
NEW JERSEY

HEALTHCARE EXECUTIVE LEADERSHIP ACADEMY

Proceedings from 2018 (Class II)

Improving Care at the End of Life
Action Plan for New Jersey

Volume II | September 2018

EST. 2016

NJHELA

New Jersey Healthcare
Executive Leadership
Academy

Prepared by:
Seton Center for Community
and Population Health
(SCCPH)
September 2018

ACKNOWLEDGEMENT

GRANT FUNDING FROM



Medical Society of New Jersey
2 Princess Road
Second Floor
Lawrenceville, NJ 08648

Published in the United States of America in 2018 by The Institute of Medicine & Public Health of New Jersey.

Copyright © 2018 by the New Jersey Healthcare Executive Leadership Academy. All rights reserved. This document or any portion thereof may not be reproduced or used in any manner whatsoever without the express written permission of the publisher.



NEW JERSEY HEALTHCARE EXECUTIVE LEADERSHIP ACADEMY

Proceedings from 2018 (Class II)

Improving Care at the End of Life
Action Plan for New Jersey

DEVELOPED & SPONSORED BY



IN PARTNERSHIP WITH



TABLE OF

CONTENTS

7	CLASS OF 2018 - FELLOWS
10	PROLOGUE
11	PROGRAM EXECUTIVE SUMMARY
16	PROJECT ASSIGNMENTS & GOALS
18	EOL ACTION STEPS, OUTCOMES & RECOMMENDATIONS
27	NJHELA FACULTY
32	REFERENCE & RESOURCES



NEW JERSEY
HEALTHCARE EXECUTIVE
LEADERSHIP ACADEMY

EST. 2016

2018 Fellows

Cohort 2 | Roster



Robyn Agri
MD

Physician

St. Lawrence
Rehabilitation Center



Amina A. Ahmed,
MD,

*Chief of Hospital Medicine
and Post-Acute Care*

Summit Medical Group



Reginald Blaber,
MD, MBA, FACC

Physician

Lourdes Health System



Victoria Brogan

*Senior Vice President of
Strategic Initiatives*

New Jersey
Hospital Association



Dominick DiRocco,
JD

*Director,
Government Affairs*

Horizon Blue Cross Blue
Shield of New Jersey



Marjorie Forgang,
MSN, BSN

*Senior Director, Clinical
Operations*

WellCare Health Plans,
Inc.



Amy Frieman,
MD, MBA, FAAHPM

*Corporate Medical Director,
Palliative Care Services*

Hackensack-Meridian
Health



Marilyn Gordon,
MD, FACP, CPE

*Chief Medical Officer –
New Jersey
Commercial and Medicare*

UnitedHealthcare



Florence Kariuki,
RN, MHA, BSN

Clinical Design Lead

Horizon Blue Cross Blue
Shield of New Jersey



Debra E. Koss,
MD, FAACAP

Board of Trustees

New Jersey
Psychiatric Association



Danielle Leone,
LCSW

Social Work Supervisor

**Community
Medical Center,
RWJBH**



Lori Leotta,
LCSW

*Vice President,
National Client
Partnerships*

Beacon Health Options



Charles Markowitz,
MD, JD

*Vice President;
Sr. Medical Director of
Quality and Utilization
Management*

**Monmouth
Medical Center
RWJBH**



**Michael Ruiz de
Somocurcio**
MBA

*Vice President,
Payer and Provider
Collaboration*

**Regional Cancer Care
Associates**



Lisa Rush,
RN, BSN

*Director,
Clinical Operations*

**Horizon Blue Cross Blue
Shield of New Jersey**



Linda Savino,
MS, OTR/L

Executive Consultant

VNA Health Group



Puneeta Sharma,
MD

*Medical Director,
Palliative Care*

Valley Medical Group



P R O L O G U E

On behalf of the three co-sponsoring organizations, the Medical Society of New Jersey, the New Jersey Hospital Association and the New Jersey Association of Health Plans, it is our great pleasure to introduce the proceedings from the 2018 Class of the New Jersey Healthcare Leadership Academy (NJHELA). We want to congratulate the 2018 NJHELA Fellows and applaud the work they did to develop seven proposals to advance improvement in the delivery of care at the end-of-life.

Given the enormous changes now taking place in health and healthcare across the nation, there has never been a greater need for physician and executive leadership. The staff & faculty have invested many hours of work and planning to build a leadership development opportunity that will build skills through multiple perspectives on solving healthcare problems statewide.

We were delighted to work with our academic partner, Seton Hall University, who developed our curriculum to help build collaborative leadership and management skills among the three pillars of healthcare. The 2018 Class consisted of 17 nominated professionals who are practicing physicians and executives from hospitals, post-acute providers and health insurers.

By 2020, NJHELA expects to provide executive leadership training to over 100 executives across the healthcare industry within the state of New Jersey. NJHELA's overall goal is to prepare a large number of physicians and executives to play a greater role in transforming New Jersey's healthcare delivery system at both the local and state levels.

Best,

Lawrence Downs, Esq.
CEO

Cathleen Bennett, Esq.
President & CEO

Wardell Sanders, Esq.
President





PROGRAM EXECUTIVE SUMMARY

The Medical Society of New Jersey, the New Jersey Hospital Association and the New Jersey Association of Health Plans collaborated to develop a first-of-its kind initiative, the NJ Healthcare Executive Leadership Academy (NJHELA) in 2017. As reported, in the Proceedings Vol.1, Cohort 1 included 26 important healthcare executives and physicians representing all three professional organization. These selected participants attended multiple learning sessions coordinated by Faculty from Seton Hall University (SHU) who also served as team mentors. The initial NJHELA cohort addressed the pressing End-of-Life (EOL) issues as New Jersey ranks among the top states in the nation for high-intensity, high-cost care, without a correlation in higher quality. The seven executive teams produced action plans and recommendations to improve EOL issues within the state.

Building on Cohort 1 achievements, NJHELA enrolled Cohort 2 in 2018 to expand and enhance the previous successes and to focus on implementing key EOL recommendations and suggestions. NJHELA convened a collaborative learning community that included 17 managers and executives representing diverse perspectives of the healthcare environment.

The 2018 NJHELA goals included:

- To facilitate the development of personal collaborative leadership competencies for each participant
- To develop a cohort of diverse New Jersey executives who will become champion leaders in solving NJ Healthcare challenges and
- To produce viable solutions for solving the New Jersey pressing healthcare challenges and transform the current programs/services in New Jersey.

Academy participants attained the following learning competencies:

- Developed and applied executive level leadership skills in planning, decision-making, conflict resolution, and collaboration
- Exhibited and refined a communication style appropriate to executive leadership
- Functioned as an expert interdisciplinary team member by advocating and modeling inter-professional/inter-organizational best-practices for process, decision making, and collaboration and
- Demonstrated problem solving, entrepreneurial and shared leadership skills in developing project solutions to healthcare challenges in New Jersey.

To meet these goals and develop collaborative leadership competencies, the executive participants discussed EOL priorities and established workgroups (teams) in the project assignment areas: Education, Advocacy and Care Practices. Each team included a member from one of the three sponsoring organizations to represent diverse viewpoints and encourage consensus building as well as an SHU Faculty facilitator. Cohort 2 team project assignments extended original concepts and projects from Cohort 1 as illustrated in Table 1.



