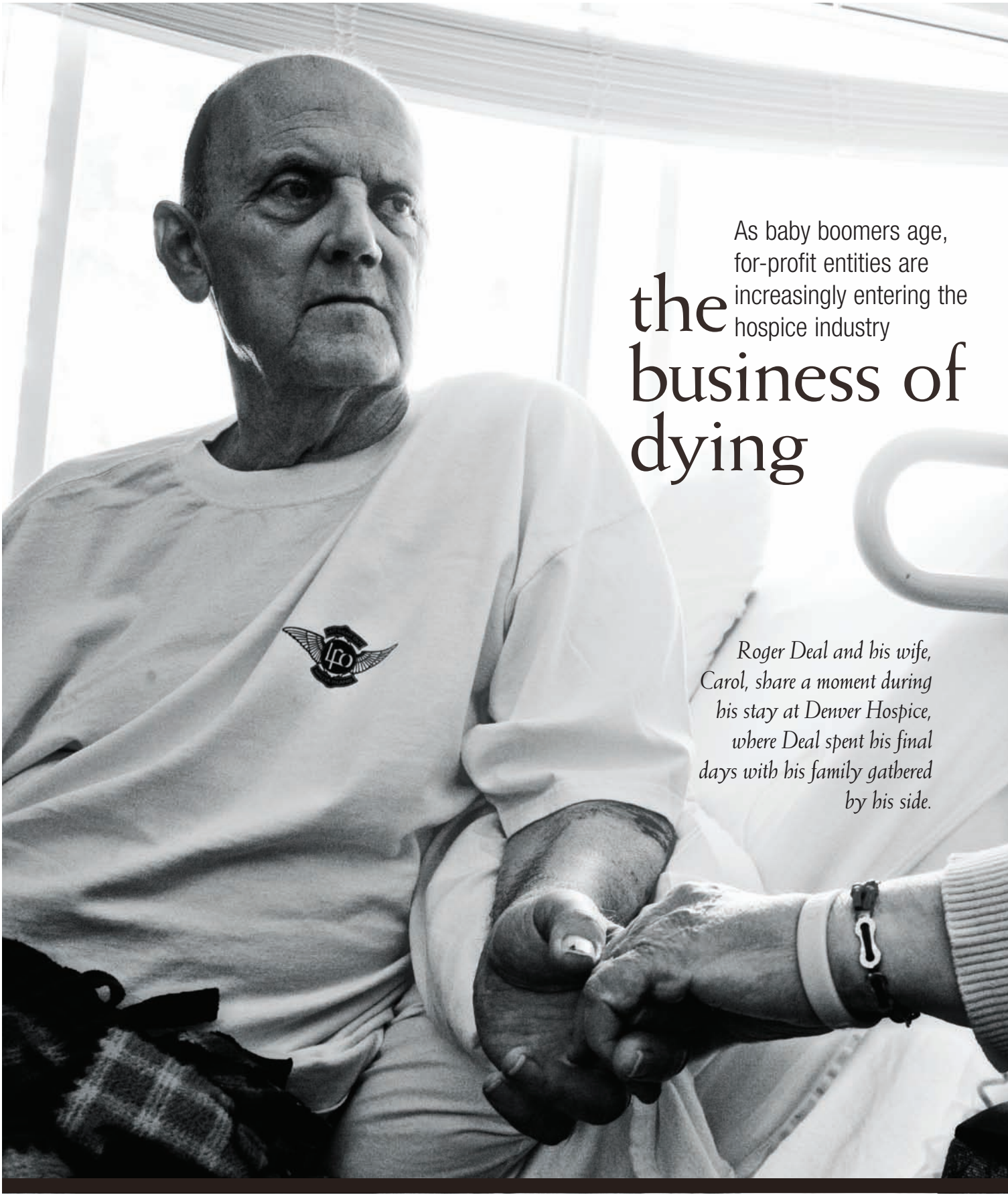

As baby boomers age, for-profit entities are increasingly entering the hospice industry

the business of dying

Roger Deal and his wife, Carol, share a moment during his stay at Denver Hospice, where Deal spent his final days with his family gathered by his side.

When death slowly made its entrance for 66-year-old Roger Deal, it looked nothing like his family had expected it would.

"I guess somehow we thought he would just fall asleep, and that would be it," said Carol Deal, Roger's wife of 47 years.

