THE CARPENTER HEALTH NETWORK

Pat Mitchell
Chief Executive Officer

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Honorable David Vitter

Dear Senator,

In the early 1980's Medicare approved a hospice benefit for terminally ill patients with an anticipated survival of 6 months or less. The original model contained 4 distinct levels of care:

1). Routine Home Care
2). Respite Care
3). Continuous Home Care
4). General Inpatient Care

At that time, the vast majority of patient days were logged as Routine Home Care. This was mostly due to the fact that many hospitals did not have pressure to discharge patients sooner, regardless of terminal diagnosis. Another factor driving the high Routine Home Care days was the fact that hospitals welcomed readmissions.

Fast forward to 2015. There is intense pressure in the Acute Care Hospitals to discharge patients quicker and sicker. Combine this with the pressure to prevent Readmissions for "penalizing diagnosis" and you effectively push the unstable, terminally ill patients home. Unfortunately, the original hospice care model adopted in the early 1980's has not adjusted to effectively meet the crisis needs of these terminally ill patients. Ultimately this results in the majority of hospices providing Routine Care only. The end result; hospice patients needing crisis management must revoke their hospice benefit and re admit to the ACH for acute symptom management. Once re admitted to the ACH, many patients die an expensive and undignified death (not of their choosing) in the ICU.

It is time for CMS to alter their expectations of hospice providers. Utilization patterns should reflect appropriate "crisis hospice care" services via:

1). General Inpatient
2). Continuous Care

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As long as this higher level of care is viewed as suspect, the average hospice will avoid provision of such. As long as this continues, terminally ill patients will continue to die in the ICU. This is an expensive failure to meet the needs of hospice patients. CMS loses and the medicare beneficiary loses.

I am requesting that you join our efforts to educate members of Congress to the value proposition that is Crisis Hospice Care. Until we adjust the antiquated hospice model to encourage appropriate Crisis Hospice Care outside of the ICU, we will continue to struggle to manage the cost and quality of care for the dying.

Thank you for your consideration. Please allow time to discuss briefly, in the future.

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