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# NEW JERSEY

## HEALTHCARE EXECUTIVE LEADERSHIP ACADEMY

Proceedings from 2017 (Class I)

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

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September 2017



NEW JERSEY  
HEALTHCARE EXECUTIVE  
LEADERSHIP ACADEMY

EST. 2016

# NEW JERSEY HEALTHCARE EXECUTIVE LEADERSHIP ACADEMY

PROCEEDINGS FROM 2017 (CLASS I)

IMPROVING CARE AT THE END OF LIFE  
ACTION PLAN FOR NEW JERSEY

DEVELOPED & SPONSORED BY



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EST. 2016

# NJHELA

New Jersey  
Healthcare Executive  
Leadership Academy

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Prepared by:  
Seton Center for Community  
and Population Health  
(SCCPH)  
September 2017

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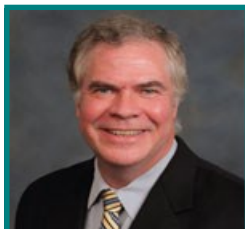
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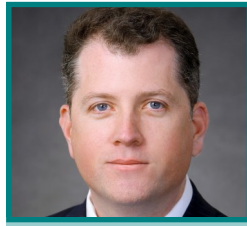




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## PROLOGUE

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 2017 Inaugural Class of the New Jersey Healthcare Leadership Academy (NJHELA). We want to congratulate the 2017 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 inaugural class consisted of 26 nominated professionals who are practicing physicians and executives from hospitals, post-acute providers and health plans.

Over the next five years, the NJHELA expects to provide executive leadership training to approximately 150 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  
MSNJ



**Elizabeth A. Ryan, Esq.**

President & CEO  
NJHA



**Wardell Sanders, Esq.**

President  
NJAHP







# NEW JERSEY HEALTHCARE EXECUTIVE LEADERSHIP ACADEMY

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## EXECUTIVE SUMMARY



## **NEW JERSEY HEALTHCARE EXECUTIVE LEADERSHIP**

### **ACADEMY PROGRAM EXECUTIVE SUMMARY**

The Medical Society of New Jersey, the N.J. Hospital Association and the N.J. Association of Health Plans collaborated to develop a first-of-its kind initiative, NJ Healthcare Executive Leadership Academy (NJHELA). Cohort 1, which included 26 important healthcare executives and physicians representing all three professional organizations, attended multiple learning sessions with coordinated by Faculty from Seton Hall University (SHU) who also served as team mentors.

The initial NJHELA cohort focused on addressing 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 NJ Hospital Association had previously published End-Of-Life Care in New Jersey Hospitals: A Blueprint for Action (2009) which articulated the rationale for necessary EOL policy changes, and protocol and clear recommendations. Building on this consensus document, NJHELA recognized the need to further develop action steps and provide state-wide EOL strategies developed by executive teams representing multiple stakeholder perspectives. To further enable this collaborative effort, NJHELA also recognized the importance of convening a learning community that emphasized collaborative leadership.

The 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) to focus on seven project assignments. 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. Team project assignments targeted EOL quality of care barriers:

Team 1: Describe evidence based/best practice informed strategies to enhance the capacity of primary care providers to integrate palliative care into their practices.

Team 2: Design a plan to enhance the effective implementation and sustainability of a telehealth program for palliative care.

Team 3: Develop novel policies and incentives for early conversations about (and referrals to) palliative care by physicians.

Team 4: Design a system of best practices to routinely assess admitted patients for end of life care planning.

Team 5: Identify opportunities to develop Palliative Care fellowships in New Jersey teaching hospitals.

Team 6: Design a plan to integrate the best practices of palliative care in the ER.

Team 7: Improving access to homecare.

The program began with a two-day, intensive retreat introducing the End-of-Life issue, followed by five monthly face-to-face sessions, and concluded with a second two-day retreat featuring a public presentation highlighting Cohort 1 group presentations and recommendations for improving EOL care for all New Jersey residents. The six month program included expert speakers not only on 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 is provided below:

Commencing Retreat:

Session 1

Welcome & Introductions (NJHELA Co-Sponsors & SHU Faculty)

Leadership Learning: *"This I Believe...." Statements*

Plenary Session: End of Life Issues (*Stephen Goldfine, MD DABFP, CAQGM, DABHPM*

Chief Medical Officer, Samaritan Healthcare & Hospice

Panel Discussion: Voice of Patients & Family Members

Leading in an Era of Whitewater: (*Drs. Terrence Cahill & Stephen Wagner*)

Cohort 1 Expectations

## Session 2

Hogan Inventory: *(Dr. Terrence Cahill, SHU)*  
Teamwork Building: Recipe for Success  
The Great Leader Exercise: *(Dr. Terrence Cahill, SHU)*  
Project Delineation and EOL Priority Discussion

## Session 3

Innovation Tactics/ Guest Faculty: *(Dr. Elizabeth McCrae, SHU)*.  
The Art of Big Data Leadership – *(Dr. Jackie Zhang, SHU)*  
Guest Faculty: *(Stephen Singer, MCP, Camden Coalition of Healthcare Providers)*

## Session 4:

Population Health Leadership: *(Dr. Anne Hewitt, SHU)*  
Guest Faculty: *(John F. Vigorita, MD, MHA, President and CEO, Optimus Healthcare Partners)*  
Leadership Styles: *(Dr. Terrence Cahill, SHU)*

## Session 5:

Big Data-EOL: *(Dr. Jackie Zhang, SHU)*  
Conflict Resolution: *(Dr. Stephen Wagner, SHU)*  
Policy Issues Related to Health System Transformation: *(Dr. Nalin Johri, SHU)*

## Closing Retreat:

Guest Faculty: *Neen James, Motivational & Productivity Expert*  
Leadership Learning: Planning for the Future *(Dr. Stephen Wagner, SHU)*  
Group Presentations: Action Learning Projects  
Guest Faculty: *David Barile, MD, Executive Director and Founder of NJ Goals of Care*  
Partner Walk Exercise *(Dr. Terrence Cahill, SHU)*  
Sponsor's Reception/ Poster Presentation to the Media and the Public  
Awarding of Certificates from SHU

In addition to the face to face learning opportunities, team members completed 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 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 1 healthcare executive participants, focusing on EOL solutions for New Jersey, successfully completed their seven projects and developed 45 strategic action steps. The accompanying implementation strategies represented viable solutions acceptable to each of the professionals representing practicing physicians and executives from hospitals and health plans. Each group's project presentation and executive summaries are included in the proceedings document as well as additional resources and references.

The New Jersey Healthcare Leadership Academy graduated its first class of Fellows in June, with a planned leadership conference at NJHA in October. All parties hope the opportunity to work across the different stakeholder groups will help in other vexing healthcare challenges. Planning is already underway to create a second cohort for 2018.

### **N.J. Healthcare Executive Leadership Academy Graduates First Class of Fellows**



Back row (left to right): Larry Downs, Terrence Cahill, Stephen Dumke, Maureen Schneider, Kevin O'Dowd, Christopher Gribbin, Marc Levine, Ward Sanders, Kenneth Kobylowski, Stephen Wagner, Ashish Parikh, Nalin Johri, Ning Jackie Zhang, Marlene Kalayilparampil

Front row (left to right): Soumen Samaddar, Sarah Adelman, Gail Kosyla, Mary Campagnolo, Gregory Rokosz, Jen Velez, Anne Hewitt

Not Pictured: Betsy Ryan, Darrell Terry, Bruce Pomeranz, Todd Way, Judy Wright, John Poole, Ralph Pothel, Adam Young, Joseph Costabile, Paul Matey, Frank Urbano, Alison Dorsey, Kenneth Sable, Mary Ann Christopher



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## EOL EXECUTIVE SUMMARIES





## **A Portfolio of Palliative Care Strategies for Primary Care**

**Strategy 1: Primary Care Provider (PCP) Care Coordination Initiative** (*Mary Campagnolo, MD, MBA – Virtua Health*)

The optimal way for individuals to discuss and implement Advanced Care (EOL) and Palliative Care planning is with their PCPs and respective practice teams. Proposed strategies include: 1) Introduce Goals of [care.org](http://care.org): short videos via tablet for patient/family education during visit, or online at their convenience. 2) Combine this education with realistic practice workflow, possibly over multiple encounters, for ACP and document completion (POLST & advanced directives). 3) Increase the opportunity for patients to enter their POLST form in NJ wide digital repository for ease of access in time of health emergency, or transfer between sites of care (NJHA emPOLST initiative). 4) Enhance payment from government and commercial insurers for clinician and practice staff time spent with patients on Advanced Care planning, and documentation. 5) Increase education on palliative care and advanced care (EOL) planning in curricula for medical students, APN and Physician Assistant students, as well as in Continuing Medical Education programs.

**Strategy 2: Providing PCPs with Palliative Care (PC) Knowledge and Support** (*Jennifer Velez, Esq., RWJBarnabas Health*)

Project ECHO is an evidence-based strategy of virtual “tele-mentoring” through web-based video collaboration, which links a multi-disciplinary team of specialists with primary care providers (PCPs), training the providers through peer-led case presentations and expert-led short didactics on relevant topics germane to the clinic focus – in this case, palliative care. By enhancing providers’ skills, knowledge, and capacity to provide an expanded degree of care to patients in the primary care setting through participation in Project ECHO, research has demonstrated an improvement in patient outcomes, provider competencies and participant satisfaction. We propose that NJHELA work in conjunction with RWJ Partners, which is the identified lead for the Nicholson Foundation-funded work in New Jersey, to establish a palliative care Project ECHO.

**Strategy 3: Conversation of your Life Communication Campaign** (*Jennifer Velez, Esq., RWJBarnabas Health*)

The NJ Healthcare Quality Institute sponsors the Mayors Wellness Campaign, an initiative designed to help mayors and communities adopt healthy lifestyles. Several available initiatives tailored for a diverse range of stakeholders are designed to help individuals and organizations plan and implement programs that aim to promote health and wellness. The Conversation for your Life project is a mature campaign,

which offers scalable opportunities to highlight and integrate Advanced Care Planning throughout New Jersey.

<http://www.njhcqi.org/initiative/mayors-wellness-campaign/mwcs-conversation-of-your-life>

**Strategy 4: Aligning Payor and PCP Incentives with Patient Outcomes** (*Kenneth Kobylowski, Esq., AmeriHealth New Jersey and AmeriHealth Administrators*)

CMS began reimbursing for Advanced Care Planning in 2016 (CPT codes 99497 & 99498) with no limit on the number of times codes can be billed and no place of service limit. A recent review of national, state and regional healthcare insurers suggest that opportunities exist, beyond Medicare reimbursement, for PCPs to receive incentives and reimbursement for Palliative Care consultations. Recommended PCP metric criteria for NJ physicians includes: # of palliative care consults, # of documented Directives, # of appropriate referrals to PC services, evidence of PC clinical skill integration in PCP practices, and decrease in cost of care in the last six months -1 year of life. Opportunities also exist to leverage payor data analytics capabilities to enhance engagement between payors and PCP practices.

**Strategy 5: Palliative Medicine Consultation Process Flow** (*Darrell Terry, MHA, MPH, FACHE*)

Care transitions within any acute care setting face multiple challenges. As part of the NJHELA initiative, Newark Beth Israel Medical Center examined its PALL CARE process flow. This quality improvement initiative on palliative care consultation processes and procedures helped identify barriers (missed patient opportunities) and advantages (skilled and experienced clinical team), and serves as a scalable example for improving the number of patients appropriately referred to optimal Palliative Care. Key findings: (a) include all appropriate in-patients based on evidence-based triggers for PM evaluation (b) Share with community & NBIMC's faculty & staff the benefits of PM team (c) Increase number of completed Advance Directives, and (d) Develop PM outpatient follow-up clinic for routine ongoing care and immediate post-discharge evaluation.

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Ashish D. Parikh, MD  
Bruce Pomeranz, MD, MMM  
Todd Way, MHA  
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Facilitator: Nalin Johri, PhD, MPH

## Current State of Telemedicine for Palliative Care in New Jersey: Executive Summary



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Telemedicine is the remote delivery of health care services and clinical information using technology. Although it is a relatively new field, telemedicine seems intuitively well-aligned with the needs of palliative and end-of-life care. However, it is essential to first understand the current state of telemedicine in New Jersey as it relates to healthcare in general, and to palliative care specifically.

### Telemedicine Modalities

Telehealth and telemedicine can be delivered in many ways.

Common modalities include:

- Live or synchronous virtual visits using video-conferencing;
- Store-and-forward or asynchronous video (sharing information outside of real time); and
- Remote patient monitoring or telemonitoring using electronic monitoring devices.

### Legal and Regulations related to Telemedicine

NJ does not have specific regulations about telemedicine, but current laws impacting remote care require that:

- The doctor must be licensed in the state where patient lives regardless the doctor's location.
- The doctor must conduct a history and physical examination before prescribing any drugs.

The NJ State Legislature has recently advanced a bill to give providers the ability to establish a patient-provider relationship and provide care through telemedicine. The bill specifies that insurance plans provide coverage and payment for telemedicine services, not to exceed the same rate that is applicable when the services are delivered through in-person contact or consultation.

### Reimbursement for telemedicine

**Medicare** only covers interactive audio and video encounters with patient who live in rural Health Professional Shortage Areas or in or in counties outside of a Metropolitan Statistical Area. The patient must originate the interaction from a medical site (office, hospital, etc.) and NOT from home.

**NJ Medicaid** only covers telepsychiatry via interactive audio-video care provided by psychiatrists and psychiatric advance nurse practitioners licensed in NJ to patients in the presence of a telepresenter.

**Private Payers** have no set of standards nationally or in NJ. Coverage varies by plan and carrier.

### Sustainability will require Measurement of Benefits

Any implementation should include meaningful outcomes to measure the impact of any telemedicine program. Measures should focus on the Quadruple Aim of improving population health, increasing patient satisfaction, reducing per-capita health-care spending and improving the experience of health-care providers.

### Action Steps

Leverage the collaborative networks forged through the first cohort of the NJHELA to:

- Assist New Jersey lawmakers in the passing laws that promote safe and secure use of telemedicine to improve patient care.
- Ensure appropriate reimbursement of providers for their services.
- Work together to develop payment models that hold all stakeholders accountable and align incentives to work towards better care.
- Leverage innovative payment models such as the CMMI Next Generation ACO that waive the rural residency and originating site restrictions to implement solutions that apply telemedicine to palliative care.
- Rigorously measure outcomes to evaluate the impact on the Quadruple Aim.