NEW JERSEY
HEALTHCARE EXECUTIVE
LEADERSHIP ACADEMY
EST. 2016

Cohort 1: Project Assignments 2017	Cohort 2: Project Assignments 2018
<p>Team 1: Describe evidence based/best practice informed strategies to enhance the capacity of primary care providers to integrate palliative care into their practices.</p>	<p>Team 1: Education Expand end-of life planning in Communities and organizations</p>
<p>Team 2: Design a plan to enhance the effective implementation and sustainability of a telehealth program for palliative care.</p>	
<p>Team 3: Develop novel policies and incentives for early conversations about (and referrals to) palliative care by physicians.</p>	<p>Team 4: Care Practices Palliative Care Reimbursement</p>
<p>Team 4: Design a system of best practices by routinely assessing admitted patients for end of life care planning.</p>	<p>Team 2: Advocacy/Policy Expand end-of life planning use in palliative and Hospice Care</p>
<p>Team 5: Identify opportunities to develop Palliative Care fellowships in New Jersey teaching hospitals.</p>	
<p>Team 6: Design a plan to integrate the best practices of palliative care in the ER.</p>	<p>Team 3: Care Practices/Advocacy Implement routine ER screening for EOL/Palliative care issues: Draft screening tool from Cohort 1</p>
<p>Team 7: Improving access to homecare.</p>	



The 2018 NJHELA program began with a two-day, intensive retreat introducing the End-of-Life issue and sharing Cohort 1 initiative results. Cohort 2 NJHELA fellows then attended five monthly face-to-face sessions, and concluded with a second two-day retreat featuring a public presentation highlighting team presentations and recommendations for improving EOL care for all New Jersey residents. The six-month program featured expert speakers on not only EOL care, but also engaged current healthcare executives to reflect and examine their own leadership skills to work across current healthcare silos. A brief synopsis of speakers and topics (described below) outlines each session's topic and focus.

Commencing Retreat:

Session 1:

Day 1

- Welcome & Introductions (NJHELA Co-Sponsors & SHU Faculty)
- Exercise: What do I hope to learn?
- Plenary Session: End of Life Issues
*Stephen Goldfine, MD DABFP, CAQGM, DABHPM
Chief Medical Officer, Samaritan Healthcare & Hospice*
- Film Presentation: Being Mortal by Dr. Atul Gawande
Moments of Life, National Hospice & Palliative Care Organization
- Panel Discussion: Voice of Patients & Family Members
Families of Deadra Gladden & Ravi Mahadevan
- Leadership Learning: "This I Believe...." Statements (SHU Faculty)
- Closing Remarks
- Network and Social Opportunity

Day 2

- Sponsor's Vision for NJ HELA
*Cathy Bennett, Esq., President & CEO, NJHA
Larry Downs, Esq., CEO, MSNJ
Ward Sanders, Esq., President, NJAHP*
- NJHELA Collaborative Leadership Development: Guest Faculty NJHELA 2017 Fellows
- NJHELA 2018 Expectations and Action learning Projects (*SHU Faculty*)

Session 2:

- Hogan Inventory: *Dr. Terrence Cahill, SHU*
- Teamwork Building: Recipe for Success—*Richard Cooper*
- Working Dinner: Action Learning Project Assignments
- Tools for Innovation: *Dr. Elizabeth McCrae, Stillman School of Business, SHU*

Session 3

- Population Health & Data Analytics: *Dr. Anne Hewitt, School of Health & Medical Sciences, SHU*
- Action Learning Teams - Group work



Session 4:

- MLQ Results Discussion *Dr. Terry Cahill, SHU*
- Social Policy Regarding EOL: *Dr. Nalin Johri, SHU*
- Working Dinner
- Action Learning Teams - Group Work

Session 5:

- Kilmann Instrument Results Discussion : *Dr. Stephen Wagner, SHU Faculty*
- Communication with Impact & Influence
Guest Faculty: *Neen James, Neen James Communication, Inc.*
- Working Dinner
- Action Learning Teams; Prepare Group Results Presentation

Closing Retreat

Session 6:

Day 1

- NJ Blueprint for Action Concerning EOL- Cohort 2 Fellows Presentation
Guest Faculty: *David Barile, MD, Executive Director and Founder of NJ Goals of Care*
- Driver Exercise Leadership Learning - Planning for the Future: *SHU Faculty*

Day 2

- Sponsor's Welcome
- National Overview & Remarks on Improving End-of-Life Care
*Lance Robertson Assistant Secretary for Aging,
Administration for Community Living, US. Dept. of Health*
- Cohort 2 Fellow Poster Presentation to the Media and the Public
- Celebration & Awarding of Certificates in Advanced Healthcare Leadership from SHU
- Closing Remarks: *Lawrence Down, Esq., CEO, MSNJ*

In addition to the face-to-face learning opportunities, team members completed five virtual meetings with their SHU faculty mentors who helped facilitate the learning processes and development of viable strategies, including action steps that required collaboration between healthcare providers, insurers, and hospital members. Cohort 2 participants also had the opportunity to utilize various leadership-development assessment instruments, the Hogan Insight Series (HPI, MVPI, and HDS), the Multifactor Leadership Questionnaire (MLQ), and the Thomas-Kilmann Conflict Mode Instrument (TKI) and to receive personalized coaching feedback.

In summary, Cohort 2 NJHELA Fellows, focusing on EOL solutions for New Jersey, successfully completed their four projects and developed 13 strategic action steps. ALL teams' implementation strategies represented viable solutions acceptable to each of the professionals composed of practicing physicians and executives from hospitals and health plans. Each group's project presentation/ outcomes, and executive summaries are included in the proceedings document as well as additional resources and references.

The New Jersey Healthcare Leadership Academy graduated its second class of Fellows in June 2018. All parties hope the opportunity to work across the different stakeholder groups will help transform collaboration for other immediate healthcare challenges in New Jersey.



NEW JERSEY
HEALTHCARE EXECUTIVE
LEADERSHIP ACADEMY
EST. 2016

CONGRATULATIONS TO THE
CLASS OF 2018 FELLOWS





PROJECT ASSIGNMENTS & GOALS

Team 1: Education

Goal: To facilitate the dissemination of education and educational materials to consumers of healthcare regarding advance care planning for the purpose of enhancing end-of-life care.

Dominick DiRocco, Esq.

* SHU Faculty: Anne M. Hewitt, PhD

Aline Holmes, DNP, MSN, RN

Debra E. Koss, MD, FAACAP

Lori Leotta, LCSW

Team 2: Advocacy/Policy

Goal 1: To help providers and health plans understand how integrating palliative care and hospice care into delivery routines can maximize value-based reimbursement in several alternative payment models.

Goal 2: Describe how data can be leveraged to expand use of palliative care and hospice care and demonstrate how patient quality of life improves while ultimate cost of care is reduced.

Goal 3: Negotiate financial models for payers to support early models of care.

Victoria Brogan, BA

* SHU Faculty: Nalin Johri, PhD, MPH

Amy Frieman, MD, MBA, FAAHPM

Michael Ruiz de Somocurcio, MBA

Lisa Rush RN, BSN

Puneeta Sharma, MD, CPE, HMDCB



PROJECT ASSIGNMENTS & GOALS

Team 3: Advocacy/Care Practices

Goal: To research and develop an evaluation tool that will evaluate the effectiveness of using a palliative care screening appropriate for Emergency Rooms

Marilyn Gordon MD, FACP, CPE

Florence Kariuki RN MHA

Danielle Leone LCSW

* SHU Faculty: Stephen L. Wagner, *PhD*,

FACHE, FACMPE, FACHT, FAcEM

Team 4: Care Practices

Goal: Improving information exchange at the point of transitions between hospitals, assisted living and LTC by increasing the completion rate of advance directives and POLST forms, and gathering information for future planning and education.