Instead, just days after doctors told the family there was "nothing left to be done" in Roger's 8-year battle with colon cancer, radical changes overcame the charismatic man who once vigorously tackled Colorado's toughest bike races and coached four sons through years of baseball.

First came the memory loss and delirium, as his liver and kidneys began to shut down and the oxygen levels to his brain began to diminish. Then came the incontinence and an inability to eat or sleep. Then came the pain and agitation that frightened his loved ones as they tried to help comfort him at home.

"We were lost," said Carol, 67. "We didn't know what to do."

Enter The Denver Hospice, which admitted Roger to a calming facility with specialized end-of-life care, and promptly encircled his family with counselors who prepared them for the physical and emotional realities to come.

"They explained it beautifully to us when we got here: the process of the soul leaving the body," said Carol, seated peacefully next to her husband as he described visions of John the Baptist coming to visit him that morning. "It has helped us so much as we have watched it happen." »

BY LISA MARSHALL
PHOTO BY TODD NAKASHIMA

Roger Deal is among the roughly 1.2 million terminally ill patients who turn to hospice each year in pursuit of the most dignified death possible. Born in the 1970s as a grassroots effort to improve the nation's somewhat abysmal end-of-life care, hospice now serves more than one-third of the nation's dying, primarily in their homes, but also in assisted living centers or inpatient care facilities like the one where Roger Deal spent his last days.

By all accounts, that number will continue to grow, as baby boomers age and demand what has come to be known as the "good death." But with its remarkable success has come a sea change for the hospice movement, as it has evolved from a volunteer, wholly philanthropic endeavor to a fiercely competitive $9 billion industry, complete with marketing consultants and quarterly shareholder reports.

In Colorado, there are now 47 hospices: 53 percent are nonprofit; 36 percent are for-profit; and the remainder are government run. On a national level, the number of for-profit hospices increased fourfold between 1994 and 2004, more than six times the rate of growth for nonprofits.

"When we look at new hospices that have opened in the last four years, 90 percent opened as for-profits," says Cordt Kassner, executive director of the Colorado Hospice Organization. "When we look at hospices that have closed over the last four years, they are 90 percent not-for-profits."

In essence, the good death has become big business. And as the trend continues, some question what that will mean for patient care.

"The biggest concern is: Will the for-profit world be providing the same high quality care that people have come to expect out of hospice?" says Dr. Jean Kutner, a palliative/hospice care expert with the University of Colorado Health Sciences Center.

The answer depends on whom you ask.

'WE DO NOT HAVE TO CURE TO HEAL'

The modern hospice movement was born in the 1960s, at a time when respirators and other life-prolonging technologies were first becoming common in hospitals, and death, like birth, was becoming increasingly sterile and medicalized.

"Back in the '50s and '60s, end-of-life care in hospitals was atrocious," Kassner says. "There was no particular focus around pain relief and suffering, and the family was treated as if they were in the way."

In 1967, a British physician named Dame Cicely Saunders opened St. Christopher's Hospice in London, giving birth to the notion that, as she put it, "We do not have to cure to heal." Hospice was, and remains, a radical departure from the medical model, in that it serves not to keep the dying patient alive, but rather to comfort them and their families through the process of death. But it was also different in another way: It served to treat what was referred to as "total pain," including physical, emotional, spiritual and social pain — and it served the whole family.

In 1974, the first hospice in the United States opened in Connecticut, and in 1976, the Hospice of Boulder County and the Hospice of St. John in Lakewood introduced the concept to Colorado. The Denver Hospice, formerly known as the Hospice of Metro Denver, opened in 1978, serving mostly terminally ill cancer patients in their homes.

"Throughout the '80s, you had this sort of missionary zeal," says Peter Benjamin, a hospice and palliative care consultant in Miami. "These folks that started programs in the 1980s were among the best salespeople I'd ever met. They'd be insulted if you told them that, but they really were selling."

The idea was somewhat slow to catch on at first, with both doctors and patients reticent to sign on to something that seemed akin to giving in to death. But then something remarkable happened.

Congress became convinced that hospice care not only improved quality of life in the final days but also saved on health-care dollars.

In late 1982, the Medicare hospice benefit was born, providing 100 percent coverage of hospice care.

"That dramatically changed the number of hospices in existence," Kassner says. "It was huge."

WHY HOSPICE MAKES SENSE

By 2005, according to the National Hospice and Palliative Care Organization, more than 4,100 programs were in operation nationwide, with roughly one-third run by for-profit companies, and financial analysts were touting hospice as one of the most promising growth areas in the health-care industry.