# INCENTIVIZING EARLIER PALLIATIVE CARE REFERRALS & CONVERSATIONS



**Participants:** Sarah M. Adelman; Steve Dumke, MBA, LNHA, FACHE; Soumen Samaddar, MD, DABFM;  
**Facilitator:** Stephen Wagner, Ph.D, FACHE, FACMPE, FACHT, FAcEM

Despite the physical, psychosocial, and spiritual benefits of palliative care, end-of-life discussions between physicians and patients are often late, inadequate, or never occur at all. This is especially the case in New Jersey, which ranks last in the nation in providing efficient palliative care intervention. Effective and timely end-of-life conversations result in, increased patient satisfaction, better informed patient and family decisions regarding care goals, and 37.5 percent lower costs among patients. However, only two-thirds of NJ adults have discussed their end-of-life care preferences and wishes, and only 25 percent are familiar with advanced directives and living wills. This can be attributed to a lack of public awareness to the benefits of palliative care and ineffective or nonexistent physician communication. Equipping physicians with the training and tools to have these conversations is vital since about two-thirds of physicians indicate that they have never received training on how to conduct end-of-life discussions and feel unprepared as to when and how to initiate discussion. Effective policies and incentives that promote these discussions should also be explored; for instance, CMS recently introduced reimbursement for advanced care planning discussions and are exploring other models for reimbursement, while private insurers have also begun reimbursing for end-of-life conversations. These models highlight the importance of these conversations and promote timely and effective discussions that will ensure patients and families understand their prognosis and can make better informed decisions that align with their care goals, values, and wishes.

## PROJECT GOALS

- ✓ Identify ways to increase provider training in palliative care practices and standards and better equip physicians to conduct early goals-of-care conversations.
- ✓ Ensure that methods are in place to identify patients in need of a palliative care consult.
- ✓ Identify strategies to build public, professional and policy-maker awareness of the importance of palliative care principles and practices.
- ✓ Propose potential policy and payment innovations that incentivize early provider discussions with an emphasis on allowing patients to make informed decisions based on their values.

## RECOMMENDATIONS

### EDUCATION:

- Incorporate curriculum around palliative care referrals and the physician-patient end-of-life conversation into medical school education.
- Improve the quality of physician education by requiring that providers of end-of-life CME track participants and demonstrate improvements in measurable patient and family oriented outcomes within 2 years.
- Allow physicians who provide no end-of-life care to opt out from existing and future CME mandates on end-of-life care to decrease physician burden and improve data.
- Incentivize physicians without specialty training in palliative care to complete additional education in palliative care (e.g., MOLST, POLST training).
- Identify partners to establish a learning collaborative among payers, providers, and physicians.
- Work with stakeholders to develop a PR campaign that promotes palliative care, early conversations, and advanced care planning (e.g., expanding NJ's Conversation of Your Life Program).
- Develop outreach strategies through multiple mediums (print, broadcast, videos, web) to raise public awareness and begin to change culture.

### CLINICAL CRITERIA:

- Develop or select clinical criteria that can be used to trigger a palliative care consult or referral using:
  - 1) utilization data;
  - 2) Medicare risk score;
  - 3) patient interview answers; and
  - 4) predictive modeling tools/algorithms.
- Develop a team to adopt a standardized palliative care screening tool for use by physicians.
- Establish Best Practice Standards for the content of the physician-patient conversation.  
Consider statewide use of pre-recorded Advanced Care Planning discussion videos to help guide conversation (e.g., Dr. Angelo Volandes' Advanced Care Planning Videos).
- Develop decision trees to provide high-quality, integrated, patient-centered, family-oriented outcomes of care.
- Develop a clear, transparent process for health care decisions to be made for patients who have no one to represent them.

### BENEFIT / POLICY CHANGES:

- Work with payers to identify incentives that could be applied to specific palliative care related outcomes, such as conducting caregiver needs assessments and goals of care discussions.
- Include a palliative care consultation as a standard benefit with no copay and adding 99497 and related CMS-reimbursable codes to NJ's Medicaid covered benefits.
- Evaluate different funding approaches such as enhanced fee-for-services, per-member/per-month, and shared savings/shared risk that could promote palliative consults and care.
- Allow palliative care benefits to be provided concurrently with disease treatment.
- Work with professional associations to advocate at the State and Federal level for regulatory changes that promote and heighten the importance of early end-of-life discussions

### SUMMARY

Effective and timely palliative care and end-of-life discussions are extremely important in the delivery of patient-centered care. Patients who receive palliative care spend less time in intensive care, are less likely to die in ICUs, and receive less unnecessary tests, which improves satisfaction and lower cost.

Unfortunately, due to insufficient physician education, unpredictable patient and family factors, policy and incentive misalignment, and poor coordination of care, these conversations often don't occur as needed.

To address these barriers, systems need to identify and implement clinical criteria and demographic information that will trigger end-of-life conversations for those who could benefit. Further incentives should be implemented to promote these discussions and increased education for physicians and clinicians on end-of-life care options and advanced care planning should occur. There is little doubt that talking with patients about life expectancy is a skill we can improve with attention and experience and we need to do so. Finally, in order to improve outcomes and change culture, we must better educate the public and our communities about the benefits, value, and importance of palliative care and advanced care planning so that patient and family goals, values, and wishes are honored and the overall quality of end-of-life care is improved.



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## **Executive Summary**

Design a System of Best Practices to Routinely Assess Newly Admitted Patients for End of Life Care Planning

**Group Members:** John Pool, MD; Ralph Pothel, MD, MBA; Gregory Rokosz, DO, JD, FACEP; Adam Young, Esq.; SHU Facilitator: Stephen Wagner, PhD, FACHE

**Background:** Many patients are transferred to an acute care hospital from an assisted living or long term care facility. These are often medically complex, frail, and vulnerable patients. It is widely agreed that conversations regarding end of life care planning are better conducted before the patients arrive at the hospital emergency department. Documentation regarding the goals of care that follow from such conversations is key to ensure proper transitions of care and the respecting of patient autonomy and should be available to EMS, the emergency department, and across the entire continuum of care. POLST is an ideal vehicle to achieve this aim. All too often patients arrive at an acute care hospital without the benefit of prior discussions on end of life goals of care and without an executed POLST form or other documentation.

**Project Goals:** The group researched care transition and intake procedures in New Jersey. The group also reviewed physician and nursing roles and responsibilities regarding end of life care planning in the various settings and the current tools available to support these efforts. Identification of barriers to success and best practices to enhance optimal end of life care planning and implementation were also a priority.

**Discussion:** Hospitals, assisted living facilities, and long-term care facilities need to develop and implement policies to better identify and address end of life issues at the time of admission. Patients near the end of life are usually medically complex and have a multitude of healthcare providers across many healthcare settings that are involved in their care, including multiple physician subspecialists. Conventional wisdom is that “no one” is taking specific ownership of this issue and if everyone is in charge, no one is in charge. Fragmentation of care can pose a significant barrier to serious advance care planning.

Lack of adequate education across the healthcare system was identified as another challenge. The need for additional specialized expertise in Palliative Care was also clearly apparent. Funding for effective models to deliver better end of life care in New Jersey was a further identified need.

Regarding use of tool kits and triggers to initiate the advance care planning process, the literature is already ripe with such resources. The task before us all is to educate the various stakeholders in this important area of healthcare that ultimately affects us all. Education efforts need to include the public, clergy, medical and nursing professions, relevant legal community, patients, families and in particular, the assisted living and long term care facility community. Education is a prerequisite to effective implementation of end of life care strategies. Our regulatory partners can clearly assist in these efforts.



Finally, the group agreed that formal expertise in advance care planning is essential to achieve all aims. Inpatient and outpatient Palliative Care physicians in concert with multi-disciplinary palliative care teams are essential to achieve optimal outcomes. Commitment to Palliative Care training programs, including Palliative Care fellowship programs for physicians, is important for the future care of our aging population.

**Recommendations/Action Steps:** Based on our findings, the group prepared a list of best practices and recommended follow-up items aimed at facilitating discussions on end of life care planning at the most opportune time and to affect meaningful change. Such recommendations are as follows:

- Mandatory education in the Assisted Living Setting. These facilities are licensed by the NJDOH. Annual education should be required for residents, families, clinical staff, and facility administration with a mandatory component for POLST education. The content of such educational programs should have regulatory oversight.
- Hospitals, long term care facilities, and assisted living facilities should implement policies to better identify and address end of life issues at the time of admission (i.e. triggers). Best practices should be freely shared across the state.
- Ensure that assisted living and long term care facilities provide documentation/information on goals of care when transferring patients to acute care settings. The use of the POLST form should be central to this effort.
- Identify opportunities and funding for further development of Palliative Care Fellowships in New Jersey (currently only one exists).
- Consider a CLE requirement in end of life care for Elder Law, Wills and Estate, and Health Law Attorneys.
- Support efforts for continued refinement, education on, and implementation of POLST in New Jersey.
- Required education in end of life care for physicians, New Jersey medical students and residents, and others in providing care at end of life.
- Collaboration on efforts for public education.
- Development of technological solutions to support education, data tracking, and tool kits for accessing newly admitted patients for end of life care planning.
- Maintain a focus on the continuum of care in the area of advance care planning (inpatient and outpatient).
- Collaboration with payers (government and commercial) to address compensation concerns regarding the provision of routine and expert Palliative Care services.
- Consideration of the formation of a broader coalition of parties with an interest and expertise in this area to further the initial efforts of NJHELA. This coalition should include, without limitation, stakeholders from academia/medical education, government, NJHA, MSNJ, NJAHP, the public, state hospice association, NJ State Chapter of AARP, various NJ Healthcare facilities across the continuum of care, EMS, physician groups, and the relevant sections of the NJ Bar Association. Cooperation of such a coalition with the NJ Advisory Council on End of Life Care would be particularly advantageous.

**Summary:** We believe that if the above action items are implemented, conversations on end of life care will occur at a greater frequency and in a more timely manner. Such efforts cannot help but lead to improved care, quality of life, and respect for patient autonomy as end of life nears.

## **The State of Palliative Care Fellowships in New Jersey**

**Joseph P. Costabile, MD**

**Paul Matey, Esq.**

**Maureen Schneider, PhD, MBA, RN, CPHQ, NEA-BC, FACHE**

**Frank L. Urbano, MD, MBA, FACP, CHIE**

**Facilitator - Ning Zhang, PhD, MD, MPH, Seton Hall University**



The escalating awareness and demand for palliative care resources has led to rapid growth in the number of patients requiring palliative care both in New Jersey and in the United States. In order to meet this need, it is essential that the number of palliative care fellowships increase immediately and meet the requirements and guidelines established by the Accreditation Council for Graduate Medical Education (ACGME) in order to provide the optimum quality care for New Jersey patients, families and community.

In order to determine the status of palliative care fellowships in New Jersey, as well as any barriers that might be present in implementing such programs, we conducted an outreach to existing programs and other centers in New Jersey that might be viable candidates for the development of a palliative care program where one did not already exist. Leadership of existing programs at Cooper University Healthcare and Rowan SOM identified adequate funding, lack of interest and a variable degree of executive support as barriers to the ongoing existence of their programs. Neither individual could confirm that their programs would continue beyond the upcoming academic year.

Leadership of potential sites for palliative care fellowship programs (RWJUH – New Brunswick, University Hospital – Newark, and Newark Beth Israel Medical Center) identified the following barriers to developing these programs:

1. **Viable Funding Option** – There is presently a moratorium by CMS on funding of new fellowship programs.
2. **Dedicated Program Structure and Faculty Support** – A need to provide for dedicated faculty to staff a fellowship program that does not have competing responsibilities was identified.
3. **Model to Support Sustainability** – Low levels of reimbursement for palliative care services necessitates cross-subsidizing from other clinical specialties, which, in turn, impacts the sustainability of any palliative care program and fellowship.
4. **Executive Support** – This may require ‘out of the box’ thinking because of the long range positive impact of developing and supporting a palliative care fellowship.

As a result of this research, the following action steps are recommended:

1. With the support and advocacy of the Medical Society of New Jersey (MSNJ), the New Jersey Hospital Association (NJHA), and the New Jersey Association of Health Plans (NJAHF), actively encourage AGCME-accredited programs in either internal medicine or family medicine to establish a palliative care fellowship. Additionally, develop and support Palliative Care Advanced Practice Nurse (APN) programs in New Jersey.
2. Develop a workgroup of stakeholders to discuss the feasibility of various funding mechanisms including federal and state educational grants, institutional grants (e.g., hospital or other institutions), or professional foundation grants (e.g. the AMA foundation).
3. Discuss with regulators the importance of establishing palliative care fellowships, including providing support for the Palliative Care and Hospice Education and Training Act (HR 1676 and S693) and funding the Palliative Care APN role.
4. Continue to work with individual institutions (as identified in this poster) to explore the feasibility of developing palliative care fellowships and APN programs in NJ hospitals.

## **NJHELA EXECUTIVE SUMMARY**



### ***IDENTIFICATION OF INDIVIDUALS WITH PALLIATIVE CARE AND HOSPICE NEEDS***

#### ***WHO PRESENT IN THE EMERGENCY DEPARTMENT***

ALISON DORSEY, MPH, MARC J. LEVINE, MD, KENNETH N. SABLE, MD, MBA, FACEP, NING J. ZHANG, MD, PhD, MPH

## **I. PROBLEM STATEMENT AND BACKGROUND**

Patients with advanced and end-stage disease in need of symptom management and pain relief often present to the emergency department (ED).<sup>1</sup> Research focusing on patients who were at the end-of-life found that these patients often did not receive the care they anticipated.<sup>2</sup> Once in the acute care setting, the patient's objectives and goals may be in direct contrast to the ED strategies of life-prolonging treatment.<sup>3</sup> The need for palliative care and end-of-life care in the ED becomes apparent when considering that these medically complex patients present to EDs every day. Providers of emergency care have a unique opportunity to support palliative care interventions early in a patients' disease trajectory, promoting quality of life as well as reducing cost associated with treatments.<sup>4</sup>

## **II. GOALS**

The primary goal is to provide a roadmap for integrating palliative care services into the emergency department setting via the implementation of a screening tool. In the short term, the tool can be used to identify individuals who might benefit from palliative care services and connect them with the appropriate resources at the time of service and/or in the post-acute setting after discharge. Longer term goals include reducing potential future ED visits by patients with chronic palliative care needs, reducing readmission rates, decreasing length-of-stay (LOS) for patients that do require hospitalization, and improving overall patient satisfaction, among others.