Robyn Agri, MD

Charles Markowitz, MD

Linda Savino, MS, OTR/L

Marjorie Forgang, MSN, BSN

Amina Ahmed, MD

* SHU Faculty: Terrence Cahill, EdD, FACHE



EOL ACTION STEPS, OUTCOMES, AND RECOMMENDATIONS

Team 1: Community Based Education for Advance Care Planning

Action Steps:

To develop appropriate educational materials for use by New Jersey's healthcare consumers in their end-of-life care planning, the team engaged in several strategic actions. These included:

- Review of NJHELA Cohort 1 initiatives,
- Review and analysis of the inventory of current resources and statewide initiatives addressing advance care planning education
- Analysis of available documentation, recommendations and resources (websites, educational templates, promotional videos, program offerings)
- Development of a power point presentation encapsulating all of the discrete elements available.
- Outreach activities with major statewide partners, NJHA, NJ Healthcare Quality Institute, and the Goals of Care Coalition of New Jersey

Outcomes:

All team members successfully completed an Advanced Care training seminar with an NJHA Clinical Quality Improvement Expert. The team next developed an Advanced Care Planning Toolkit, designed a presentation tailored for NJ residents, and completed a pilot presentation via a *Lunch and Learn* experience employees of Horizon Blue Cross Blue Shield. The final step included synthesizing the pilot assessment data and developing recommendations for the implementation and sustainability of the toolkit.

Recommendations:

To increase dissemination and adoption of the Advance Care Planning Toolkit we recommend:

1. Sustainability with community organizations.
2. Expand current partnerships and stakeholders.
3. Identification of champions to help spread advance care planning education (faith-based leaders).
4. Increase access to Advanced Care Planning Toolkit available to all populations via diverse language materials, and tailor to focus on disparities between populations.

Community Based Education for Advance Care Planning



Dominick DiRocco, Esq. - Horizon BCBSNJ, Aline M. Holmes, DNP, MSN, RN - NJHA, Debra E Koss, MD, FAACAP, Lori Leotta, LCSW – Beacon Health Options

Introduction

NJHELA Team 1 recognized the need for improved communication and education around Advance Care Planning (ACP). Substantial evidence suggests that adoption of ACP lags among NJ Residents for the past 10 years. Individual healthcare consumers remain unsure how to begin end-of-life care discussions with the family and healthcare providers. Major NJ healthcare stakeholders addressed the issue with the formation of NJ Health Executive Leadership Academy (2).

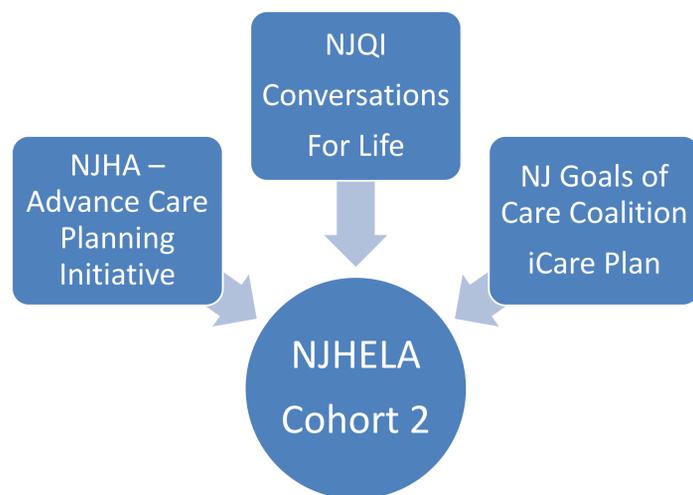
Project Goal

To disseminate Advance Care Planning materials to NJ residents and organizations via a Train-the-Trainer Toolkit

Action Steps

- Review NJHELA Cohort 1 initiatives
- Complete a Gap Analysis of current resources
- Inventory statewide ACP initiatives and opportunities

ACP Partners and Projects



What is Advance Care Planning?

Advance care planning is making decisions about the care you want to receive if you become ill and are unable to speak for yourself

Why is Advance Care Planning so Important?

- Making your choices known** early supports understanding of family and healthcare providers
- Lessens the anxiety** for the patient
- Assists the patient in **remaining in control of their own life**
- Protects the family making those difficult decisions
- Ultimately...it **empowers the patient.**

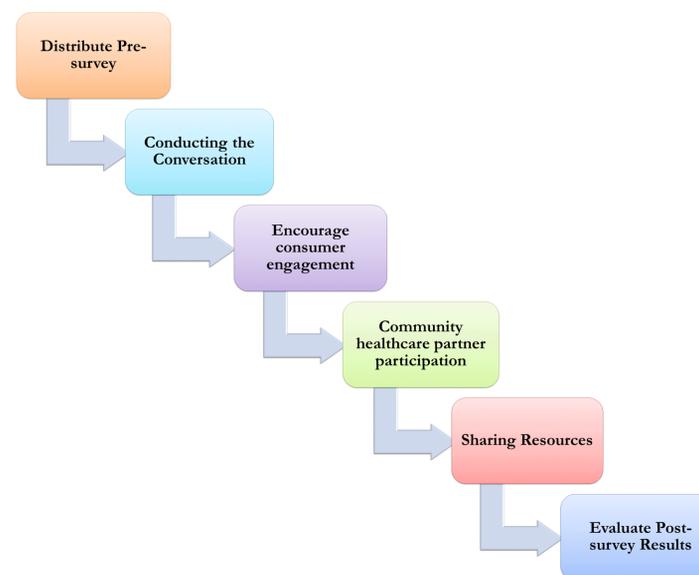
Advance Care Planning Steps



Toolkit Content

Conversation starters - videos, stories, conversation guides
 Sample letters explaining end-of-life care wishes for family and physicians
 Sample documents - advance directive, proxy form, living will, etc.
 Practitioner Orders for Life Sustaining Treatment (POLST) form

Training Presentation Process



ACP Pilot Test Assessment

10 Healthcare outreach managers/patient care coordinators (HBCBS) participated in Pilot Test of ACP toolkit. The majority of participants were female with an avg. age of 40. The population was predominantly Caucasian with diverse marital status noted. Pre/post survey results:

Pre-survey group score: 30.7

Post-Survey group score: 37.6

Paired samples t-test p-value: 0.16

Conclusion: there was a statistically significant difference between the pre and post survey. Attendees felt significantly more ready and confident to discuss Advance Care Planning after attending the Lunch & Learn.

Objectives for the Healthcare Consumer



Recommendations

- Sustainability** with community organizations
- Expand current partnerships** & stakeholders
- Identification of champions** to help spread the ACP education (faith based leaders)
- Available to all populations** in appropriate languages and examine disparity between populations

Summary

- ✓ Team members participated in an ACP training session
- ✓ Designed a Train-the-Trainer ACP Toolkit
- ✓ Completed a pilot presentation with HBCBS employees at a Lunch and Learn
- ✓ Synthesized assessment data to refine toolkit
- ✓ Developed recommendations for dissemination, sustainability & next steps!



Team 2: Palliative Care Reimbursement

Action Steps for Expanded Use of Palliative and Hospice Care in NJ

- Evaluate different funding approaches such as enhanced fee-for-service, per member/per month and shared savings/shared risk models that could promote palliative consultations.
- Launch an education campaign to commercial, state, federal and value-based payers regarding the cost savings benefit of palliative care and hospice care
- Advocate for Medicaid reimbursement for advance care planning codes.
- Implement \$0 copay for universal palliative care and advance care planning benefit.
- Develop standardized quality metrics for palliative care and hospice care applicable to value-based agreements (e.g. PCMH, ACO, bundles and episodes of care).
- Embed data points for identification of potential high-risk vulnerable patients eligible for palliative care or hospice care.
- Work with professional associations to advocate at the state and federal level for regulatory changes that promote and heighten the importance of early advance care planning.