"It still makes sense," says Michael Wiederhorn, an equity analyst with New York-based CIBC World Markets. "It's cost effective, more and more people are becoming aware of hospice, and you have the rising tide of the aging baby boomer population playing out in the future."

Hospice spending has grown at a rate of 26 percent annually since 1989, compared with an increase of 7 percent in overall health expenditures over the same period, according to CIBC. Yet of the roughly 2 million anticipated deaths in 2003, a CIBC report states, just 710,000 were in hospice.

"As a result, we believe the hospice market is still untapped," the CIBC report predicted.

In 2005 in Colorado, 26,499 people died anticipated deaths (not the result of trauma or sudden illness), and 13,179 of them were served by hospice.

Thanks to new government regulations in the 1980s that allowed hospice providers to enter assisted-living centers and skilled nursing facilities — where they can treat more than one patient per visit, and the patients tend to have fewer needs — the market has become even more attractive from a business standpoint, Benjamin says.

For nearly a quarter-century, the Medicare benefit has remained the most sacred of cows, virtually immune to the annual budget ax, and now most private insurers and Medicaid also cover it.

Another economic plus: In 2001, Medicare spent just $125 per day on in-home hospice care — which makes up roughly 90 percent of it — versus $3,000 for a day as an inpatient in a hospital.

"The fact is, a health plan would rather you go into hospice as opposed to trying to keep you alive technologically," says Scott McLagan, director of executive and corporate programs (including health care) for the Daniels College of Business at the University of Denver. "It is much less expensive on the health-care system if you decide to die with dignity."

While it may and does seem crass to some longtime hospice advocates, the long laundry list of economic benefits has attracted numerous publicly traded companies into the hospice care field, including Chemed (which

owns both Vitas Innovative Hospice Care and Roto-Rooter Plumbing & Drain Service), and VistaCare, which runs 50 programs in 14 states, including Colorado.

While most experts agree the increased competition has driven innovation and vastly increased awareness of hospice, some can't help but wonder if the initial mission is changing as the balance begins to tip toward a for-profit model.

"At the heart of a for-profit is return to shareholders. At the heart of a nonprofit is return to the community," says Bev Sloan, executive director of the nonprofit Denver Hospice. "These are pretty fundamentally different motivations."

THE NUMBERS PROBLEM

Rosy analyst forecasts aside, running a hospice is financially challenging at best. Hospices operate on relatively thin margins — 8 percent to 12 percent on average — and are typically paid just $125 per day per patient for routine home care. That often has to cover a physician, a nurse, a chaplain, a social worker, alternative therapies such as music and pet therapy, and, at times, expensive medications. Fortunately, the industry has a longstanding backbone of thousands of volunteers who pitch in. But making a profit can be exceedingly difficult.

Typically, the longer a patient stays, the better the hospice fares financially, but thus far, hospice patients in general aren't taking advantage of it early enough. While Medicare regulations state that a patient can use hospice for up to six months, half of Colorado hospice patients die within 18 days of arrival, and one-third die within the first week.

"The most costly part of hospice care is admission and death," Kassner says. "When you put admission and death within two weeks for some people, that becomes very costly."

On the other hand, problems arise if a hospice patient stays too long.

In order to be recommended to hospice, a patient must have two physicians agree that they likely have six months or less to live, and the patient must agree to halt life-saving treatments and shift to "palliative" treatments aimed at making them comfortable.

If a patient lives beyond six months, Medicare payments dry up, and the hospice may ultimately have to reimburse some of the money.

Another emerging expense: Many costly new drugs sit on a fine line between life-saving and comfort giving, such as a chemotherapy that shrinks a tumor so that a patient can breathe and swallow, or radiation aimed at quelling pain.

"If you are a 50-census hospice, one or two patients can literally get you in financial trouble," Benjamin says.

Throw in a group of shareholders looking to see a return on their investment, and some industry observers fear staffing may be cut, and things like community grief centers (long the product of not-for-profits), extensive bereavement care, alternative therapies, and inpatient care centers (which families need, but which tend to be unprofitable) may go by the wayside.

> *"Competition is good, but if there is ever a time when patients should come before money it is at the end of life."*
>
> — Bev Sloan, executive director, Denver Hospice

One 2004 study by researchers at Yale School of Medicine examined services provided to 2,080 patients cared for at 422 hospices nationwide. It found that "patients of for-profit hospices received a significantly narrower range of services than patients of nonprofit hospices."