## **III. PALLIATIVE CARE SCREENING TOOL**

A two-step screening tool was developed utilizing components of existing content and best practices identified through a literature search. Step one involves a top-level filter based on triage nursing-entered patient diagnoses. Patients with certain categories of diseases would trigger physicians to complete step two of the palliative screening tool to determine if an official order for a palliative care consultation is required and appropriate. This two-step process builds upon existing ED work flow processes and should therefore not be overly burdensome to practitioners. This screening tool can be implemented manually via paper charts, but more ideally can be embedded within the Electronic Health Record (EHR) for a truly automated and efficient solution.

## **IV. FUTURE ACTION STEPS**

- Work with commercial health plans and NJ Department of Human Services to identify codes for billing palliative care services on both Medicaid and commercial side, potentially mirroring Medicare.
- Additional training may be needed to help providers become effective communicators with regard to palliative care and end-of-life issues. One potential guide to improving conversations about end-of-life, "Serious Illness Conversation Guide" is available through Ariande Labs.
- Work with EHR vendors to build workflows and screening tools directly into EHR applications.

## **Home Based End of Life/Palliative Care**

Mary Ann Christopher, Christopher Gribbin, Gail Kosyla  
Facilitator: Terrence Cahill (Seton Hall)

### **PROBLEM:**

While public and private insurers have typically provided hospice services to support individuals who are at the end of their lives, it is less common for insurers to provide home based palliative care support. As a result, patients receive care unnecessarily in emergency departments and acute care hospitals. Demonstration and pilot programs funded by commercial insurers and CMS suggest that home based palliative care improves quality, enhances the patient and family experience and reduces total cost of care. What needs to change in order for home based palliative care services to be generally available to patients and their families?

### **WHAT NEEDS TO CHANGE?**

- Palliative care should not be exclusively associated with impending concern for death.
  - While EOL patients may benefit from palliative care, the need for palliative care should be triggered by a “significant burden of illness,” not exclusively an end-of-life prognosis.
- Home based palliative care reimbursement should not require that a patient is homebound.
  - While palliative care may include the homebound, others with a “significant burden of illness” should also qualify for reimbursement support.
- Home based palliative care should not require that all curative and/or ameliorative care is discontinued.
  - Reasonable curative/ameliorative care should also qualify for reimbursement support.

### **RECOMMENDATIONS:**

1. An inter-professional palliative care team is proposed to include a board certified or equivalently experienced palliative care physician, advanced practice nurse, physician assistant, nurse, social worker, nutritionist, pharmacist, and other relevant ancillary supports.
2. Insurance coverage for palliative services should not prohibit continued pursuit of potentially curative or ameliorative therapy.
3. Models for delivering palliative care on a per member per month basis (eg, Medicare’s CMMI project, Aetna’s project) are suggested as a method for providing these services.
4. Charge our professional associations to advocate at the State and Federal level for legislative and regulatory changes that allow for the fullest implementation of home-based palliative care.
5. Engage Health, Research and Educational Trust of NJ (HRET) in establishing a learning collaborative among payers, physicians and providers to implement these recommendations including appropriate Pilots.



NEW JERSEY  
HEALTHCARE EXECUTIVE  
LEADERSHIP ACADEMY

EST. 2016

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**EOL PROJECT PRESENTATIONS**





## Project Assignments | Overview

1. Describe evidence based/best practice informed strategies to enhance the capacity of primary care providers to integrate palliative care into their practices.
  - Mary Campagnolo, MD, MBA
  - Kenneth Kobylowski, Esq.
  - Darrell Terry, Sr., MHA, MPH, FACHE
  - Jennifer Velez, Esq.
  - SHU Faculty: Anne Hewitt, PhD
2. Design a plan to enhance the effective implementation and sustainability of a telehealth program for palliative care.
  - Kevin O'Dowd, Esq.
  - Ashish Parikh, MD
  - Bruce Pomeranz, MD, MMM
  - Todd Way
  - Judy Wright, MD
  - SHU Faculty: Nalin Johri, PhD, MPH
3. Develop novel policies and incentives for early conversations about (and referrals to) palliative care by physicians.
  - Sarah Adelman
  - Steve Dumke, LNHA, FACHE
  - Soumen Samaddar, MD
  - SHU Faculty: Stephen Wagner, PhD, FACHE, FACMPE, FAcEM
4. Design a system of best practices to routinely assess newly admitted patients for end of life care planning.
  - John Poole, MD
  - Ralph Pothel, MD, MBA
  - Gregory Rokosz, Esq., DO, FACEP, FAcOEP
  - Adam Young, Esq.
  - SHU Faculty: Stephen Wagner, PhD, FACHE, FACMPE, FAcEM
5. Identify opportunities to develop Palliative Care fellowships in New Jersey teaching hospitals.
  - Joseph Costabile, MD
  - Paul Matey, Esq.
  - Maureen Schneider, PhD, MBA, RN, CPHQ, NEA-BC, FACHE
  - Frank Urbano, MD, MBA, FACP
  - SHU Faculty: Ning Jackie Zhang, MD, PhD, MPH
6. Design a plan to integrate the best practices of palliative care into the ER.
  - Alison Dorsey, MPH
  - Marc Levine, MD
  - Kenneth Sable, MD, MBA, FACEP
  - SHU Faculty: Ning Jackie Zhang, MD, PhD, MPH
7. Improving access to homecare.
  - Mary Ann Christopher, MSN, RN, FAAN
  - Christopher Gribbin, MD
  - Gail Kosyla, CPA, MBA/MS, FACHE
  - SHU Faculty: Terry Cahill, EdD, FACHE



# A Portfolio of Palliative Care Strategies for Primary Care

**Mary Campagnolo, MD, MBA,** Virtua

**Kenneth Kobylowski, Esq.** AmeriHealth NJ

**Darrell K. Terry, Sr. MHA, MPH, FACHE** Newark Beth Israel Medical Center

**Jennifer G. Velez, Esq.,** RWJBarnabas Health

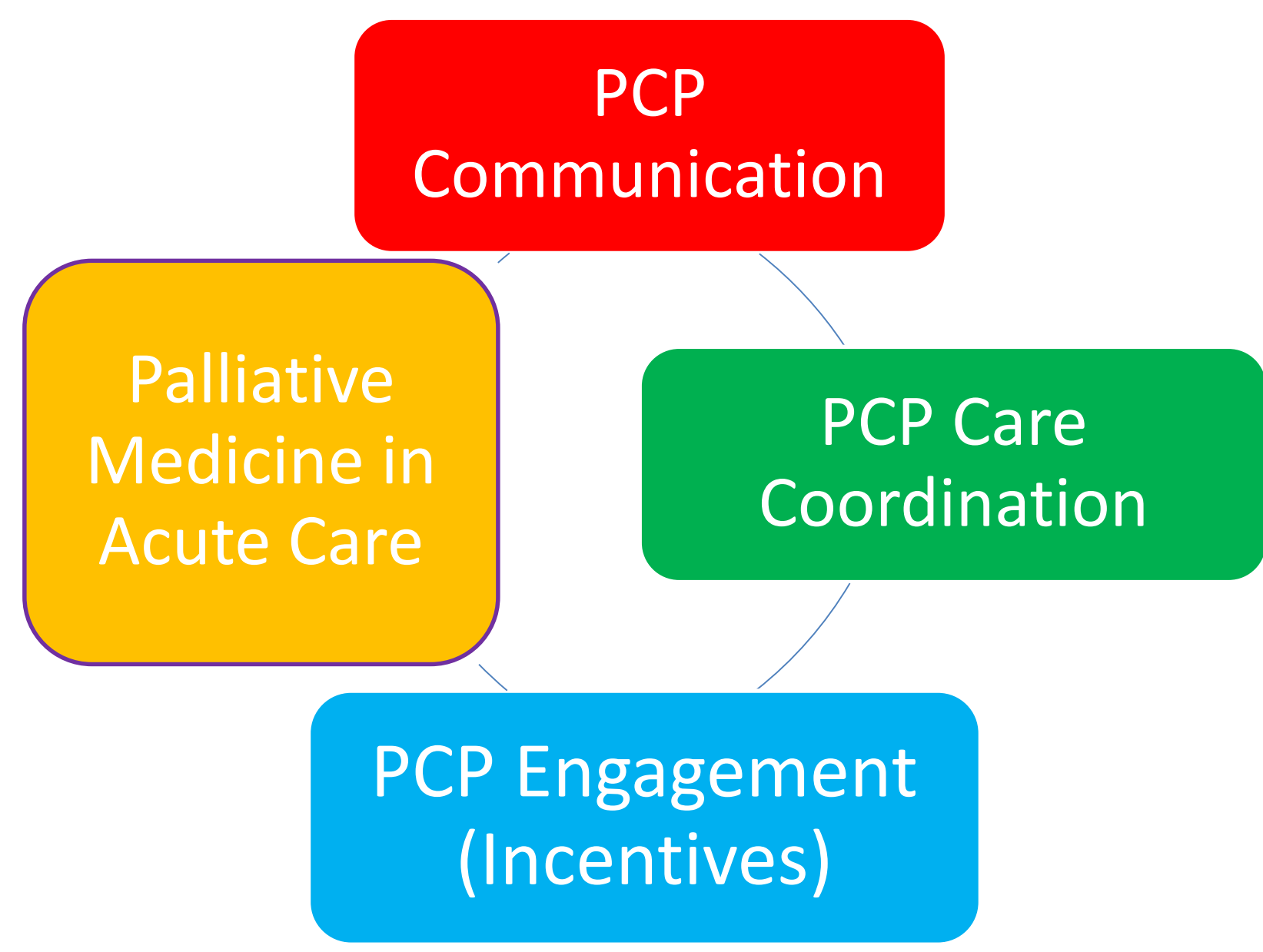
## Introduction/Background

NJ's health professionals seek to increase the use of Advanced Care Planning (EOL) and to prepare and encourage Primary Care Practitioners (PCPs) to manage their patients' palliative care needs. The optimal scenario involved an informed public and an educated and engaged PCP. Group 1 explored opportunities, best practices and solutions for overcoming EOL barriers.

## Project Goals

- ✓ Identify PCP care coordination and workflow
- ✓ Review available industry insurance incentives
- ✓ Examine acute care to palliative care transition protocols
- ✓ Find best practice examples of EOL/ Advanced Care Planning communications