Outcomes:

The team conducted an analysis of recent studies that revealed a positive impact of palliative care on patient quality, patient/family satisfaction, and costs. The team also assessed examples from two New Jersey models. A CMS demonstration Oncology Care Model, implemented by Regional Cancer Care, showed an increased cost (\$10,000 more) for patients not using hospice care. The second model, a Hackensack Meridian Health and Horizon BCBS pilot program focused on home-based palliative care reimbursement. This palliative care program covers reimbursement for the entire interdisciplinary team. Both models relied on metrics such as ICU stays, ER visits and advanced care planning use.

Recommendations:

To increase the use of these valuable and underutilized services, it is critical that providers, health plans and government work collaboratively to develop programs that provide broader use of these services by:

1. Standardizing quality and cost metrics that would help identify patients to enroll in these services
2. Increasing interoperability around POLST documentation
3. Educating providers via health plans and government to demonstrate how these services can benefit those ACO's and value based groups who are accountable for quality and cost effective care.
4. Supporting reimbursement for Medicaid patients while creating a mechanism to pay for currently non-reimbursable support services.

Palliative Care Reimbursement

Problem

Lack of reimbursement inhibits provision of high quality interdisciplinary Palliative Care.

Introduction

According to the NJ Department of Health, "Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." (73 FR 32204, June 5, 2008). As such, high quality palliative care requires a full interdisciplinary team. However, palliative care services are not fully reimbursed through the current payment structures. Services such as social work and chaplaincy that are integral to palliative care are not reimbursable. This makes it very difficult for palliative care programs to obtain adequate funding and resources, and very few programs are self-sustaining. Numerous studies have shown that high quality, interdisciplinary palliative care services improve outcomes for the sickest and most vulnerable patients. Palliative care is well-positioned with the shift from volume based to value-based care. Despite all of this information and the 2014 Dartmouth Atlas report, the national announcement of use of comfort care by former-First Lady Barbara Bush, and many other medical journal articles and Ted Talks, barriers to palliative care continue to exist. Barriers identified are: provider confusion between palliative care and hospice; lack of clinician training and comfort of topic; and limited understanding of how palliative care adds value.

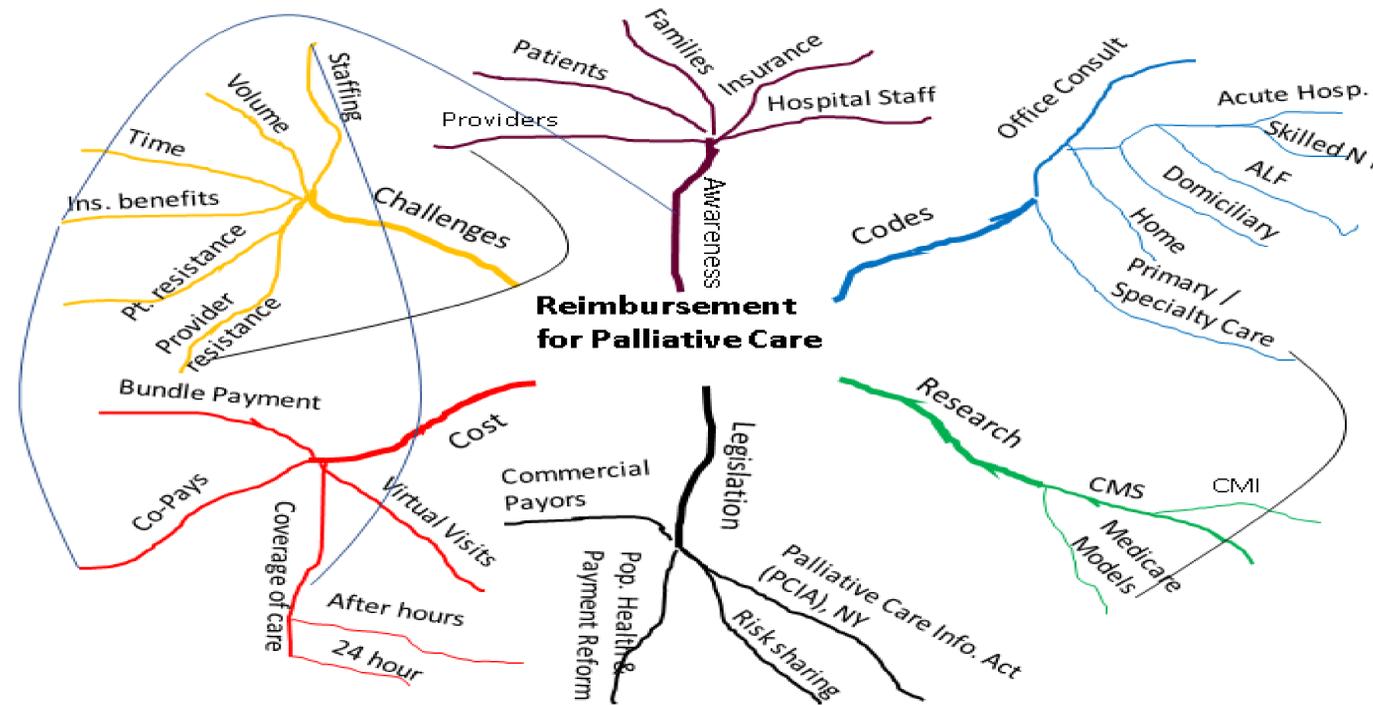
Project Goals

- To help providers and health plans understand how integrating palliative and hospice care into delivery routines can maximize value-based reimbursement in several alternative payment models.
- Describe how data can be leveraged to expand use of palliative and hospice care and demonstrate how patient quality of life improves while ultimate cost of care is reduced.
- Negotiate financial models for payers to support early models of care.

GLOSSARY

PPS-Palliative Performance Scale
ECOG-Eastern Co-operative Oncology Group
DME-Durable Medical Equipment
HCC-Hierarchical Condition Categories
ADL- Activities of Daily Living
RCCA: Regional Cancer Care Associates

Victoria Brogan; Amy Frieman, MD, MBA, FAAHPM; Michael Ruiz de Somocurcio; Lisa Rush RN, BSN; Puneeta Sharma, MD, CPE, HMDCB



Mind Map of Project

Standard Metrics to Identify Patients for Palliative Care Referrals

Claims Based	EMR Based
2 ED/Observation Visits in 6 months	Non Cancer: PPS of <60% or 1 or more ADLs
2 Hospitalizations in 6 months	Cancer: PPS of <70% or ECOG >2
DME Utilization • Oxygen • Wheelchair • Hospital Bed	Disease specific triggers (with impaired ADL) e.g. COPD oxygen dependent CHF Stage 3 & 4
3 or more documented Chronic Conditions or HCC Risk Score profile of patient	Dementia Fast Stage 5 & > Cancer stage 3 & 4 Cirrhosis encephalopathy, coagulopathy

Examples of Value Based Metrics

Item	Source of Metric
Hospice Use – at least 7 days prior to death	Claims
ICU Days – last 6 months of life	Claims
Inpatient Visits – last 6 months of life	Claims
ED Visits – last 6 months of life	Claims
For Cancer: Chemo use last 14 days of life	Claims
Advance Care Planning	EHR
Pain Intensity – if Yes, Plan of Action	EHR
Patient and family satisfaction	Survey

Impact

Numerous studies demonstrate the positive impact of palliative care on patient quality, patient/family satisfaction and costs. Recent studies showed home-based palliative care programs lower costs by 36 percent or \$12,000 per patient (Lustbader 2016), and decrease hospital admissions by 48-56 percent (Cassel, 2016). Inpatient palliative care programs result in a 48 percent reduction in readmission (Adelson, 2017), 43 percent decrease in ICU admissions (Gade, 2008), cost savings ranging between \$1,696 /admission for live discharges, \$4,908/death, and reduction in LOS averaging 1.1 day. Outpatient Palliative Care programs showed 20-50 percent fewer hospital admissions (RTI international 2006, Scibetta, 2015), and a 35 percent reduction in ED visits (Scibetta, 2015). SNF Palliative Care showed a 43 percent reduction in care transitions to ED or hospital (Miller, 2016).

