Parties. In fact, Seasons believes that its approach will more broadly educate the public about hospice care in a way that benefits all hospices by increasing acceptance and understanding of this choice.

The status of the Northwest Hospital Center inpatient hospice services is no barrier to approval of the Recommended Decision.

In a “red herring” argument, the Interested Parties seek to distract the Commission from approval of Seasons’ unit at MSFSMC by pointing to the inpatient hospice services at LifeBridge Health’s Northwest Hospital Center. The Recommended Decision rightly uses information about the NWHC location as evidence of the validity of the Seasons approach, and that the dedicated inpatient hospice unit will address an unmet need as reflected in a reduction of hospital mortality rates.

receive an unspecified number of referrals from its affiliate, Mercy Hospital. I.e., Stella Maris used its table to aggregate MedStar hospital referrals but did not use a similar approach to identifying Mercy Health System referrals.

The Recommended Decision does not rely on inpatient hospice referrals presently at the NWHC location going to the MSFMC location. The Recommended Decision correctly identifies that referrals within MedStar, not LifeBridge, support the pending application.

The status of inpatient hospice services at NWHC is under review, as an element of Seasons' efforts to comply at all times with applicable CON and licensing requirements. As the Recommended Decision notes, Seasons initiated services at NWHC in 2007 during a period when there was no CON regulation of inpatient hospice bed capacity. Services have been effectively provided there during the past 6 years. We appreciate that the Recommended Decision identified as "unclear" the status of inpatient hospice services at NWHC in the chart on page 25. Only after discussion and correspondence with the Commission did Seasons reconfigure services to use clustered, dedicated hospital beds under agreements that ensured no interruption of services. The manner in which hospice services are maintained at NWHC is under discussion as a result of communications among Seasons, LifeBridge, the Commission and OHCQ relating to inpatient hospice services at Sinai Hospital that were initiated after the 2010 change in Commission policy. Notwithstanding a disagreement about the interpretation of the hospice licensing and CON rules, in complete good faith and cooperation with the regulatory process, Seasons is not providing hospice services in a dedicated area of Sinai Hospital and filed a letter of intent with the Commission. However, it is Seasons' position (and LifeBridge's position) that the inpatient hospice services available at NWHC from their inception in 2007 can and should be maintained.

Seasons is confident a solution can be reached about NWHC that does not result in an interruption of a six-year history of beneficial, effective inpatient hospice services at that location.

At every turn, even when it disagreed with an approach or interpretation of the Commission, Seasons has cooperated with the CON process and this agency. It did so when, as noted on page 2 of the Recommended Decision, Seasons was the only hospice not permitted to complete its inpatient hospice project under development when the Commission changed its policy in 2010 so as to place inpatient hospice capacity under CON development at MSFSMC. (Gilchrist was permitted to complete a second inpatient facility, but Seasons was denied that same opportunity.) As the Recommended Decision states on page 2, when Seasons' efforts at MSFSMC were not accepted as sufficient to qualify for a CON exemption under the grandfathering process the Commission established, Seasons was advised to file a CON application for this project. Seasons disagreed but cooperated and filed this pending CON application.

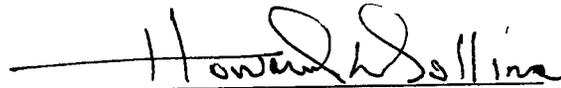
In any event, the relevant point is that the status of NWHC is not related to approval of the Recommended Decision. What is relevant is that the experience at NWHC demonstrates that there is no adverse impact under the above-quoted CON review criterion that has been -- or could be -- demonstrated by the Interested Parties.

In summary, Seasons has demonstrated its commitment to meeting the needs of terminally ill individuals throughout its service area. This includes meeting its obligation to provide inpatient hospice care. The population served, the growing future population, and the population of hospitalized individuals who qualify for hospice care

and may be interested in that choice but who are refraining from making a choice for hospice care all support the finding of a need that the Seasons project will address. Hospice care is an essential, growing part of the health care delivery system and Seasons must have available the tools it needs to meet its obligations. The Interested Parties have presented Exceptions and comments that reflect a static view of hospice care and a desire to maintain the status quo, based on an unrealistic and unsupported position that only they have the right to dedicated inpatient hospice capacity and any additional choice will diminish referrals to which only they are entitled. In essence, the Exceptions are based on the view that Seasons patients who need inpatient hospice care should be limited to the option of terminating their hospice relationship with Seasons and instead switch hospices and transfer to the Interested Parties' freestanding facilities, unless the patients are willing to receive inpatient hospice care in randomly available hospital beds scattered through MSFSMC. The approach urged upon the Commission, which was rejected in the Proposed Decision, does not address an identified patient need, and denies terminally ill individuals choice and access.