## Mindmap of Projects

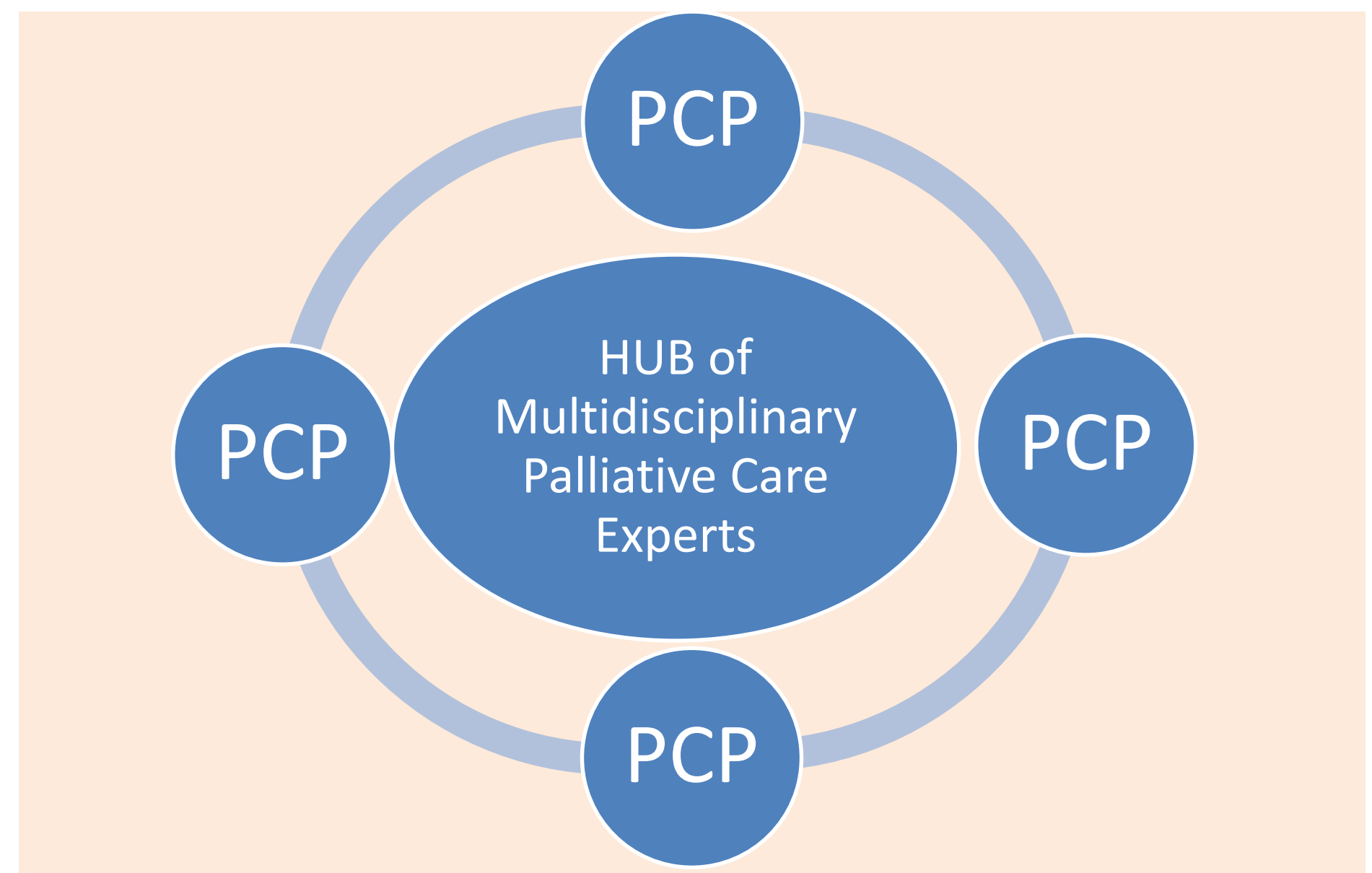


Group Facilitator, Anne M. Hewitt, PHD Seton Hall University

## Discussion

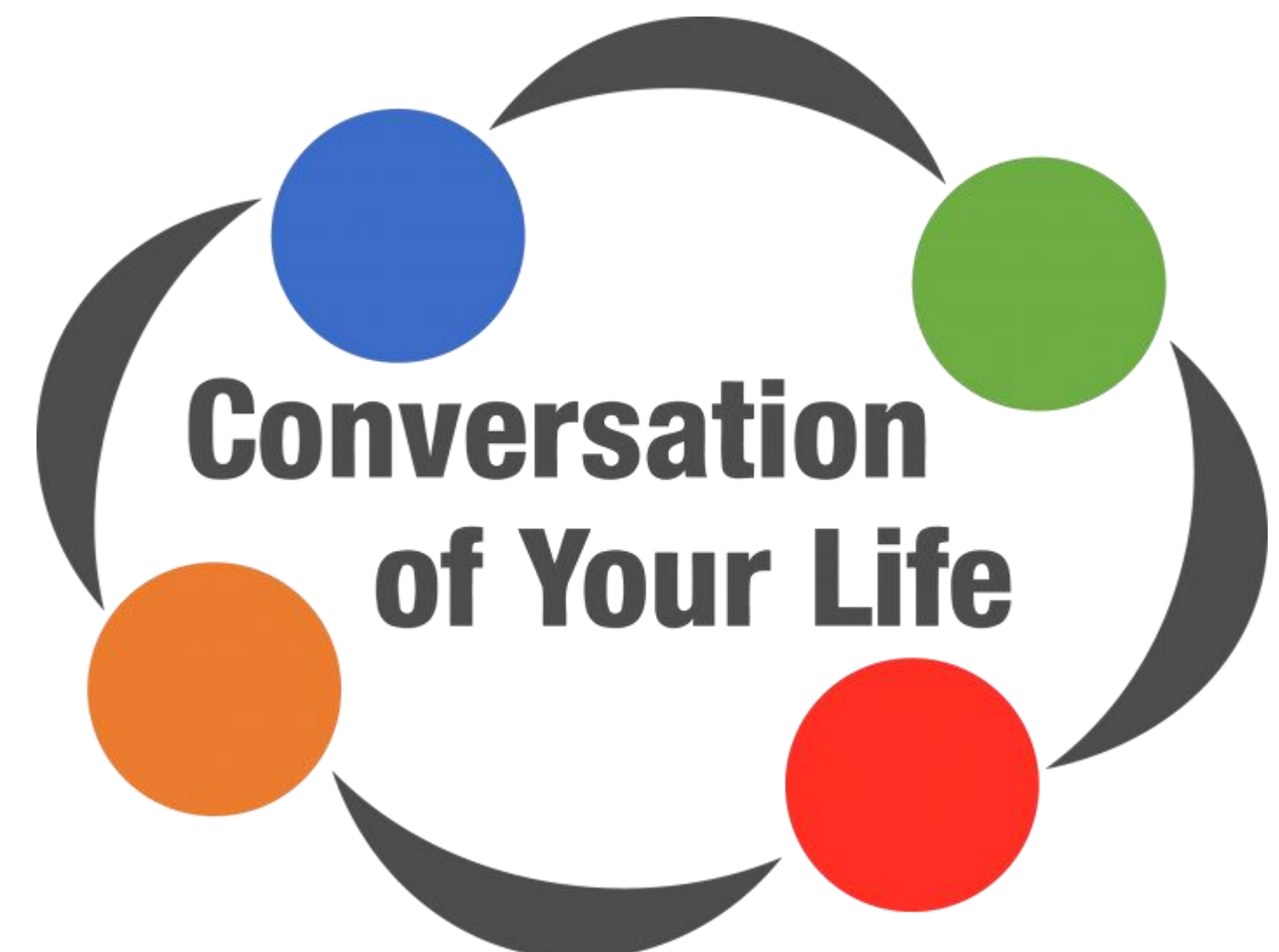
CMS began reimbursing for advanced care planning in 2016 under CPT codes 99497 and 99498 with no limit on the number of times the codes can be billed and no place of service limit; most commercial payors reimburse for these activities under evaluation and management (E&M) codes

## Project ECHO



Provide PCPs support to manage palliative care through video-conference participation in a hub/spoke model with identified, multi-disciplinary experts.

## Conversation of your Life



## Incentives/ Criteria

NJ Insurance Incentive-PCP Criteria
# of Palliative Care (PC) Consults
# of patients with documented Directives
# of appropriate referrals to PC services
Evidence of PC clinical skill integration in PCP practice
Costs of care in the last six months-1 year of life

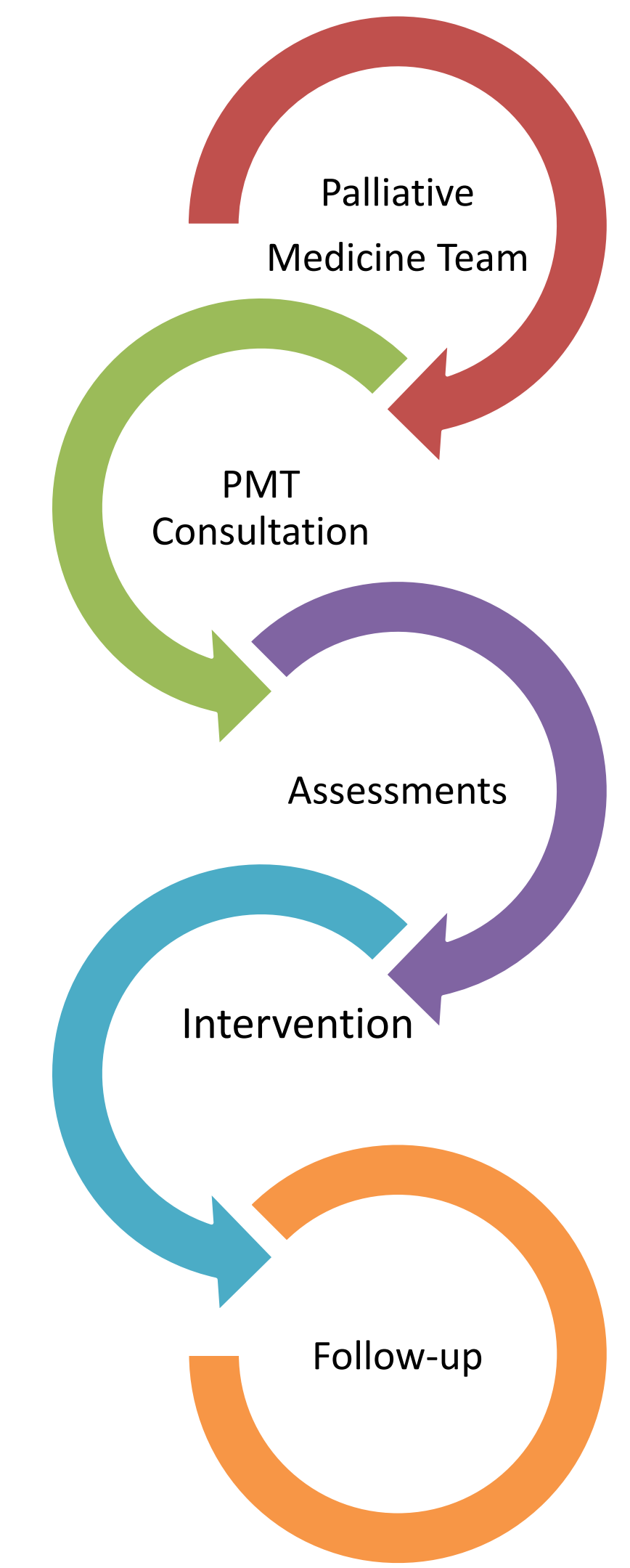
## Action Steps !

- \* Encourage active, weekly participation among PCPs for collaborative, case-based learning, including patent case presentations with didactic learning and mentoring.
- \* **Launch Statewide public relations campaign by supporting the existing efforts of the NJ HealthCare Quality Institute's "Conversation of Your Life" in conjunction with the Mayor's Wellness Campaigns.**
- \* Increase payor-engagement with PCPs to identify members in the patient base appropriate for services through data analytics
- \* **Develop payor clinical teams designated to work with PCP practices to provide services and identify ancillary resources available (pain management; behavioral health; social services)**
- \* Advocate enhanced payments for PCP practices who have completed palliative care training courses

## PCP Care Coordination

- **Multi-visit strategy** – Avoid trying to complete all in one visit
- **Utilize practice staff** (Med Asst., LPN/RN) and Advanced Practice Clinicians (APN/PAs) to introduce discussion & facilitate document completion
- **Digital Aides:** Goals of Care.org videos, NJHA NJ POLST state wide repository
- **Ongoing best practice education:** medical school, residency & CE curriculums

## Acute Care → Palliative Care



## Summary

Our Portfolio of Advanced Care Planning and Palliative strategies provides a template for New Jersey to meet EOL challenges by engaging practitioners, administrators. and healthcare plans.

# The Current State of Telemedicine in Palliative Care in New Jersey

Kevin O’Dowd, JD, Cooper University Health Care

Ashish D. Parikh, MD, Summit Medical Group

Bruce Pomeranz, MD, MMM, Kessler Inst for Rehab

Todd Way, MHA, Inspira Health Network

Judy Wright, MD, UnitedHealthCare

## Introduction/Background

Enhancing patients’ and caregivers’ access to healthcare could greatly improve delivery of palliative care and support at the end of life. Telemedicine can positively impact comfort, satisfaction, and outcomes by allowing patients to access care from a variety of locations including their own homes. Thus telemedicine can be another tool towards achieving the Quadruple Aim of better outcomes, lower costs, improved patient experience, and higher professional satisfaction as it relates to end-of-life and palliative care

## Project Goal

- Assess the status of Telemedicine in palliative care in New Jersey
- Propose considerations for developing payment models

## Telemedicine

Telemedicine includes but is not limited to:

Live virtual visits

Store-and-forward

Remote patient monitoring

**Sites of Care:** Home, Medical Offices, Skilled Nursing Facilities, Acute Rehab, Hospital, Hospice.



**Participants:** Patient, Caregiver/Family Members, Providers, One-to-one or in group conferences.

Use cases for telemedicine in palliative care
Discussion of advanced care plans
Pain and other symptom management
Medication review and adjustment
Family meeting with patients and their caregivers
Evaluation of a patient while visiting nurse is at the home
Counseling for behavioral issues
Evaluation and follow up of wounds
Care for acute issues such as upper respiratory infections
Chronic condition management
Review and discussion of test results

Group Facilitated by: Nalin Johri, PhD, MPH, Seton Hall University

Medicare Coverage of Telemedicine	
Type of service:	<ul style="list-style-type: none"><li>Must use an interactive audio and video telecommunications system that permits real-time communication.</li><li>Asynchronous (store and forward) technology is NOT covered except in Alaska and Hawaii.</li></ul>
Originating site (location of patient) is limited to:	<ul style="list-style-type: none"><li>The offices of physicians or practitioners;</li><li>Hospitals including Critical Access Hospitals (CAH);</li><li>Rural Health Clinics;</li><li>Federally Qualified Health Centers;</li><li>Hospital-based or CAH-based Renal Dialysis Centers (not private dialysis centers);</li><li>Skilled Nursing Facilities (SNF); and</li><li>Community Mental Health Centers (CMHC).</li><li>The patient home is NOT a covered originating site.</li></ul>
Geographic location of the patient is limited to:	<ul style="list-style-type: none"><li>A rural Health Professional Shortage Area located either outside of a Metropolitan Statistical Area or in a rural census tract; or</li><li>A county outside of a Metropolitan Statistical Area.</li></ul>
Medicaid Coverage of Telemedicine in New Jersey	
<ul style="list-style-type: none"><li>Practitioner must be licensed in NJ to prescribe medications.</li></ul>	
<ul style="list-style-type: none"><li>Covers telepsychiatry psychiatry, when practiced by psychiatrist or psychiatric advance nurse practitioner to a patient at a mental health clinic or outpatient hospital.</li></ul>	
<ul style="list-style-type: none"><li>Coverage is only available for interactive audio-video, when a telepresenter is with the patient.</li></ul>	
<ul style="list-style-type: none"><li>As noted below, currently there is no telemedicine parity law; however, a bill regarding this is currently under review</li></ul>	

## Laws and Regulations: New Jersey

- No direct regulations or statutes that address telemedicine.
- Current laws require that to prescribe meds:
  - The doctor must be licensed in NJ.
  - The doctor must conduct an appropriate and sufficient history and physical examination before prescribing.
- Proposed bill would allow health care provider to establish a proper patient-provider relationship and provide health care services through the use of telemedicine.

## Proposed Federal Bills

CONNECT Act: (a) Allows experiments with telehealth in alternative payment models and incentive programs and (b) expands remote patient monitoring programs for chronic care, rural and underserved populations.

CHRONIC Act: (a) Allows freestanding dialysis facilities to be originating site for telemedicine, (b) eliminates geographic restrictions on telestroke consultation, (c) expand telehealth coverage under Medicare Advantage Plan B, and (d) gives ACOs more flexibility to use telehealth services.

