



Presentation Notes to the Regulatory Modernization Initiative Task Force
Albany, New York
Tuesday, December 12, 2017

Good Morning, my name is Michael Kaminski and for the past two years I have been the President and Chief Executive Officer of the Hudson Valley Hospice which serves the counties of Dutchess and Ulster. Prior to Hudson Valley Hospice, I was a Chief Executive Officer for over 25 years, in three hospitals, two in New York City and one in Kingston, New York.

Thank you for the opportunity to offer my thoughts relative to whether or not additional hospices should be permitted to apply for operating certificates through the certificate of need process.

New York State's Department of Health's basis for the possible lifting of the moratorium of the Certificate of Need legislation applying to hospices relies on the false assumption that hospices can control the stream of patient referrals to them, unfortunately;

1. Hospices have no control over the reluctance of society to accept the inevitability of our mortality. Patients and their loved ones will try every last medicine, therapy, or procedure hoping for a miracle to keep them alive rather than pick up the phone and call their local hospice.
2. The myth that hospices hasten death remains prevalent in society. Some falsely believe that hospices force some new spiritual philosophy on patients or strong arm patients and families into doing something that they don't want to do, and most everyone believes that hospices can't extend a patient's final days, which in some cases actually can occur.
3. Many Medicare recipients still have no idea that they are entitled to free hospice care, which includes medications, supplies, equipment, etc., and a constellation of clinical and non-clinical professionals under their Medicare benefit.
4. Hospices can't control the ability or lack thereof, of MD's to effectively communicate an honest prognosis and in turn a reasonable treatment plan for those patients who's ongoing aggressive care would be both futile and in some cases physically and emotionally cruel.
5. Hospices cannot control the hospital's medical staff need to keep beds filled by documenting the acute nature of the patient in the throes of an end stage disease, to ensure acute care reimbursement for the hospital rather than a piece of hospices nominal reimbursement.
6. Hospices don't control the large numbers of patients in hospitals who are referred to hospice and die before the hospice staff gets to the patient, or dies within days of being admitted to hospice.



7. Hospices don't control the nursing home staffs who stretch the circumstances every way possible to keep a patient on rehabilitative care at a higher reimbursement rate, or the nursing home's staff who convince patients that the nursing home's so called "palliative care" is just as good, if not better than hospice, or the nursing home owner who refuses to contract with the hospice, because its not required, and convinces the patient who wants hospice that they don't really need hospice care.
8. Hospices don't control the family members who, even when the patient is ready and willing to be admitted to hospice, can't accept that their loved one is dying, so they pressure the patient to stay off of hospice and refuse to even talk to hospice staff.
9. Hospices don't control physicians who are financially motivated to continue to "cure" the incurable, often resulting in "deathbed" referrals to hospice, or in some cases, no referral at all.
10. And finally, hospices don't control the lack of understanding most in our society of the importance of ensuring that their family understands their wishes for their care at the end of life by creating an advance directive and naming a health care proxy.

Competition will do absolutely nothing to reverse any of these referral deficits, issues, challenges, and obstacles to reaching greater numbers in need of true hospice care. Rather than creating a competitive environment, removing the existing barriers to hospice referrals would be the best course of action to both improving the quality of hospice care and increasing the number of Medicare deaths on hospice in New York State.

The Department of Health should be enacting regulations requiring nursing homes, assisted living facilities and hospitals to contract with hospices, and insurance companies should be required to change their policies to encourage the use of hospices, as well as improving procedures to make payment to hospices more efficient.

Rather than creating negatively charged environments through competition, funding should be provided to reward exceptional efforts by existing hospices which have developed creative ways to overcome the objections of physicians, families, nursing home owners, etc. It is all but impossible for individual hospices to change the attitudes of the referral sources. State funded programs to educate the general public, physicians, hospital executives, for-profit nursing home owners, the clergy and elected officials on the importance and value of hospice care and on having an advance directive and health care proxy would help mitigate the reluctance to refer to and embrace the benefits hospice care.

I considered asking for a show of hands how many people here today have an advance directive and a health care proxy but to avoid embarrassment, I will not. But if I did ask, I'll bet that not more than 30% of you would have raised your hands. You all know that the presence of an advance directive that has been developed with the knowledge of family members makes end of life decision easier for everyone involved, removes the burden of guilt and generally makes for earlier referral to hospice.



Further, the state's current algorithm for determining whether or not need exists in a county for more hospice agencies looks back too far and doesn't take into account significant growth of patients in 2016 and 2017. The data from the required state reporting forms for hospices is not available to the hospice programs for review and has not been published since 2007. Allowing more hospices to compete with the 45 or so hospices across the state will only divide the current patients among more hospices, thus creating weaker and weaker bottom lines, resulting in greater turnover of staff, and ultimately a reduction in quality of care.

The highly specialized practice of care for patients at the end of life requires a unique engagement of patient and families which speaks to the cultural paradigm required for the health care industry to recognize. Hospices in New York State employ generally lower paid, but highly skilled, dedicated, compassionate, mission driven professionals who daily wrestle with the need to ease the pain and discomfort of patients on their final journey.

One last point, or question to consider during your debate, every hospice in New York has incorporated in its mission, visions and values some reference to the fact that they exist to improve the quality of life for those at the end of life, or that no one should die alone or in pain, so do you honestly think that hospices in New York don't want to admit every patient who qualifies for hospice.

I hope you will consider these elements, all of which mitigate against the Department of Health's idea that increasing the number of hospices in New York will effortlessly increase the number of patients who die on hospice. I sincerely and respectfully request that the Regulatory Modernization Initiative Task Force recommend to the New York State Department of Health that the current moratorium on new hospices in New York State be maintained and preserved and other avenues and devices be considered to improve society's attitude, understanding and acceptance of the benefits of end of life hospice care.

Thank you.