Action Steps

- Evaluate different funding approaches such as enhanced fee-for-service, per member/per month and shared savings/shared risk models that could promote palliative consultations.
- Launch an education campaign to commercial, state, federal and value-based payers regarding cost savings benefit of palliative and hospice care.
- Advocate for Medicaid reimbursement for advance care planning codes.
- Implement \$0 copay for universal palliative care and advance care planning benefit.
- Develop standardized quality metrics for palliative and hospice care applicable to value-based agreements (e.g. PCMH, ACO, bundles and episodes of care).
- Embed data points for identification of potential high risk vulnerable patients eligible for palliative or hospice care.
- Work with professional associations to advocate at the state and federal level for regulatory changes that promote and heighten the importance of early advance care planning

Current N.J. Pilots

RCCA participates in a CMS demonstration model called the Oncology Care Model. Data is shared about how each group performs on certain end of life metrics including hospice, chemotherapy and ICU stays prior to death. The data shows that costs are \$10k more for those patients who have not had any hospice use in last 30 days of life vs. those who did. Performance on each metric is provided to each physician to provide education and comparison to peers for improvement. A similar program was recently launched with Horizon BCBS. 7,000 patients are covered under both programs annually.

Hackensack Meridian Health and Horizon BCBS have developed a pilot program for home-based palliative care reimbursement. Using a per beneficiary, per month care management fee, HMH's Palliative Care program is caring for a cohort of Horizon's commercial patients appropriate for palliative care. This payment structure covers the entire interdisciplinary team. Metrics will include hospital admissions, ICU days, ED visits, advance care planning and patient satisfaction.



Team 3: A Design and Implementation Plan for Adoption of a Palliative Care Screening Evaluation Tool in the Emergency Room

Action Steps:

To meet their target goal, the team researched and developed an evaluation tool to assess the effectiveness of the palliative care screen tool developed by Baylor Health Care System and identified by Cohort 1 colleagues. The team also drafted a readiness assessment tool for facilities to consider if they express interest in implementing palliative care screening in their emergency room. The team also suggests that the NJ health care systems consider responses to the following questions:

- Is the Board of Directors, executive leadership of the emergency department, Administration and other key stakeholders invested in the program?
- Are you able to collect pre-implementation data regarding the number of Palliative consults/referrals made in the past?
- Are you able to integrate the screening tool seamlessly into your emergency room's workflow?
- Does your EMR allow for the emergency room team assigned to a patient to view the screening results?
- Does your EMR have real time clinical decision support such that a positive screen will prompt the physician to order the consult and create a hard stop to document a reason if the consult is not ordered for a patient who screens positive?
- In order to encourage shared decision making between providers teams around disposition and care plan. Will there be a process to notify the patient's PCP that a palliative care consult was ordered?
- Will your palliative care consultant/team have the capacity to complete a greater volume of referrals?
- Does your EMR have the capability to flag a patient's EHR with screen results and consultation status (refused, ordered, pending, completed, canceled) for future reference if the patient presents to the emergency room later?

Outcomes:

The team collaborated with multiple stakeholders including leadership at Saint Barnabas Medical Center, Livingston, NJ. Saint Barnabas Medical Center has agreed to pilot the tools in their Emergency Room. After implementation of the pilot, the Medical Center intends to rollout the screening tool to the entire Robert Wood Johnson Barnabas Healthcare system.

Recommendations:

The team recommends the following proactive approach to ensure adoption of the Implementation of Palliative Care Screening Tool for patients presenting in an Emergency Room.

1. Share with hospital facilities the readiness assessment, screening, and evaluation tools to identify facilities interested in piloting the tools
2. Obtain baseline data from hospital facilities regarding number of palliative consults completed prior to implementation of screening tool in the emergency room
3. Measure data from hospital facilities regarding number of palliative care consults completed after implementation of screening tool in the emergency room

Implementation of Palliative Care Screening Tool for Emergency Room Patients

Marilyn Gordon MD, FACP, CPE, Florence Kariuki RN MHA BSN, and Danielle Leone LCSW

PALLIATIVE CARE SCREENING EVALUATION TOOL AND RECOMMENDED GUIDELINES FOR IMPLEMENTATION



Introduction & Background

- Frequently, patients seeking care for serious illnesses, lifesaving, or life-prolonging treatment are seen in the ED and then usually transferred to an inpatient unit, transferred to another hospital, or discharged home. Rarely is there a proactive approach in the ED to identify patients that could benefit from palliative care, followed by referrals to Palliative care services as appropriate.
- Such patients often experience a delay in receiving timely access to palliative care
- Cohort 1 identified a palliative care screening tool developed by Baylor Health Care System to identify these patients in the ED and increase opportunities to refer patients to obtain palliative care.

Our Intervention

- This team worked with Cohort I team members with a goal to implement the screening tool in at least one facility.
- This team built an evaluation tool to support the determination of the tool's effectiveness.
- Working with representatives from Cohort 1, and leadership support, the team identified and engaged St. Barnabas Medical Center, Livingston NJ.
- The team met with the Chairman of Saint Barnabas Medical Center's Emergency Department. The tool was also shared with Atlantic Health System (AHS).

Outcomes

- Leadership from St. Barnabas Medical Center's ED and Palliative program has agreed to pilot the tool in their Emergency Department
- Based on pilot experience and learnings, the plan is to scale use of the tool to the additional 11 facilities that make the RWJB System
- The tool was shared with the System's Chief Information Technology Officer. The questions will be embedded within their Electronic Health System for efficiency.



A journey of a thousand miles begins with a single step.

EMERGENCY DEPARTMENT PALLIATIVE SCREENING TOOL



Baylor Health System

Identification of Palliative Care Patients in the Emergency Department

Screening questions

1. Is the patient on a ventilator or pressors post CPR in the field or ED
2. Does the patient have an advanced life-limiting illness? (You wouldn't be surprised if the patient died in the next six months).
 - a. Severe CNS disease such as massive stroke, severe encephalopathy with multiple co-morbid conditions, or severe dementia. Exclude trauma.
 - b. History of progression despite treatment of cancer, major organ failure (Chronic Lung Disease with prior intubation, Chronic Liver Disease with encephalopathy), HIV.
 - c. Patient who are admitted from hospice (patients actively dying; in pain/discomfort).
3. Is there severe functional debility due to advanced life limiting illness? This might be manifested by:
 - a. Cachexia/Nutritional complications
 - b. Progressive loss of ADLs leading to bed/chair bound status.
 - c. Multiple trips to ED or hospital in past six months.
 - d. Exclude chronically disabled persons such as cerebral palsy patients.

If the answer is yes to any of the above questions it constitutes a positive palliative care screen and the Social Worker should be notified to begin the process.

EVALUATION TOOL

Palliative Care Evaluation Tool Emergency Room patients being screened for Palliative Care using the Baylor Model Health System Screening Questions

1. Was the screening tool used to identify a potential palliative care patient? **YES NO**

2. Did the patient meet the criteria for a palliative care consult? **YES NO**

If yes; was a palliative consult ordered? **YES NO**

If not, why not?