Established and Experimental Payment Models	
Fee-for service	<ul style="list-style-type: none"><li>Predominant model for reimbursement</li><li>Does not cover any services not on the fee schedule</li></ul>
Capitation	<ul style="list-style-type: none"><li>Emerging payment model, not commonly used</li><li>Providers receive a fixed payment for each individual</li><li>Reduced cost from using telehealth services would benefit the provider/provider organization</li><li>Holds substantial risks for providers</li></ul>
Accountable Care Organizations (ACOs)	<ul style="list-style-type: none"><li>Providers’ payments tied to the total costs of care for an attributed patient population</li><li>Incentive to utilize technologies that increase patient access, improve quality of care, and reduce cost</li><li>Shared risk and shared benefit between provider and payer</li></ul>
Bundled payment model	<ul style="list-style-type: none"><li>Currently being utilized on a limited basis, with exploration for expanding use</li><li>E.g. Bundled Payment Care Improvement Initiative (BCPI) – being used by Medicare; looking to expand flexibility in the use of telehealth with lower restrictions</li></ul>

Metrics to Measure Impact	
Patient experience:	<ul style="list-style-type: none"><li>Quality of life</li><li>Patient / family / caregiver satisfaction</li><li>Experience with telemedicine technology</li><li>Perception of experience in comparison to in-person encounter</li></ul>
Quality:	<ul style="list-style-type: none"><li>Percentage of patients with advanced directives</li><li>Functional assessment</li><li>Pain and symptom management</li><li>Hospice, hospital, ICU, and SNF util during last 6 months of life</li><li>Avoidable adverse events (e.g. falls, infections, pressure ulcers, etc)</li><li>Percentage of patients dying at home</li></ul>
Cost/Utilization:	<ul style="list-style-type: none"><li>Total ED visits; avoidable ED visits</li><li>Hospitalizations and readmissions</li><li>Utilization of outpt services (Is teledemed substitutive or additive?)</li><li>Drug/pharmacy costs</li><li>Total cost of care (PMPM)</li></ul>
Provider satisfaction:	<ul style="list-style-type: none"><li>Quality of encounter (technical and interpersonal)</li><li>Ease of use, sufficiency for obtaining H&amp;P</li><li>Providers perception of patient satisfaction</li><li>Provider sat, interest in using more frequently in future</li></ul>

## Discussion

Telemedicine is well-aligned with the needs of palliative and end-of-life care. Current models for type of care, delivery modality, coverage, and reimbursement are variable. New models should be tested with measurement of impact and sustainability.

## Action Steps

- Leverage the collaborative networks forged from the first cohort of the NJHELA to:
- Assist in passing laws that promote safe and secure use of telemedicine. Ensure appropriate reimbursement.
  - Develop payment models that hold all stakeholders accountable and align incentives towards better care.
  - Apply telemedicine to palliative care and measure the impact on the Quadruple Aim.

# INCENTIVIZING EARLY PALLIATIVE CARE REFERRALS AND CONVERSATIONS

Sarah Adelman, *New Jersey Association of Health Plans*     Steve Dumke, MBA, LNHA, FACHE, *Christian Health Care Center*  
Soumen Samaddar, MD, DABFM, *Hunterdon Healthcare*

## Introduction

Studies have shown that despite the physical, psychosocial, and spiritual benefits of palliative care, physicians end-of-life discussions with patients are often late, inadequate, or never occur at all. As a result, quality and patient/family experience suffers and costs increase. Increasing the timeliness and effectiveness of these discussions is imperative to ensuring that the patients and families understand the prognosis and nature of an illness so that they can make informed decisions that align with their care goals, values, and wishes.

## Project Goals

- Identify ways to increase provider training in palliative care practices and standards and better equip physicians to conduct early goals-of-care conversations.
- Ensure that methods are in place to identify patients in need of a palliative care consult.
- Identify strategies to build public, professional and policy-maker awareness of the importance of palliative care principles and practices.
- Propose potential policy and payment innovation that incentive early discussion provider discussions with an emphasis on allowing patients to make informed decisions based on their values.

## Background

A Dartmouth Atlas Study showed that New Jersey is last in the nation in providing efficient palliative care intervention. Major drivers for this ranking include: a high total cost of care in the last 6 months of life, avoidable inpatient stays, and high ICU spend.

Research shows that end-of-life discussions result in 37.5 percent lower costs among patients, and patients with higher costs had worse quality of life in their final weeks.

Only two-thirds of NJ adult residents have discussed their end of life care preferences with only 34 percent having documented their End-of-Life wishes.

Only 25 percent of NJ residents are familiar with advanced directives or living wills.

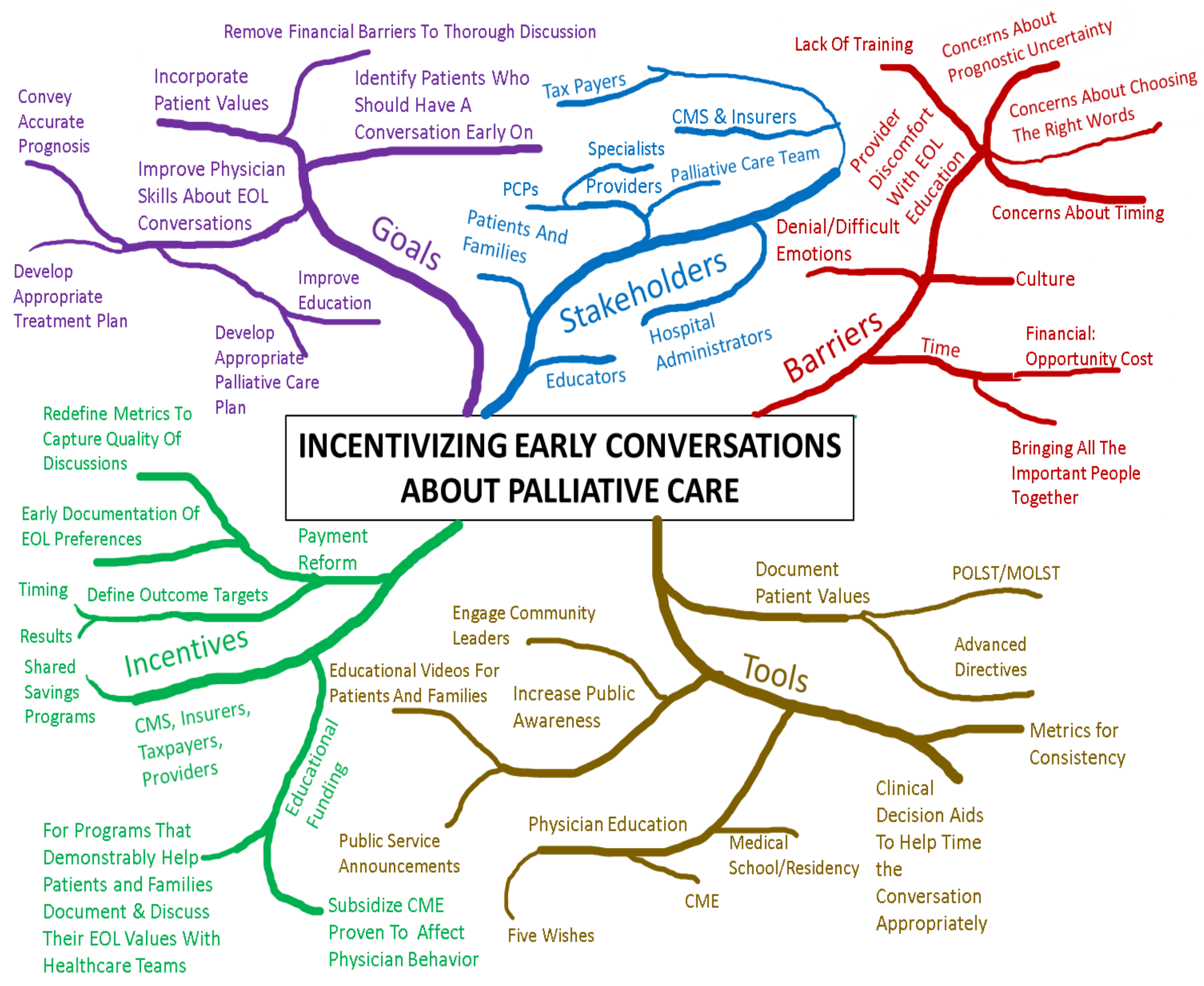
About two-thirds of physicians in a recent survey said they have never received any training on how to conduct end-of-life discussions

The Center for Medicare and Medicaid Services has recently introduced reimbursement for advanced care planning discussions and are exploring other models for reimbursement.

Multiple private insurers across the country have begun reimbursing physicians for having end-of-life conversations.

Group Facilitated by: **Stephen Wagner, Ph.D, FACHE, FACMPE, FACHT, FAcEM**, Seton Hall University

## Mindmap of Project



## Barriers and Issues

### Education

- Generalist physicians should be trained to develop competencies to practice primary palliative care.
- Ongoing clinician training after graduation
- Explore incentives for increased training
- Easily accessible and effective resources
- Palliative care fellowships

### Patient and Family Factors

- Normalization of death and dying conversations
- Build awareness of palliative care and its benefits
- Provide resources to the community and promote community support
- Highly skilled and sensitive communication
- Individualized with focus on patient values

### Timing Uncertainty

- Clinical criteria is needed
- Community collaboration and awareness
- Clear and transparent processes

### Policy and Payment Alignment

- Incentivize early discussion
- Improve access
- Competitive reimbursement

### Coordination of Care

- Communication between physicians and providers
- Communication between providers and payers
- Use of technology

## Action Steps

### Education:

- Improve the quality of physician education by requiring that providers treating patients with advanced illness or in the last months of life receive CME track participants and demonstrate improvements in measurable patient and family oriented outcomes within 2 years
- Allow physicians who provide no end-of -life care to opt out from existing and future CME mandates on end-of-life care to decrease physician burden and improve data.
- Incentivize physicians without specialty training in palliative care to complete additional education in palliative care. (MOLST, POLST training)
- Identify partners to establish a learning collaborative among payers, providers, and physicians.
- Work with community agencies and providers to develop a PR campaign that promotes palliative care, early conversations, and advanced care planning. (e.g. expanding NJ's *Conversation of Your Life* program)
- Develop outreach strategies through multiple mediums and (print, broadcast, videos, web) raise awareness.

### Clinical Criteria:

- Establish Best Practice Standards for the content of the physician-patient conversation. Consider statewide use of pre-recorded Advanced Care Planning discussion videos to help guide conversations (e.g., <https://www.acpdecisions.org/products/videos/>)
- Develop or select clinical criteria that can be used to trigger a palliative care consult or referral. Among the considerations recommended are: 1)Use of utilization data, 2) Medicare risk score, 3) Patient interview answers, and 4)Predictive modeling tool/algorithms.
- Develop a team to adopt a standardized and brief palliative care screening tool for use by physicians.
- Develop decision trees to provide high-quality, integrated, patient-centered, family-oriented outcomes of care.
- Develop a clear, transparent process for health care decisions to be made for patients who have no one to represent them.

### Benefit/Policy Changes:

- Work with payers to identify incentives that could be applied to specific palliative care related outcomes such as conducting caregiver needs assessments and goals of care discussions.
- Recommend including a palliative care consultation as a standard benefit with no copay and adding 99497 and related CMS-reimbursable codes to NJ's Medicaid covered benefits..
- Evaluate different funding approaches such as enhanced fee-for-services, per-member – per month, and shared savings/shared risk that could promote palliative consults and care.
- Allow for hospice and palliative care benefits to be provided concurrently with disease treatment.
- Work with professional associations to advocate at the State and Federal level of for regulatory changes that promote and heighten the importance of early end-of-life discussions.

## Summary

- Effective and timely palliative care and end-of-life discussions promote informed decisions, honors the values and choices of the patient and typically lead to increased quality of life.
- Patients who receive palliative care spend less time in intensive care, are less likely to die in ICUs, and receive less unnecessary tests and procedures that ultimately results in quality care being provided at a lower cost.
- Systems need to identify and implement clinical criteria and demographic information that will trigger end-of- life conversations for those who could benefit.
- In order to improve outcomes and change culture, we must better educate the public and our communities about the benefits, value, and importance of palliative care and advanced care planning.
- Increased education for physicians and clinicians on end-of–life care options, advance care planning, POLST/MOLST is needed to ensure successful palliative care conversations.
- Talking with patients about life expectancy is a skill we can improve with attention and experience.
- Ensuring proper alignment of incentives will further promote important end-of-life discussions.

# Design a System of Best Practices to Routinely Assess Newly Admitted Patients for End of Life Care Planning

Ralph Pothel, MD, MBA, *Horizon BCBSNJ*

John Poole, MD, *North Jersey Surgical*

Gregory Rokosz, DO, J.D., FACEP, *Saint Barnabas Medical Center*

Adam Young, Esq, *Brighton Health Plans Solutions*

## Introduction

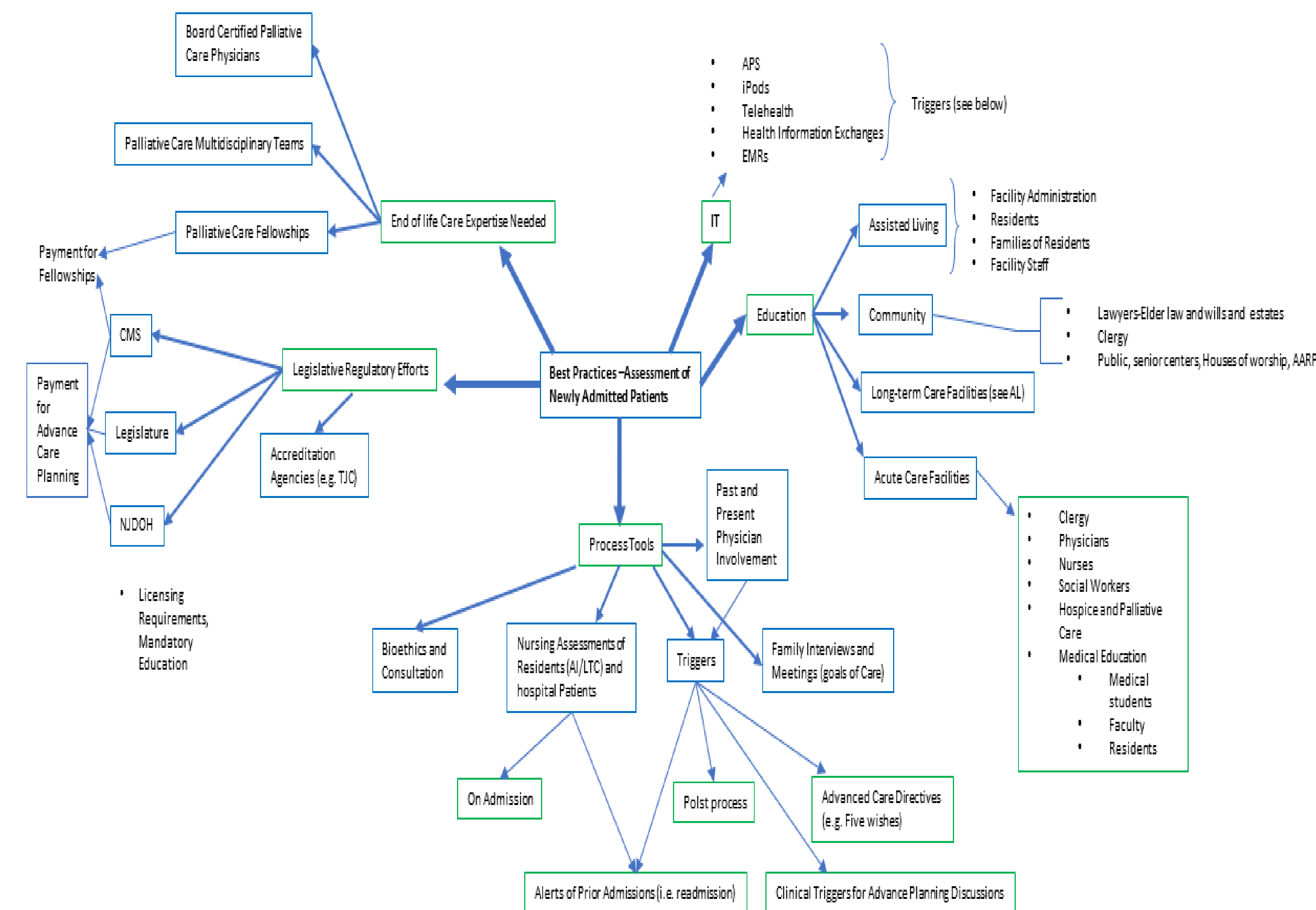
Many patients arrive at the acute care Hospital from an assisted living or long term care facility without having had a discussion or developed a plan for their healthcare goals at the end of life. It is widely agreed that a conversation and end of life care planning is better conducted before the patient arrives at the emergency department.