"As the number of for-profits has grown, we have already begun to see a blurring between mission and margin," Denver Hospice director Sloan says. "Competition is good, but if there is ever a time when patients should come before money it is at the end of life."

THE FOR-PROFIT ADVANTAGE

Cindi Borggreve, executive director of the for-profit EverCare Hospice and Palliative Care in Denver, bristles when she hears suggestions that for-profits aren't as serious about patient care:

"It is a myth, and I really wish it would go away. I find it insulting," says Borggreve, who has worked in hospice — in both the for-profit and not-for-profit arena — since the early '80s. "This is not easy work. The nurses and the social workers and the aides who take care of dying patients do it because they are passionate about it. Whether they are working for profit or not for profit doesn't matter to those people."

Patty Brooks agrees. When her elderly mother Anna Herrman began to succumb to cancer this spring, Brooks and her family put little thought into whether her hospice care came from a nonprofit or for-profit. They just followed their doctor's recommendation and hired EverCare, expecting them to care for their mother's physical needs and advise the family about how to get her affairs in order.

They got much more than that. The agency followed Herrman from assisted-living facility to home to skilled-nursing facility as her condition evolved, stepping in with palliative care expertise when those caring for her were ill-equipped to make her comfortable. When the agency learned she loved music and was Catholic, they arranged for a music minister to come to her room and play for the family. After her death, they attended the funeral and the rosary, and counseled Brooks by phone at her California home for months.

"They did everything in a spiritual and emotional way that I could hope for, and I never even expected it," Brooks says. "I wish everyone could have that kind of a positive experience in closing a chapter in someone's life."

When it comes to providing benefits, some experts say, larger, national for-profits may be better equipped to offer attractive benefits packages and, thus, retain employees longer. They may also be able to benefit from national training programs and implement national inspection programs that a smaller hospice couldn't afford.

"We have a system for managing compliance that I believe is unprecedented," says Linda Gaetani, executive director of VistaCare in Denver. Each year, the parent company requires each facility to undergo two internal clinical surveys to ensure the facility is being run according to state and federal regulations — a system Gaetani says is necessary in the absence of adequate government oversight.

"We used to be able to rely upon the state

and federal government in terms of policing us. It's not happening anymore," Gaetani says. "We believe if it's not happening externally, it should be happening internally."

For-profits versus not-for-profits aside, some local hospice experts say they are growing increasingly concerned that as the sheer number of hospices increases, consistency between them is decreasing, and the notion of just what hospice should be is becoming fuzzy. For instance, says Kassner, while one may offer in-person support groups for the family for 13 months after a death, another may follow up with a couple of letters in the mail.

"The number one concern I have about the growth in the industry is around quality and consistency of care," Kassner says. "We need it more than we have it."

Consultant Peter Benjamin sees it slightly differently: "One of the great moments in the evolution of the industry is occurring right now."

With the uphill battle won, and the population now well aware that a good death is indeed possible, the hospice pioneers who once fought to keep their doors open can now divert their funds and energy into trying to get patients in sooner, so they can benefit them even more, he says.

And the increased competition is motivating everyone to provide better service:

"In the early 1990s, if you called a hospice anywhere around America at 5 o'clock on a Friday and said, 'I have a patient for you,' they would say, 'OK. We'll be out on Monday.' Today, they say 'Can we come over right now?' Which situation is better for the family?" he says. "If you get hospice care circa 2007, I promise you are getting better care than you were in circa 2002."

A REMARKABLE GOODBYE

For Roger Deal and his family, the care couldn't have been better.

Rather than fight to the last breath surrounded by machines in a sterile hospital room, or struggle at home with a family that felt overwhelmed, Deal spent his final days in a brightly lit room, surrounded by his four sons, their wives, and his grandchildren, at the 18-bed Denver Hospice inpatient care center.

Nurses popped in, unobtrusively, to ensure his pain medication was adequate, and a harpist played softly in the background as Roger and his wife sat side-by-side.

"I feel like if I stop, all this is going to stop," said Roger, explaining to a visitor why he hadn't slept in almost 48 hours.

After a day of cracking jokes and sharing memories with his family, Roger Deal died at 12:05 a.m. on June 18 — five minutes after Father's Day drew to a close.

"We had the opportunity to truly say the long goodbye — to see the different sides of each other that you don't get to see every day," says Roger's son Ken. "It was truly a remarkable experience."