- a) Physician did not feel it was appropriate
 - i. Primary physician
 - ii. Emergency Room physician
- b) Patient/Family declined

3. Was a palliative consult completed? **YES NO**

If not, why not?

- a) Physician did not feel it was appropriate
 - i. Primary physician
 - ii. Emergency Room physician
- b) Patient/Family declined



Readiness Assessment To Consider When Implementing Palliative Care Screening in the ED

- Key stakeholder investment
- Pre-implementation palliative care awareness campaign
- Universal palliative care education and screening tool training
- Pre-implementation data collection
- Integration of screening tool
- Real time clinical decision support to prompt physician order for positive screens
- PCP notification
- Capacity for palliative care consultant/team to complete a greater volume of referrals

Action Steps

- Follow up with Saint Barnabas Medical Center on pilot progress .
- Offer direction and guidance as needed during their planning, implementation, and roll out phases as needed.
- Follow up with AHS for any updates.

Summary



St. Barnabas Medical Center

Will pilot tool in Emergency Department, and plan to scale to additional facilities.

Atlantic Health System

Found the tool very valuable. Will review with team in considerations to enhance their palliative program.

REFERENCES

NJ HELA Cohort 1 2017
Center to Advance Palliative Care: <https://www.capc.org/>
Medical Society of New Jersey: www.msnj.org/
Baylor Health System: www.baylorhealth.com/



Team 4: Improving Information Exchange at Point-of-transitions between Hospitals, Assisted Living and LTC by increasing the Completion rate of Advance Directives and POLST forms

Action Steps:

The team identified the completion of an Advance Directive and or a POLST form as one of the main barriers to palliative care adoption. Projects were initiated at the acute care, rehabilitation hospital, and outpatient settings. A major focus was the education of health care professionals in all settings, with a goal of facilitating the completion of an Advance Directive or a POLST form.

- Initiate projects in different types of health care settings
- Ensure completion rate of advance directives or POLST form via administration of the *Five Wishes* booklet
- Increase the number of POLST forms completed at pilot facilities with a protocol or policy in place
- Facilitate and improve communication between the practitioner and patient regardless of setting

Outcomes:

After the initiation of the action steps, the team noted that in a *rehabilitation hospital setting* the POLST completion rate increased from 7% to 31% and that all forms (100%) transferred to next site of care. In the *health plan setting*, documentation of advance directives/POLST or defined code status increased from 16% to 79% for patients transferred to a Rehab/SNF/Assisted Living unit along with 100% transfer of completed forms. As part of a *VNA-Visiting MD services* program the Advanced Care plans increased from 0% to 60%, of which 40% of the forms included POLST. At the fourth setting, *a primary care group organization*, the facility adopted the *Five Wishes* booklet and a serious-illness guide to improve communication regarding EOL and palliative care. The step helped standardize the collection process for both advance directives and POLST forms.

Recommendations:

Future recommendations include:

1. Assuring that advance care planning is a standard for all health system providers.
2. That continued education, both at the health professional level and community level, would improve communication during transitions of care.
3. Focus on communication at the primary care level, as this may be the best setting for addressing this topic.



Transitions of Care: Advance Directives & POLST Documentation

Robyn Agri, MD Amina Ahmed, MD Marjorie Forgang, MSN, BSN Charles Markowitz, MD Linda Savino, MS, OTR/L

Introduction

In providing End-Of-Life (EOL) care, understanding the wishes of the patient is the “gold standard.” Yet, too often that goal is not met. Our team took actions to better understand this health system problem from multiple perspectives and to initiate actions to improve EOL care planning via 5 different pilot projects.

Project Goals

- Project Goal 1: To increase the completion rate of Advance Directives (AD) and/or POLST forms
- Project Goal 2: To improve EOL continuity of care by increasing the rate of transfer of Ads and/or POLST forms to the next care site
- Project Goal 3: To gather recommendations for future planning and education, based upon the results of these pilot programs.

PILOT EOL CARE PLANNING SITES

Rehabilitation Hospital

Focus: All patients admitted to and discharged from rehab facility have AD, but, POLST preferred, as it provides detailed preferences

Actions:

- EOL Education session: rehab staff & external palliative care MDs
- Patient/family handout developed re. POLST form in relation to AD

Results: (pre & post measures)

- Increased POLST completion rate from 7% to 31%
- Maintained 100% transfer of forms to next care site

Health Plan

Focus: AD completion rate for patients in long term care program

Actions:

- Multiple staff education sessions re. AD & POLST forms
- Future staff session planned to complete personal AD forms

Results: (pre measure only)

- Sample 1: 4.36% AD completed
- Sample 2: 8.91% AD completed

TB measured in future: post measure

Acute Care Hospital

Focus: All patients being discharged from hospital to sub-acute/SNF, Rehabilitation and/or Assistant Living facilities have ADs documented in History & Physical notes and patients’ advance wishes conveyed in the transfer.

Actions:

- Letter signed by CEO and CMO to all medical staff and nursing supervisors announcing the new AD goal and its benefits
- Conducted meetings with MD and Nursing leaders, case mgt staff and patient representatives concerning the new initiative and their individual roles
- Distributed “Five Wishes” AD booklet to all MDs and case mgt work stations
- Circulated 2 educational articles to all MDs re: benefits of obtaining ADs

Results: (pre & post measures)

- Increased documented (i.e. history & physical exam notes) AD/POLST or defined code status from 16% to 79% for pts transferred to Rehab/SNF/Asst Living
- Maintained 100% transfer rate of documented advance wishes to next site of care

Primary Care Group

Focus: All patients have goals of care (GOC) communication &, when appropriate, EOL conversations

Actions:

- Initiated focus group planning sessions with primary care MDs and department Chairs
- Adopted “5 Wishes” & serious illness guide to improve communication
- Increased care management and social work participation in GOC conversations
- Developing standardized collection process for ADs and POLST forms

Results: to be measured in future

VNA-Visiting MD Services

Focus: AD completion rate for homebound patients

Actions:

- Staff education sessions re. standardized plan for advanced care planning discussions
- Adopted EHR advanced care planning template
- Initiated monitoring of results

Results: (pre & post measures)

- Increased Advanced care plans from 0% to 65%, of which 40% of forms included POLST

Discussion

As we considered our charge, the complexity of the task became more obvious, with the resulting conclusion that we all have roles to play in encouraging patients to convey their advance wishes. Plus, we have a critical role in assuring that this information accompanies patients as they transition between different care levels and sites. By drawing attention to these roles, all of our pilot sites demonstrated improved results. While this was also true of our acute care pilot, due to the potential for misinterpretation of advance directive planning when a patient is in the hospital, we concluded that non-acute care sites, particularly primary care settings, are a better alternative for addressing this topic.