## Project Goals

The practicum group researched care transition and intake procedures in New Jersey. The group also reviewed physician and nursing roles and responsibilities with respect to end of life care planning in these settings, and the current tools available to facilitate these discussions.

## Background

- Hospitals, skilled nursing facilities, long term care facilities and assisted living facilities need to implement policies to better identify and address end of life issues at time of admission (i.e., triggers).
- Best practices should be freely shared across the state.
- Conventional wisdom is that “no one” is taking specific ownership of the issue.
- Funding is also a significant issue as very few payors cover these services.



## Mindmap of Project

### Education:

- Clinical Staff, Facility Administration, residents & their family, Community (senior centers, clergy, and lawyers)

### Advocacy:

- Regulatory, legislative, (DOH & Accreditation Bodies)
- Reimbursement (CMS, Medicaid, private insurance)

### Processes/Tools:

- Prior/current physicians, nursing staff, family (prior to and upon admission)
- Triggers (advanced care planning, POLST, and advanced directives)

### Adoption tools:

- Technology (apps, data tracking)

### Building Expertise:

- Fellowship training

## Discussion

Based on the findings, the group prepared a list of best practices aimed at facilitating discussions on end of life care planning at the time of admission, or when clinically indicated if not at the time of admission.

## Action Steps

- Both inpatient and outpatient focus. Often when the patients are in an acute setting, it is too late in the care process for effective planning.
- Better incentives and compensation.
- Lobbying for more training – fellowships slots for palliative care – there are simply not enough specialists.
- More Education of medical and nursing staff, better team building for advanced care planning.
- Better policy, practices and understanding of triggers and targets for advanced care planning.
- Developing opportunities to increase awareness and understanding of POLST and other advanced planning toolkits and material.
- Better engaging of Assisted living, Nursing home and Rehab facilities in the Advanced Care Planning process (all subacute facilities).
- Development of technological solutions (apps, data tracking)

## Summary

We believe that if the above action steps are taken, conversations on end of life care will occur at a higher frequency and more appropriate time. This, in turn, will ultimately lead to improved care and quality of life for the patient.

# The State of Palliative Care Fellowships in New Jersey

**Joseph P. Costabile, MD; Paul Matey, Esq.; Maureen Schneider, PhD, MBA, RN, CPHQ, NEA-BC, FACHE  
and Frank L. Urbano, MD, MBA, FACP, CHIE** **FACILITATOR: Ning Zhang, PhD, MD, MPH Seton Hall University**

## Introduction

Medicine has long recognized the fundamental need of humanity to understand, explore, and contend with the limits of physical existence. Medical education has evolved in response to these philosophical enquires, as scientific gains provide deeper insights into the options for extending life. Palliative care stands at the intersection of these disciplines, and at the crossroad between the traditional practice of ensuring health, and the emerging promise of enabling well-being. Now, as dying has become more of a medical process managed by health care providers, a common language of compassion is needed to navigate the choices surrounding the end-of-life. A new fellowship focused on educating caregivers on the conversational skills essential to palliative care can lead to improved quality, patient experience, and a better use of resources, all aimed at a cultural change that recognizes not merely the options for living, but the reasons.

## Background

The escalating awareness and demand for palliative care resources has led to rapid growth in the number of patients requiring palliative care both in New Jersey and in the United States. Therefore, there is a strong need to develop, support and increase medical fellowship programs for palliative care in New Jersey. Additionally, it is imperative that the physician workforce is supported and fostered with appropriate education, palliative care preparation, and mentorship for the next generation of physicians. Due to the rapid transformation of health services it is essential that palliative care fellowships increase immediately and meet the requirements and guidelines established by the Accreditation Council for Graduate Medical Education (ACGME) in order to provide the optimum quality care for New Jersey patients, families and community. Palliative care is truly an interdisciplinary care program which also supports a strong need for fellowship trained advanced practice nurses (APNs) who can align with physicians to focus on the care needs of the patient and family. Therefore, there is a need to create and develop Palliative Care Nurse Practitioner based fellowship programs in New Jersey. Palliative Care Fellowship programs are focused on practical training outcomes as emphasized by ACGME. Essential components for a palliative care program are as follows:

- Define competencies and measurable outcomes for the field in line with ACGME.
- Fellowship programs will report the progress of individual fellows to the ACGME based on milestones.
- Sponsoring institutions interested in creating a fellowship program in hospice and palliative medicine and advanced nursing need to link to the appropriate accreditation bodies.
- Research grant opportunities that could be used to develop additional geriatric-palliative fellowship programs and augment existing programs.
- Seek grants to support the clinical training of fellows and APNs in order to increase the number of funded fellowship positions:
  - Kindred Gentiva Hospice Foundation
  - Y.C.Ho/Helen and Michael Chiang Foundation
  - Fan Fox & Leslie R. Samuels Foundation
  - Hearst Foundations
  - Oncology Nursing Society- End-of-life Care Nursing Career Development Award

## Goals:

- To increase and expand the number of Palliative Care Fellowship programs in New Jersey.
- To develop the administrative support necessary to support the Palliative Care Fellowship program.
- To review opportunities to develop, and increase Advanced Nurse Practitioner Palliative Care Fellowships in New Jersey.

For more information on the Fellowship accreditation process, please see the link below:

[https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/540\\_hospice\\_and\\_palliative\\_medicine\\_2017-07-01.pdf](https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/540_hospice_and_palliative_medicine_2017-07-01.pdf)



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## Barriers to Implementation

In order to determine the status of palliative care fellowships in New Jersey, as well as any barriers that might be present in implementing such programs, we conducted an outreach to existing programs and centers in New Jersey that might be viable candidates for the development of a palliative care program where one did not already exist.

### Outreach occurred to the following individuals:

1. **Mark Angelo, MD**, Director of the Palliative Care Fellowship Program at Cooper University Healthcare
2. **Stephen Goldfine, MD**, Director of the Palliative Care Fellowship Program at Rowan School of Osteopathic Medicine and Samaritan Hospice
3. **Elizabeth Poplin, MD**, Medical Oncologist and Co-Director, Gastrointestinal/Hepatobiliary Program, Cancer Institute of New Jersey
4. **Joshua Rosenblatt, MD**, Chair of Pediatrics and Vice-President for Medical Education, Newark Beth Israel Medical Center
5. **Anne C. Mosenthal, MD**, Chair of Surgery and Professor of Surgery, Rutgers - New Jersey Medical School

### The two existing programs (Cooper and Rowan) expressed the following concerns:

1. **Funding** - While, at present, both programs are fully funded, there is no set source of ongoing funding, so both program directors indicated that they have to solicit funding on a regular basis to maintain their program. Dr. Angelo indicated that if he was unable to solicit funding, he was uncertain that his program would continue to operate.
2. **Interest** - Dr. Goldfine indicated that while his program presently has 3 available positions, they have not had a fellow for the past several years. He suspects that this is due to a lack of interest in pursuing a palliative care fellowship given poor reimbursement for palliative care in general.
3. **Executive Support** - Both program directors indicated that it was essential, although not always possible, to secure executive (i.e., C-suite) support for a palliative care program at all, let alone a palliative care fellowship. They indicated that such support would go a long way in providing visibility to the specialty.

Additionally, the following barriers were identified by those interviewed who did not presently have a palliative care fellowship:

1. **Lack of CMS Funding** - All interviewees indicated that CMS was no longer funding any new residency or fellowship positions beyond capped levels which were established several years ago. Several institutions are presently above their capped limit and are funding a number of positions out of their organization's operating budget. Because of this, it is unlikely that the institutions who do not have programs would be willing or able to fund additional positions without external support.
2. **Lack of Faculty Structure** - While the underlying issue identified by all was financial, one interviewee (Dr. Poplin) indicated that even with sufficient funding, it would also be necessary to develop the components of a program, including dedicated faculty to provide education to those participating in the fellowship. At present, she indicated that palliative care was not her primary focus, nor was it the focus of any other physician who presently provided palliative care services at her institution. She speculated that in order to have a successful palliative care fellowship, there would need to be dedicated faculty who could support this program who did not have other responsibilities which competed with their primary goal of educating the fellows. This would require support which is beyond financial resources.
3. **Sustainability** - All interviewees indicated that this was a significant barrier to developing more palliative care fellowships. Palliative care, as a specialty, is reimbursed at a very low level, and it is therefore difficult for programs to sustain themselves without support from other disciplines. Unless there was ongoing support for palliative care, the regular funding of a fellowship could be in jeopardy because it would not be sustainable. It would not be optimal to have to determine on an annual basis if a program would exist the following year solely based upon an institution's ability to fund it. Long-term sustainability would be key to the success of any program.
4. **Executive Support** - As noted above by those individuals who had programs, others felt that executive champions were key to the success of any palliative care program and fellowship. In the interviewees' opinions, this would require 'out of the box' thinking by a supportive administrator who believed in the promise of palliative care as both an altruistic endeavor and an evidence-based practice. It was also noted that while it is difficult to prove, palliative care likely saves money in the long term, so this fact would have to be accepted by the executive champion.

In summary, key factors which must be addressed in order to increase the number of palliative care fellowships include:

1. A viable funding option
2. Dedicated program structure and faculty support
3. A model to support sustainability
4. Executive support

# The State of Palliative Care Fellowships in New Jersey

Joseph P. Costabile, MD; Paul Matey, Esq.; Maureen Schneider, PhD, MBA, RN, CPHQ, NEA-BC, FACHE  
and Frank L. Urbano, MD, MBA, FACP, CHIE **FACILITATOR:** Ning Zhang, PhD, MD, MPH Seton Hall University

## Discussion

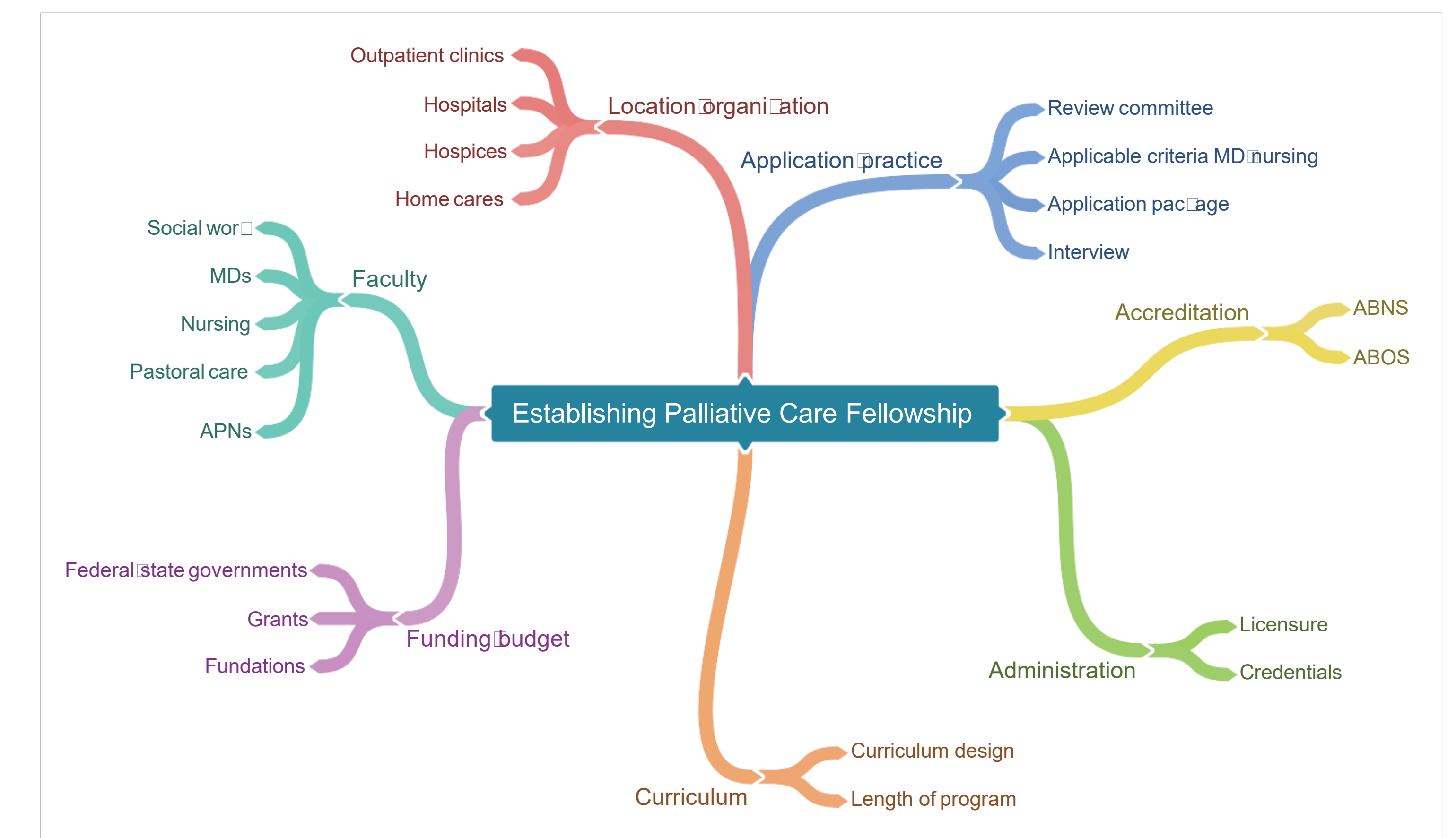
From the aforementioned research, it is clear that there is a need for increased education in palliative care medicine. While this is a relatively new specialty, it is, now more than ever, a critically important specialty, and it is therefore imperative that barriers be overcome to fund the educational programs needed to prepare physicians and other advanced healthcare practitioners in this field. As a specialty, palliative care provides reasonable, rational, humane and appropriate care for patients both with chronic and terminal disorders; in addition, it can provide significant cost savings for the healthcare system. In the era where healthcare providers are consistently trying to meet the 'Triple Aim', increasing the amount of palliative care providers has the unique potential to satisfy all three objectives of this important approach:

1. Improving the experience of patients with terminal illness through the provision of palliative care services.
2. Improving the overall health of populations by diminishing unnecessary suffering, better defining goals of care, and eliminating low value care which is of limited benefit to the patient.
3. Reducing the cost of care by helping patients to utilize the healthcare system in a more effective manner.