The Recommended Decision offers a well-reasoned explanation based on substantial evidence in the record, the careful consideration of opposing views in a complete record and consideration of oral argument. The Recommended Decision should be sustained.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Howard L. Sollins", with a horizontal line extending to the left from the start of the signature.

Howard L. Sollins

John J. Eller

Ober | Kaler

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Baltimore, Maryland 21202

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Attorney for Seasons Hospice and Palliative
Care of Maryland, Inc.

CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of July, 2013, a copy of Seasons Hospice and Palliative Care of Maryland, Inc.'s Response to Motion to Supplemental Record was sent via electronic transmission and first-class mail to:

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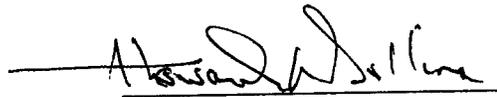

Howard L. Sollins

EXHIBIT A

ADVANCE FOR NURSES VOL. 12, NO. 1

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Two Worlds Unite

Hospice and hospitals often exist as two separate silos. What happens when the two meet under the same roof?

BY AINSLEY MALONEY DI DUCA

Over the years, hospice and hospitals have come to exist as something like two separate nations, each with its own culture and values. Hospitals save lives, hospices ease the pain of death. Hospitals find

cures, hospices comfort. Hospitals seek quantity of life; hospices seek quality at the end of life.

So what happens when a hospital adds a hospice unit and these two worlds combine? Northwest Hospital, part of LifeBridge Health, discovered this in February 2008 when, in partnership with Seasons Hospice and Palliative Care of Maryland, it became the first hospital in the state to open a fully dedicated hospice unit.

Here, Seasons staff and an outside expert from the hospice field explore the various ways a strong hospital/hospice relationship can benefit everyone — from the hospital and hospice, to the patient and his family, and even the community; in this case, in and around Randallstown, MD.

When Hospice Isn't 'Home'

To most people, hospice is synonymous with the word "home." It is thought of as an alternative to hospitals; as a way for patients to die peacefully in the comfort of home.

But at times this is not always best for everyone. Sometimes, a patient's symptoms become so acute he needs more aggressive pain management than can be provided at home.

For him, inpatient hospice is the only way to find comfort and pain relief near the end of life.

All hospice companies must offer access to inpatient services under the Medicare Hospice Conditions of Participation. To do this, some hospices might lease beds at a nearby hospital and transport acute patients there. However this isn't always ideal.

"Patients and families were starting to say, 'I needed inpatient hospice care but I really didn't want to be in a hospital.' Or, 'I really wanted a place that was more home-like,'" explained Judi Lund Person, MPH, vice president of regulatory affairs and state leadership, National Hospice and Palliative Care Organization.

So some hospices, such as Seasons, decided that if more than 300 at-home hospice patients ever needed inpatient care, it would do more than lease a few beds: It would partner with a hospital to build an entire hospice unit — and one that is completely different from the hospital in look, feel and mindset.

Home-Like Atmosphere

When visitors open the frosted-glass doors to Northwest Hospital's 14-bed inpatient hospice unit, they are transported out of a hospital into a warm, home-like atmosphere, explained Michele Parisi, BSN, RN, team director of the unit.

The unit, run by Seasons Hospice staff, offers

all-private rooms with flat panel TVs and walls decorated in soft yellows and warm greens. It offers a shared family room, kitchen and eating area for family and friends, who are welcome 24/7.

Herein lays the first benefit an on-site hospice unit offers a hospital: It's the perfect solution for patients who need inpatient care, but would rather spend their final months in a place that looks and feels like home. "The air is different on this unit," Parisi said. "When people come here, they instantly feel a sense of calm."

The Right Expertise

In addition to the right atmosphere, Seasons Hospice also offers the right expertise to Northwest patients who are near the end of life.

"People do well what they do often," said Gary E. Applebaum, MD, executive director of Seasons Hospice. "Hospitals do a great job of taking care of acute patients; in making them healthy and getting them home. Hospitals do not do as well when the goal is comfort rather than cure. Tending to a patient's symptoms is what we do well. We are enormously aggressive about providing high-technology care to make the patient as comfortable as possible."