Recommendations

- Assure that advance care planning (e.g. Advance Directives/POLSTs...etc) is a standard of care for all health system providers
- Provide health professionals and communities with education on this topic
- Monitor the results of these activities



NEW JERSEY
HEALTHCARE EXECUTIVE
LEADERSHIP ACADEMY

EST. 2016

NJHELA FACULTY





- **Terrence Cahill, EdD, FACHE**, is Chair & Associate Professor, Department of Interprofessional Health Sciences and Health Administration, Seton Hall University. His scholarship and teaching focus on topics concerning generational issues, senior leadership, strategic thinking and organizational change. Terry has served in numerous hospital and managed care executive leadership roles. In addition to his academic responsibilities Terry maintains a health care consulting practice providing executive coaching services
- **Anne M. Hewitt, PhD** is Program Director for the Masters in Healthcare Administration (MHA) and Associate Professor at Seton Hall University. Dr. Hewitt also serves as Director of the Seton Center for Community and Population Health. She received a dissertation grant from the American Lung Association while completing her PHD from Temple University, and has been awarded additional grants from federal and state agencies and national non-profit foundations. She was previously selected as a RWJ Foundation Community-Campus Health Fellow She has numerous publications, participates as a peer reviewer for several health journals, and serves on state nonprofit and public health advisory boards. Dr. Hewitt also provides expert commentary on health issues via social and traditional communication channels. Her research interests focus on community health needs assessments, population health models and health professions education including online pedagogy. She is a member of Upsilon Phi Delta, Kappa Omicron Phi, and Sigma Beta Delta honor societies.
- **Stephen Wagner, PhD, FACHE, FACMPE, FAcEM**, has been active in the field of healthcare for more than 40 years and is an expert in the American healthcare system and its ongoing transformation. He held a number of positions at the Carolinas Healthcare System (CHS) over the last 20 years and was instrumental in the creation of the Sanger Heart and Vascular Institute (formerly the Sanger Clinic where he served as Senior Administrator). Before coming to Sanger and CHS, Dr. Wagner was the Senior Executive for Physician Practices at Alliant Health System in Louisville, Kentucky, one of the first health systems to embrace Total Quality Management. In addition to his extensive experience as an executive, Dr. Wagner is devoted to educating the future leaders of healthcare. He actively serves as a Faculty Member and as the Executive in Residence for the Master of Health Administration program in the School of Health and Medical Sciences at Seton Hall University, where he has taught for the last 19 years. His work today focuses on change and managing the difficult process of changing the healthcare organization to meet the challenges of the future. His principal areas of emphasis include the neurobiology of change, health policy, leadership and governance, organization development, medical practice administration, medical economics, new healthcare and educational technologies, and emergency management. Recent research has focused specifically on outcomes measurement.
- **Nalin Johri, PhD, MPH** is Assistant Professor in the Masters in Healthcare Administration program/ Dept. of Interprofessional Health Sciences and Healthcare Administration/ School of Health and Medical Sciences at Seton Hall University and teaches several courses, including Research Methods, Healthcare Economics, Healthcare Policy, Financial Management and Strategic Planning and Marketing. Dr. Johri's work experience includes program development, monitoring and evaluation experience on maternal and child health and nutrition and prevention of mother-to-child transmission of HIV and spans over 10 years with NGOs such as CARE and EngenderHealth, Francois-Xavier Bagnoud Center at the University of Medicine and Dentistry of New Jersey as well as consulting with UNICEF and until April 2013 he was the Impact Evaluation Advisor for USAID's Palestinian Health Sector Reform Project.



Featured Guest Faculty

- **Stephen Goldfine, MD, DABFP, CAQGM, DABHP** is a renowned palliative care physician with more than 25 years of experience. Since 2003, he has served as the full-time chief medical officer for Samaritan Healthcare & Hospice – South Jersey’s first and largest hospice – where he is the liaison between Samaritan and the medical community. He also sees patients and families as a physician with Samaritan’s medical practice, called Palliative Medical Partners, and with Primary Care of Moorestown. Dr. Goldfine is certified by both the American Board of Hospice and Palliative Medicine and the American Board of Family Practice. With the latter, he has added qualifications in geriatrics and hospice and palliative medicine. Named Hospice Physician of the Year in 2009 by the New Jersey Hospice and Palliative Care Organization, Dr. Goldfine previously served as medical director for several rehabilitation facilities, including Virtua Rehabilitation Center at Mount Holly, the Lutheran Home of Moorestown, and Moorestown Estates. An articulate and engaging speaker, Dr. Goldfine has presented a range of educational workshops to healthcare professionals and the public. He received his medical degree from Temple University School of Medicine in Philadelphia, and his undergraduate degree from Emory University in Atlanta.
- **Elizabeth A. McCrea, PhD, MBA**, is an Associate Professor of Management and Entrepreneurship at Seton Hall University, focusing on entrepreneurship, innovation, and pedagogy. Her publications have won three “Bright Idea” awards for applied research, sponsored by NJ Policy Research Organization and NJ Business & Industry Association. Dr. McCrea is Vice President Program Elect of the Eastern Academy of Management. Her professional experience includes finance, operations and executive training roles in the consumer products and health care industries.
- **David Barile, MD** is Executive Director and Founder of New Jersey Goals of Care, a non-profit entity devoted to improving medical decision-making for seniors. In addition to his roll with Goals of Care, he is chief of the Section of Geriatric Medicine and Medical Director of the Acute Cart for the Elderly (ACE) unit at the University Medical Center of Princeton at Plainsboro. He also serves as Medical Director of Princeton Care Center, a skilled nursing and rehabilitation facility located in Princeton. Dr. Barile completed his undergraduate education at University of California at Santa Cruz and received his Doctorate of Medicine from Eastern Virginia Medical School. He completed his Internship and Residency at Beth Israel Medical Center in New York City and a two-year Geriatric Fellowship at Mount Sinai School of Medicine. He received Internal Medicine board certification in 1999, Geriatric Medicine certification in 2001 and Hospice/Palliative Medicine certification in 2005. He has been in clinical practice since 2000.
- **Neen James, MBA, CSP** - Dubbed the ‘energizer powerhouse’ by event planners worldwide, she’s the expert and speaker to connect with if your goals include: Exceptional performance. Through-the-roof sales. Best-in-business productivity, and insightful, growth-fueling leadership. Neen delivers high-energy, rich content empowering message that shares how the art and practice of paying attention holds the key to greater success. Neen is a Certified Speaking Professional—a valuable accreditation earned by less than 10% of speakers worldwide With a strong corporate background in development and managing large teams throughout several industries, Neen is the perfect fit for organizations who want implementable strategies to increase sales, accelerate engagement, save time, and help people get more done.



NEW JERSEY
HEALTHCARE EXECUTIVE
LEADERSHIP ACADEMY

EST. 2016

REFERENCE & RESOURCES

1. A Playbook for Managing Problems in the Last Chapter of Your Life. http://khn.org/news/a-playbook-for-managing-problems-in-the-last-chapter-of-your-life/?utm_campaign=KHN%3A%20Topic-based&utm_source=hs_email&utm_medium=email&utm_content=50991852&_hsenc=p2ANqtz-9nva9BNDMmeJ0glwOK69xJzk4TJjEM4HkOsojHzenBveT2qMKuo_ehPTjyv8YdZZCUjDtgxAmKVYiSyAXsjoJU9Y8SIQ&_hsmi=50991852
2. Advanced Care Planning Decision Library. <https://www.acpdecisions.org/products/videos/>
3. American Telemedicine Association: <http://www.americantelemed.org/home>
4. ASHP Foundation. (2012). Leading Change in a Complex Health Care System. <http://www.ashpfoundation.org/transformational/TransformationalChange110212.html>
5. Barriers to End-of-Life Care Conversations. (2016). http://www.todaysgeriatricmedicine.com/news/ex_071416.shtml
6. Barriers to Goals of Care Discussions with Seriously Ill Hospitalized patients and their families. (2015) <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2107609>
7. Bélanger, E., Rodríguez, C., Groleau, D., Légaré, F., Macdonald, M. E., & Marchand, R. (2014). Initiating decision-making conversations in palliative care: an ethnographic discourse analysis. *BMC Palliative Care*, 13, 63. <http://doi.org/10.1186/1472-684X-13-63>
8. Blue Shield of CA. (January 25, 2017). Blue Shield of California, Hill Physicians Medical Group and Snowline Hospice Collaborate to Offer Home-based Palliative Care to Seriously Ill Patients. Retrieved from <https://media.blueshieldca.com/2017/01/25/blue-shield-hill-physicians-snowline-palliativecare/>
9. Blue Cross Blue Shield of MA. December 17, 2015. Blue Cross Members with Advanced Illnesses Will Receive Enhanced Benefits to Improve Their Quality of Life. Retrieved from <https://www.bluecrossma.com/visitor/newsroom/press-releases/2015/2015-12-28.html>
10. Center to Advanced Palliative Care., Improving Care for People with Serious Illness through Innovative Payer-Provider Partnerships., New Jersey Hospital Association.