Considering the above, and due to the both limited number of palliative care physicians and paucity of training programs, a significant effort needs to be placed in creating and funding more fellowships to meet the needs of this essential specialty in patient care.

## Action Steps:

- With the support and advocacy of the Medical Society of New Jersey (MSNJ), the New Jersey Hospital Association (NJHA), and the New Jersey Association of Health Plans (NJAFP), actively encourage AGCME-accredited programs in either internal medicine or family medicine to establish a palliative care fellowship.
- Develop a workgroup of stakeholders to discuss the feasibility of various funding mechanisms including federal and state educational grants, institutional grants (e.g., hospital or other institutions), or professional foundation grants (e.g. the AMA foundation).
- Discuss with regulators the importance of establishing palliative care fellowships, including providing support for the Palliative Care and Hospice Education and Training Act (HR 1676 and S693).
- Continue to work with individual institutions (as identified in this poster) to explore the feasibility of developing palliative care fellowships in NJ hospitals.



## Summary

- New educational models addressing the changing goals of palliative care are needed to link emerging options for treatment and pain management with effective patient counseling.
- Significant barriers, including lack of public funding, inadequate faculty development, and suboptimal physician interest have impeded the development of palliative care fellowships in New Jersey and across the USA.
- Hospital administrators and executives do not identify palliative care as a significant priority, limiting institutional support.
- A new vision for palliative care fellowships, therefore, should center on sustainability rather than immediacy to create the momentum necessary for widespread adoption.
- An incremental approach would allow for targeted funding requests that provide realistic, but cost-conscious support for palliative education.

# IDENTIFICATION OF INDIVIDUALS WITH PALLIATIVE CARE AND HOSPICE NEEDS

## WHO ARE PRESENT IN THE EMERGENCY DEPARTMENT

ALISON DORSEY, MPH, AMERIGROUP

MARC J. LEVINE, MD, TRENTON ORTHOPAEDIC GROUP

KENNETH N. SABLE, MD, MBA, FACEP, JERSEY SHORE UNIVERSITY MEDICAL CENTER

### PROBLEM STATEMENT AND BACKGROUND

- Patients with advanced and end-stage disease in need of symptom management and pain relief often present to the emergency department (ED).
- Research focusing on patients who were at the end-of-life found that these patients often did not receive the care they anticipated. Once in the acute care setting, the patient's objectives and goals may be in direct contrast to the ED strategies of life-prolonging treatment.
- The need for palliative care and end-of-life care in the ED becomes apparent when considering that these medically complex patients present to the EDs every day.
- Providers of emergency care have a unique opportunity to support palliative care interventions early in a patients' disease trajectory, promoting quality of life as well as reducing cost associated with treatments.

### GOALS

The primary goal is to provide a roadmap for integrating palliative care services into the emergency department setting via the implementation of a screening tool.

#### Short-Term Goal

The tool can be used to identify individuals who might benefit from palliative care services and connect them with the appropriate resources at the time of service and/or in the post-acute setting after discharge.

#### Long-Term Goals

- Reducing potential future ED visits by patients with chronic palliative care needs, reducing readmission rates
- Decreasing length-of-stay (LOS) for patients that do require hospitalization
- Improving overall patient satisfaction, among others

### PALLIATIVE CARE SCREENING TOOL

**Step 1: Utilize top-level filter based on triage nursing-entered patient diagnoses to determine if palliative screening tool triggered**

Diagnosis includes one or more of the following:

- Cancer: metastatic, recurrent or locally advanced and incurable
- Out-of-hospital cardiac arrest
- Advanced dementia (defined as needing assistance with all ADLs, having limited to no coherent speech or ambulation, and incontinence)
- Stroke, with decreased function by at least 50%
- End Stage Renal Disease (ESRD)
- Advanced cardiac disease (Congestive Heart Failure, Severe CAD, CM (LVEF < 25%))
- Other life-limiting illness (ALS, chronic pain etc.)

NO

Do not trigger Baylor Model

YES

**Step 2 Baylor Health System screening model as endorsed by IPAL-EM**

ED physician evaluates the following:

**Patients with a serious, life-threatening illness and one or more of the following:**

- UNCONTROLLED SYMPTOMS:** ED visit prompted by difficult-to-control physical or psychological symptoms (Y/N)
- BOUNCE-BACKS:** More than one ED visit or hospital admission for the same condition within several months (Y/N)
- FUNCTIONAL DECLINE:** Decline in function, feeding intolerance, unintentional weight loss or caregiver distress (Y/N)
- INCREASINGLY COMPLICATED:** Complex long-term care needs requiring more support (Y/N)
- NOT SURPRISED:** You would not be surprised if the patient died in the next 12 months, or if pediatric patient, will not survive to adulthood (Y/N)

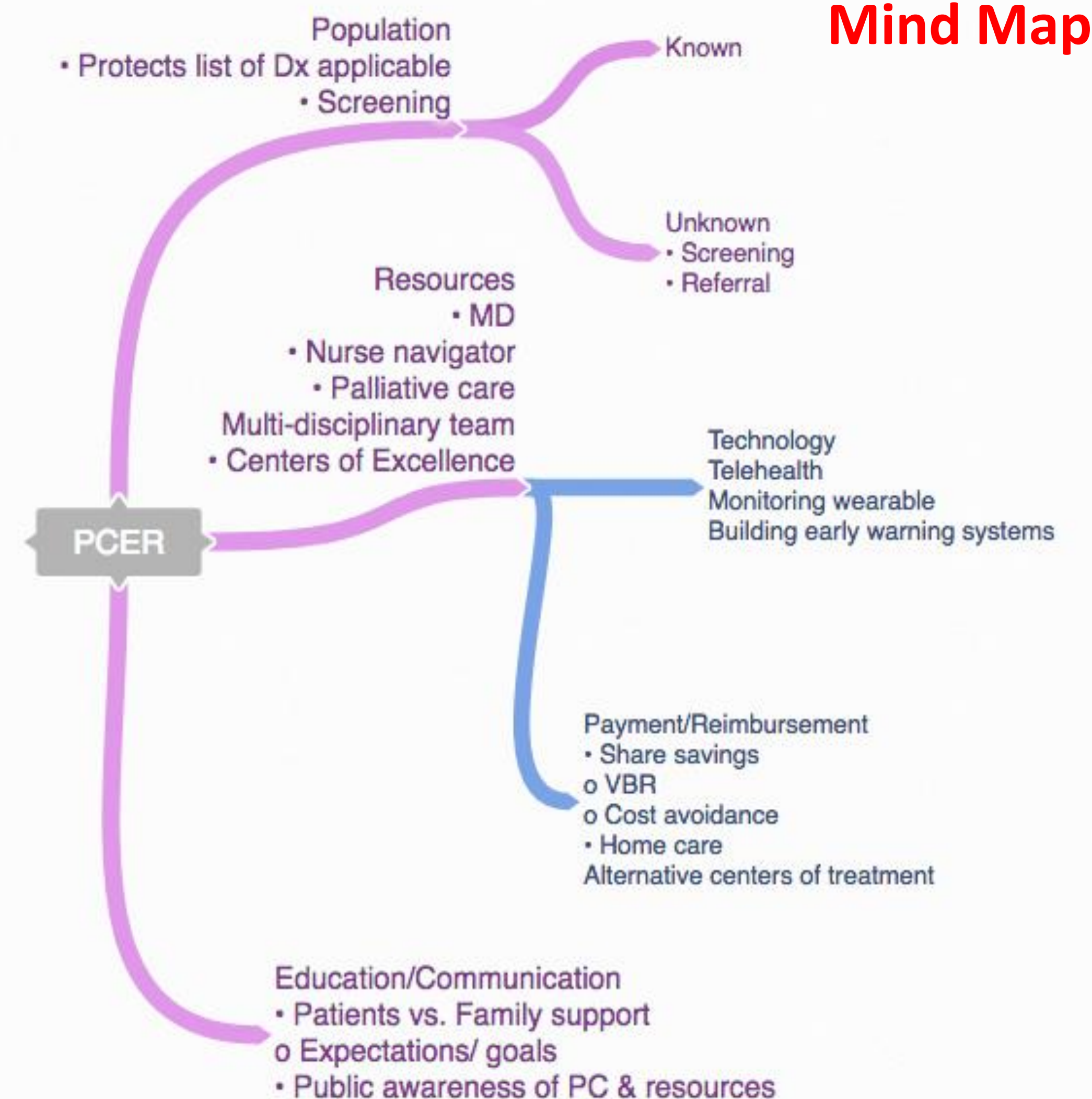
YES

If screening tool positive for one or more factors, MD to order palliative care consult, following typical order entry process.

NO

Do not request palliative care consult

### Mind Map



### FUTURE ACTION STEPS

- Work with commercial health plans and NJ Department of Human Services to identify codes for billing palliative care services on both Medicaid and commercial side, potentially mirroring Medicare.
- Additional training may be needed to help providers become effective communicators with regard to palliative care and end-of-life issues.
- Work with EHR vendors to build workflows and screening tools directly into EHR applications.

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## Introduction

**Home Based Palliative Care (HBPC)** has traditionally not been a reimbursed benefit under the public and private payment systems. People dealing with the burden of illness consequent from a complex illness or the end of life trajectory receive care unnecessarily in emergency departments and acute care hospitals. Demonstration and pilot programs funded by commercial insurers and the Center for Medicare and Medicaid Services suggest that home based palliative care improves quality, enhances the patient and family experience and reduces total cost of care.

## Project Goals

- ◆ Conduct an environmental scan of home based palliative care models
- ◆ Develop recommendations for regulations, payment policy and practice that will facilitate the expansion of home based palliative care
- ◆ Propose the key elements for HBPC including key interventions, inter-professional team composition, quality and utilization metrics and exclusions.

## Background

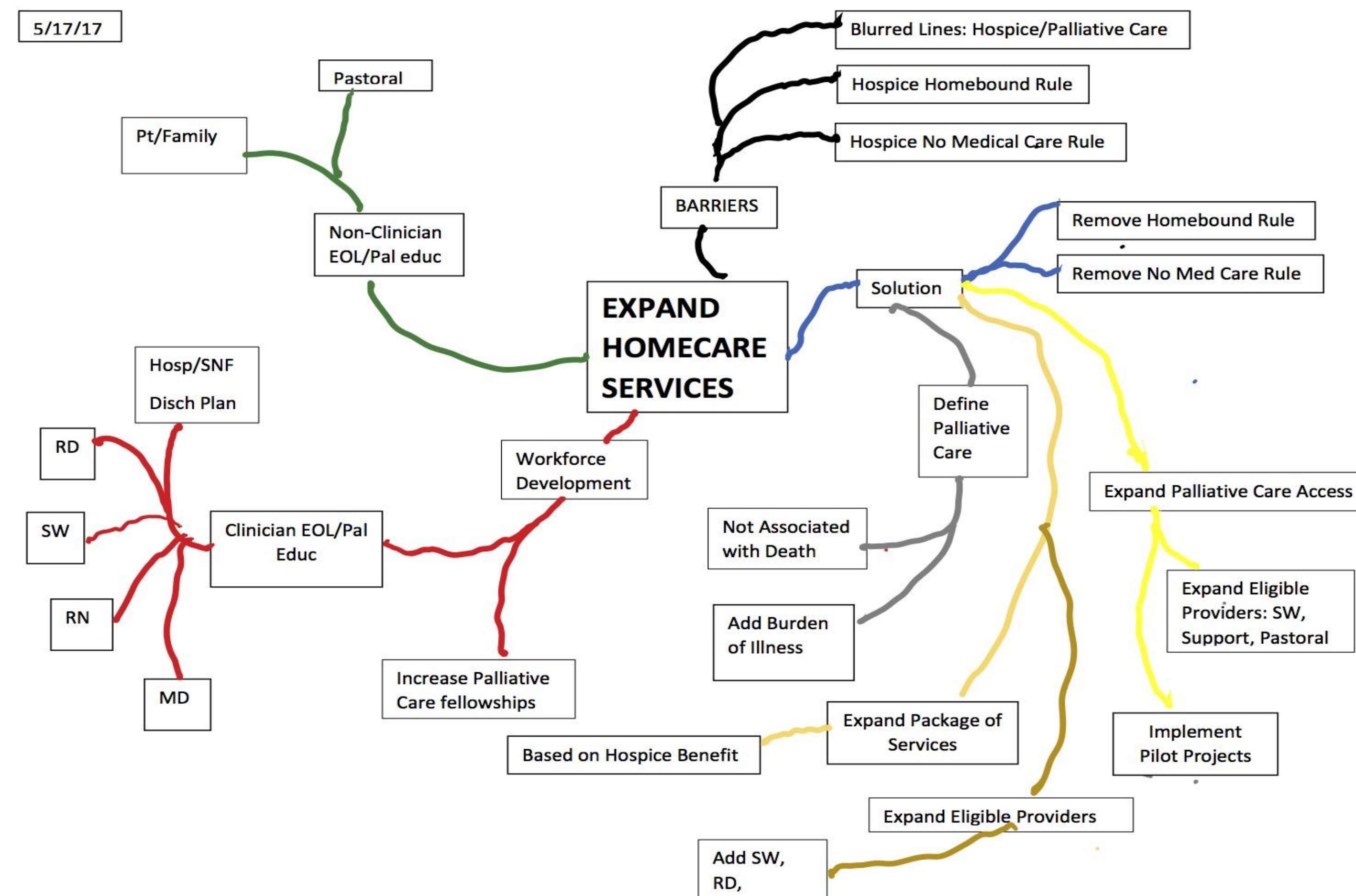
Research indicates that 70% of Americans want to receive care at home in the last months of life, while only a third actually do so.