Easing a patient's pain is more than physical, however. It also requires emotional, psychosocial

PETS, PRAYERS, SUPPORT. With the opening of Seasons Hospice and Palliative Care of Maryland at Northwest Hospital, Randallstown, MD, acute and hospice care blend seamlessly. The hospice unit, right in the hospital, allows patients to be transported easily from hospital to hospice. Although it's a hospice unit, life is celebrated in many ways. Social worker Jane C. Fisher, MSW, and chaplain Nathi Storey, who plays a spiritual part over with a patient.

and spiritual support, said Jane Fisher, social worker. Seasons offers a variety of services a patient would rarely see in an acute care setting. This includes a therapy dog who snuggles with and calms patients, board-certified music therapists who use instruments and song to provide comfort and relieve stress, a chaplain who visits daily to help with all things spiritual, and volunteers who sit with patients and listen to their stories.

This raises an interesting question. If hospitals have separate units for each niche — a unit for surgery (an OR), a unit for traumas and acute illness (an emergency department), and a unit for births (labor/delivery) — why doesn't every hospital have a unit that specializes in end of life, and managing the physical and emotional pain that comes with it?

Northwest Hospital can now say it does, and by having this hospice unit, has "added a needed dimension of care to our hospital that completes the life cycle in a compassionate, caring way," said Candace Hamner, vice president for care management at Northwest.

Support for Grieving Families

Seasons Hospice helps not only Northwest Hospital's patients, but their families, by providing them with the right support to make tough end-of-life decisions.

Imagine a young woman on a busy ICU whose mother just suffered a catastrophic stroke. Her mother is on a ventilator, brain dead. The daughter now has to make the very difficult decision about how and when to let her mother go. But as the noise and busyness of the ICU flows around her, her brain feels scattered; her emotions in chaos.

At Northwest Hospital, this woman can instead be moved — with her mother still on the ventilator — from the busy ICU to the calm, quiet environment of Seasons, where staff can provide as much time and support as the daughter needs.

"I've seen many families in the process of making a hospice decision. And when they step onto our unit, that's often when they make the decision, because the environment is so warm," Fisher said.

The capacity to be there for families at the "transition point" when they decide to move loved ones from hospital to hospice, is unique to being attached to a hospital.

"In outpatient hospice, the family has already made that decision [to accept hospice care] and have come to terms with the fact their loved one isn't going to recover," said Applebaum. "Our staff



helps family through very high-stress situations: maybe their loved one has gone into renal failure and decides he doesn't want dialysis. We have the resources to help them through this crisis."

Meeting Community Needs

Looking at Seasons and Northwest from an outsider's perspective, Diane Meier, MD, said the hospice's location alone within the hospital "legitimizes palliative care" and leads to an increased number of appropriate hospice referrals.

"Hospitals and hospices are used to working in very different cultural and professional silos; that's been one of the big problems," said Meier, director of the Center to Advance Palliative Care. "Physicians train in acute care settings, and only really know about acute care. Some have never even seen a hospice patient. They don't know what hospice is or how to refer people to it. Right now more than 30 percent of hospice referrals live less than a week, because they're referred so late.

"Having a unit like this in the midst of an acute care hospital changes the culture," she added. Physicians hear and learn more about hospice; it's in the front of their minds when faced with a patient who can benefit from it.

A hospital, whose physicians are making more appropriate hospice referrals, frees up acute care beds for patients who have a hope of recovery — a dual benefit to the hospital and community.

"If 10 of your 12 ICU beds are filled with people who are not going to leave the hospital alive, your hospital can't take new patients from the ED," Meier said. "That is why you see EDs stacked to the rafters and surgeries that don't take place because the ICU is full. Having a hospice unit on-site opens up acute care beds — and the hospital is now matching the needs of its patients and better serving the community." ■

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EXCELLENCE IN CARE: Staff at Seasons Hospice and Palliative Care of Maryland hospice unit at Northwest Hospital, Randallstown, MD, believe in all that hospice care has to offer, including pain management, dignity at the end of life, family support and music therapy. Above: Music therapist Terel Jackson, NMT, MF-BC (left), and Bode Alabi, RN (center), demonstrate how music therapy fits into hospice care. Center photo below: Ike Oriachuna, RN, checks a patient's vital signs. Bottom photo: Hospice staff include (seated from left), Jane C. Fisher, MSW, Antonio E. Gayle, chaplain, and Sherry Davis, CNA, (standing from left) Ajanna Arotin, MF-BC, LCAT, music therapist, Jackson, Alabi, Royce E. Jones, chaplain, and Oriachuna.