https://media.capc.org/filer_public/0f/2f/0f2f8662-15cf-4680-baa8-215dd97fbde6/payer-provider-toolkit-2015.pdf

11. Discussing End-of-Life Care. (2015).
http://www.todayseriatricmedicine.com/news/ex_032015.shtml
12. Discussing End-of-Life Care With Older Patients: What Are You Waiting For? (2007).
http://www.medscape.com/viewarticle/564628_3
13. Fulmer, T. (April 4, 2016). Talking with Patients about End-of-Life Care: New Poll Reveals How Physicians Really Feel. Retrieved from <http://www.johnhartford.org/blog/view/talking-withpatients-about-end-of-life-care-new-poll-reveals-how-physician/>
14. Grudzen CR, Stone S, Morrison S. The palliative care model for emergency department patients with advanced illness. *J Palliat Med.* 2011;14:945-950.
15. Hess, S. (2009) Key Determinants in Health End of Life Care (Handout)
<http://www.jhsph.edu/academics/degree-programs/master-of-public-health/curriculum/Sally%20Hess%20capstone%202009.pdf>
16. Hibbard, J.H., Stockard, J., Mahoney, E., & Tusler. (2004). Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers. *Health Serv Res.* Aug; 39(4 Pt 1): 1005–1026.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361049/> doi: [10.1111/j.1475-6773.2004.00269.x](https://doi.org/10.1111/j.1475-6773.2004.00269.x)
17. Hickson, G. B., Pichert, J. W., Webb, L. E., & Gabbe, S. G. (2007, November). A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. *Acad Med.* 2007 Nov; 82(11): 1040–1048.
<https://www.ncbi.nlm.nih.gov/pubmed/17971689> doi: [10.1097/ACM.0b013e31815761ee](https://doi.org/10.1097/ACM.0b013e31815761ee)
18. Improving the Care of Serious Illness Through Innovative Payer-Provider Partnerships: A Palliative Care Toolkit and Resource Guide. Center to Advance Palliative Care.
www.capc.org/payers/palliative-care-payer-provider-toolkit/
19. Jacobs JA, Jones E, Gabella BA, Spring B, Brownson RC. Tools for Implementing an Evidence-Based Approach in Public Health Practice. *Prev Chronic Dis* 2012;9:110324.

https://www.cdc.gov/pcd/issues/2012/11_0324.htm DOI:

<http://dx.doi.org/10.5888/pcd9.110324>

20. Kelley, A. S., M.D., & Morrison, S., M.D. (2015, August 20). Palliative Care for the Seriously Ill — NEJM (E. W. Campion M.D., Ed.). N Engl J Med 2015; 373:747-755
<http://www.nejm.org/doi/full/10.1056/NEJMra1404684#t=article> DOI:
10.1056/NEJMra1404684
21. Lamba S. Early goal-directed palliative therapy in the emergency department: A step to move palliative care upstream. J Palliat Med. 2009;12:767.; Penrod J, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: Effects on hospital cost. J Palliat Med. 2010;13:973-977.; Stone S. Emergency department research in palliative care: Challenges in recruitment. J Palliat Med. 2009;12:867-868.
22. Lewis, M. Fitzgerald, T., Zulkiewicz, B., Peinado, S., & Williams, P. (2017). Identifying Synergies in Multilevel Interventions: The Convergence Strategy. Health Education & Behavior, Vol 44(2), 236-244
23. Mayor's Wellness Campaign: Conversation of Your Life.
<http://www.njhqci.org/initiative/mayors-wellness-campaign/mwcs-conversationof-your-life/>
24. Medicaid Telemedicine Services:
<https://www.medicaid.gov/medicaid/benefits/telemed/index.html>
25. Medicare Telehealth Services: <https://www.cms.gov/Outreach-and-Education/MedicareLearning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsh.pdf>
26. National Hospice and Palliative Care Organization-Best practices for using telehealth in palliative care:
https://www.nhpco.org/sites/default/files/public/palliativecare/PALLIATIVECARE_Telehealth.pdf
27. New Jersey Health Care Quality Institute and Rutgers Eagleton Center for Public Interest Polling "Health Matters Poll: End-of-Life Care in New Jersey." (2016)

<http://eagletonpoll.rutgers.edu/rutgers-eagleton-nj-health-care-quality-institute-end-of-life-apr2016/>

28. New Jersey Legislature Bill Search: <http://www.njleg.state.nj.us/Default.asp>
29. Old, J. (2008, March 01). Discussing End-of-Life Care With Your Patients. <http://www.aafp.org/fpm/2008/0300/p18.html>
30. Practitioner Orders for Life-Sustaining Treatment., End of Life Care in New Jersey Hospitals – A Blueprint for Action. http://www.njha.com/media/85145/NJHA_PolstBlueprint.pdf
31. Quest T, Asplin B, Cairns C, et al. Research priorities for palliative and end-of-life care in the emergency setting. Acad Emerg Med. 2011;18, e70-e76.; Grudzen C, Richardson L, Morrison M, et al. Palliative care needs of seriously ill, older adults presenting to the emergency department. Acad Emerg Med, 2010;17:1253-1257.; 7. Smith A, Fisher J, Schnoberg M, et al. Am I doing the right thing? Provider perspectives on improving palliative care in the emergency department. Ann Emerg Med. 2009;54:86-94.; 8. Ausband S, March J, Brown L. National prevalence of palliative care protocols in emergency medical services. Prehosp Emerg Care. 2002;6:36-40
32. Respecting Choices. Advance Care Planning. Return on Investment Implementation of Respecting Choices Model of Advance Care Planning. Retrieved from <http://www.gundersenhealth.org/app/files/public/2205/RC-Return-on-Investment.pdf>
33. Risk Assessment 8P - Project BOOST® Implementation Toolkit: Touch Points: Admission, During Hospitalization, and Discharge. http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality_Innovation/Implementation_Toolkit/Boost/BOOST_Intervention/Tools/Risk_Assessment.aspx
34. The Care of Patients with Severe Chronic Illness. (2006) http://www.dartmouthatlas.org/downloads/atlas/2006_Chronic_Care_Atlas.pdf
35. The Center for Connected Health Policy: <http://www.cchpca.org/>

36. The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). JAMA. 1995; 274(20):1591-98.
37. Wade, M. A Comprehensive Case Management Program to Improve Access to Palliative Care. Retrieved from http://www.ehcca.com/presentations/palliativesummit1/wade_ms3.pdf
38. Weiner, B., Lewis, A., Clauser, S., & Stitzenberg, K. (2012). In Search of Synergy: Strategies for Combining Interventions at Multiple Levels. Natl Cancer Inst Monogr, 44:34-41.

<http://people.oregonstate.edu/~flayb/MY%20COURSES/H671%20Advanced%20Theory%20Winter16/Readings/Weiner%20etal12%20Strategies%20for%20combining%20interventions%20at%20multiple%20levels%20-%20synergy.pdf>