The Center for Medicare and Medicaid Services has funded HBPC demonstration programs, the early results of which include reductions in total cost of care, reductions in unnecessary emergency department visits and inpatient admissions and increased patient engagement in advanced planning

Private insurers across the country are testing various models of home based palliative care with resultant improvements in quality and cost.

As reported by the Dartmouth Atlas Study, New Jersey ranks last in the nation in terms of efficacious palliative care intervention, as measured by cost of care in the last 6 months of life, low utilization of hospice and high avoidable inpatient and ICU spend.

## Mindmap of Project



## Barriers and issues

**How do we define? The lines are blurred between palliative and hospice**

- Palliative should not be associated with death. Should be triggered by burden of illness

**Current reimbursement rules need to be addressed**

- Must be homebound for home care
- No curative care under hospice
- Rules need to be modified

**Service Offerings should be expanded**

- Package of offerings
- Access
- Eligible providers

**Development and Education Required**

- Clinician End of Life education
- Non-clinician End of Life education
- Increase palliative care fellowships

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<http://www.njspotlight.com/stories/11/1129/0024/#>

## Observations and Discussion

- Improving and expanding palliative care in the home setting respects the dignity of those with a significant disease burden, improves the ability of the family to help care for the patient, when possible, and keeps the patient out of the acute health care system for issues better addressed at home.
- Eliminating unnecessary encounters with the acute health care system benefits the patient and reduces costs.
- Barriers currently exist which prevent the delivery of such services to the patient, resulting in deleterious and often unnecessary encounters with the acute health care system.
- Patients with a significant disease burden may wish to pursue continued curative therapy, while still benefiting from palliative services.
- The transition from palliative care to home hospice care needs to be a part of any model.

## Action Steps

- ◆ An inter-professional palliative care team is proposed to include a board certified or equivalently experienced palliative care physician, advanced practice nurse, physician assistant, nurse, social worker, nutritionist, pharmacist, and other relevant ancillary supports.
- ◆ Insurance coverage for palliative services should not prohibit continued pursuit of potentially curative, or ameliorative therapy.
- ◆ Models for delivering palliative care on a per member per month basis (eg, Medicare's CMMI project, Aetna's project) are suggested as a method for providing these services.
- ◆ Professional associations to advocate at the State and Federal level for legislative and regulatory changes that allow for the fullest implementation of home-based palliative care and expand eligibility for care.
- ◆ Engage HRET in establishing a learning collaborative among payers, physicians and providers to implement these recommendations including appropriate Pilots

## Summary

- *Treatment of patients near end of life, and those with significant disease burdens but not near end of life, is presently inadequate due to constraints in insurance coverage, patient education, frank discussions and the overall under appreciation of the importance of palliative care for these patients.*
- *Significant cost savings and improved quality of life will accrue with increased attention to palliative care, especially regarding those services delivered in the home setting.*
- *Proposed structure for improved delivery of palliative care in the home setting, as specified, will benefit patients and payers.*



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EST. 2016

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## EOL ACTION STEPS



## Project #1 | Describe evidence based/best practice informed strategies to enhance the capacity of primary care providers to integrate palliative care into their practices.

### Team:

*Mary Campagnolo, MD, MBA*

*Kenneth Kobylowski, Esq.*

*Darrell Terry, Sr., MHA, MPH, FACHE*

*Jennifer Velez, Esq.*

### SHU Faculty:

*Anne Hewitt, PhD*

Many patients with serious illnesses can benefit from the integration of palliative care into their overall plan of primary care. For patients facing a terminal illness, palliative care at an early stage in their illness can promote both their quality of life and their length of life. Because of their often longer term relationship with patients, primary care providers and teams are in a unique position to have initial discussions with patients about their goals and desires and to coordinate care with specialist palliative care resources.

The Cohort 1 learning team reviewed evidence-based/best practices for primary care practices to enhance their ability to: (1) identify which members of the primary care team have a role in supporting and/or facilitating palliative care (consider also their level of comfort and ability to fulfill their role effectively), (2) identify appropriate and effective tools and strategies for promoting effective palliative care in practice, (3) identify partners and resources in their region to support the team and their patients dealing with serious illnesses. The group gathered feedback from primary care stakeholders to assess what/how/if these strategies might be useful in New Jersey.

**Outcomes:** The team developed a portfolio of recommended strategies for primary care practices to enhance their capacity to integrate palliative care into their care coordination and delivery.

### Action Steps: A Portfolio of Palliative Care Strategies for Primary Care

- ✓ Encourage active, weekly participation among PCPs for collaborative, case-based learning, including patent case presentations with didactic learning and mentoring.
- ✓ Launch statewide public relations campaign by supporting the existing efforts of the NJ HealthCare Quality Institute's "Conversation of Your Life" in conjunction with the Mayor's Wellness Campaigns.
- ✓ Increase payer-engagement with PCPs to identify members in the patient base appropriate for services through data analytics
- ✓ Develop payer clinical teams designated to work with PCP practices to provide services and identify ancillary resources available (pain management; behavioral health; social services)
- ✓ Advocate enhanced payments for PCP practices who have completed palliative care training courses

## Project #2 | Design a plan to enhance the effective implementation and sustainability of a telehealth program for palliative care.

### Team:

*Kevin O'Dowd, Esq.*

*Ashish Parikh, MD*

*Bruce Pomeranz, MD, MMM*

*Todd Way*

*Judy Wright, MD*

### SHU Faculty:

*Nalin Johri, PhD,*

For some, palliative care is a very limited or even unavailable resource. One way of extending this resource to a larger number of patients is through the use of telehealth technologies.

Telehealth monitoring technology allows patients and their caregivers to collect biometric information (e.g., blood pressure, body weight) and/or to communicate with the medical and/or healthcare providers at a remote location. At this point, the use of telehealth technologies in palliative care is not widespread and the scope of services is often limited.

This executive learning team researched how telehealth technologies have been implemented successfully in the support and/or delivery of palliative care services and explore how those technologies/services might be implemented in a sustainable manner.

**Outcome:** The learning team designed a proposed plan with recommendations to enhance the effective implementation and sustainability of a telehealth palliative care program (including social and emotional support services).

### Action Steps: **The Current State of Telemedicine in Palliative Care in New Jersey**

Leverage the collaborative networks forged from the first cohort of the NJHELA to:

- ✓ Assist in passing laws that promote safe and secure use of telemedicine. Ensure appropriate reimbursement.
- ✓ Develop payment models that hold all stakeholders accountable and align incentives towards better care.
- ✓ Apply telemedicine to palliative care and measure the impact on the Quadruple Aim.

## Project #3 | Develop novel policies and incentives for early conversations about (and referrals to) palliative care by physicians.

### Team:

*Sarah Adelman*

*Steve Dumke, LNHA, FACHE*

*Soumen Samaddar, MD, DABFM*

### SHU Faculty:

*Stephen Wagner,*

*PhD, FACHE, FACMPE, FAcEM*

We heard first hand patient (and family) accounts of the difficulty they encountered interacting with medical professionals when facing a terminal diagnosis. Often times multiple physicians will be involved with the care of an individual with a serious medical condition(s). Each of these physicians may be charged with focusing on a particular aspect of the patient's condition. This can result in many consultations and procedures before a conversation about the patient's goals of care can be conducted.

This executive learning team designed a method for including the community and hospital - based physicians that are involved in the patient's care together for a clinical discussion. This alignment could occur through the implementation of full time ICU intensivist physician staffing model or other system changes. The result would provide better coordinated care, less confusion for patients and families, a more consistent message to patients and families, less consultants on the case, and better addressing of end of life care, particularly in the ICU setting.

**Outcomes:** The group will develop and draft a plan to implement these changes including:

- (1) Identifying key stakeholders, (2) crafting communication objectives (3) developing clinical criteria, and (4) designing benefit changes

### Action Steps: **Incentivizing Earlier Palliative Care Referrals & Conversations**

#### **Education:**

- ✓ Improve the quality of physician education by requiring that providers treating patients with advanced illness or in the last months of life receive CME track participants and demonstrate improvements in measurable patient and family oriented outcomes within 2 years
- ✓ Allow physicians who provide no end-of -life care to opt out from existing and future CME mandates on end-of-life care to decrease physician burden and improve data.
- ✓ Incentivize physicians without specialty training in palliative care to complete additional education in palliative care. (MOLST, POLST training)
- ✓ Identify partners to establish a learning collaborative among payers, providers, and physicians.
- ✓ Work with community agencies and providers to develop a PR campaign that promotes palliative care, early conversations, and advanced care planning. (e.g. expanding NJ's *Conversation of Your Life* program)
- ✓ Develop outreach strategies through multiple mediums and (print, broadcast, videos, web) raise awareness.

**Clinical Criteria:**

- ✓ Establish Best Practice Standards for the content of the physician-patient conversation. Consider statewide use of pre-recorded Advanced Care Planning discussion videos to help guide conversations (e.g., <https://www.acpdecisions.org/products/videos/>)
- ✓ Develop or select clinical criteria that can be used to trigger a palliative care consult or referral. Among the considerations recommended are: 1) Use of utilization data, 2) Medicare risk score, 3) Patient interview answers, and 4) Predictive modeling tool/algorithms.
- ✓ Develop a team to adopt a standardized and brief palliative care screening tool for use by physicians.
- ✓ Develop decision trees to provide high-quality, integrated, patient-centered, family-oriented outcomes of care.
- ✓ Develop a clear, transparent process for health care decisions to be made for patients who have no one to represent them.

**Benefit/Policy Changes:**

- ✓ Work with payers to identify incentives that could be applied to specific palliative care related outcomes such as conducting caregiver needs assessments and goals of care discussions.
- ✓ Recommend including a palliative care consultation as a standard benefit with no copay and adding 99497 and related CMS-reimbursable codes to NJ's Medicaid covered benefits.
- ✓ Evaluate different funding approaches such as enhanced fee-for-services, per-member – per month, and shared savings/shared risk that could promote palliative consults and care.
- ✓ Allow for hospice and palliative care benefits to be provided concurrently with disease treatment.
- ✓ Work with professional associations to advocate at the State and Federal level of for regulatory changes that promote and heighten the importance of early end-of-life discussions.

## Project #4 | Design a system of best practices to routinely assess newly admitted patients for end of life care planning.

### Team:

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*Ralph Pothel, MD*

*Gregory Rokosz, Esq., DO, FACEP*

*Adam Young, Esq.*

### SHU Faculty:

*Stephen Wagner,*

*PhD, FACHE, FACMPE, FACEM*

Many patients arrive at the acute care hospital from an assisted living or long term care facility without having had a discussion or developed a plan for their healthcare goals at the end of life. It is widely agreed that a conversation and end of life care planning is better conducted before the patient arrives at the emergency room.

Hospitals, skilled nursing facilities, long term care facilities and assisted living facilities should implement policies to better identify and address end of life issues at time of admission (i.e., triggers). Best practices should be freely shared across the state.

This executive learning team researched care transition and intake procedures at two or three skilled nursing facilities and/or long term care centers in New Jersey. The group also reviewed physician and nursing roles and responsibilities with respect to end of life care planning in these settings.

**Outcomes:** Based on the findings, the group prepared a list of best practices that result in the identification of residents that should engage in end of life care planning at the time of admission, or when clinically indicated if not at the time of admission. Where a best practice does not exist the team created a list of action steps for consideration.

### Action Steps: Design a System of Best Practices to Routinely Assess Newly Admitted Patients for End of Life Care Planning

- ✓ Both inpatient and outpatient focus. Often when the patients are in an acute setting, it is too late in the care process for effective planning.
- ✓ Better incentives and compensation.
- ✓ Lobbying for more training – fellowships slots for palliative care – there are simply not enough specialists.
- ✓ More Education of medical and nursing staff, better team building for advanced care planning.
- ✓ Better policy, practices and understanding of triggers and targets for advanced care planning.
- ✓ Developing opportunities to increase awareness and understanding of POLST and other advanced planning toolkits and material.
- ✓ Better engaging of Assisted living, Nursing home and Rehab facilities in the Advanced Care Planning process (all subacute facilities).
- ✓ Development of technological solutions (apps, data tracking)

## Project #5 | Identify opportunities to develop Palliative Care fellowships in New Jersey teaching hospitals.

### Team:

*Joseph Costabile, MD*

*Paul Matey, Esq.*

*Maureen Schneider, PhD, MBA, RN, CPHQ, NEA-BC, FACHE*

*Frank Urbano, MD, MBA*

### SHU Faculty:

*Ning Jackie Zhang,*

*MD, PhD, MPH*

Care at the end-of-life is a considerable cost driver in New Jersey. Palliative care resources can provide better outcomes for patients at significantly reduced cost. Despite these facts, palliative care resources remain scarce in New Jersey. One method of developing more palliative care capacity in our state is by creating fellowship opportunities.

This executive learning team researched grant opportunities and other opportunities that could be used to develop additional geriatric fellowship programs or augment existing ones. The team developed a business case/ rationale to submit to potential funders based on the current spend in EOL care and the proposed quality and cost improvements from palliative care. Sponsorship and or state funded opportunities for existing Palliative and Geriatrics Programs with new and innovative proposals should also be considered.

**Outcomes:** The learning team prepared a business case/proposal narrative. The plan included a rationale for cost/benefit analysis and the clinical care and quality benefits that would accrue.

### Action Steps: **The State of Palliative Care Fellowships in New Jersey**

- ✓ With the support and advocacy of the Medical Society of New Jersey (MSNJ), the New Jersey Hospital Association (NJHA), and the New Jersey Association of Health Plans (NJAFP), actively encourage AGCME-accredited programs in either internal medicine or family medicine to establish a palliative care fellowship.
- ✓ Develop a workgroup of stakeholders to discuss the feasibility of various funding mechanisms including federal and state educational grants, institutional grants (e.g., hospital or other institutions), or professional foundation grants (e.g. the AMA foundation).
- ✓ Discuss with regulators the importance of establishing palliative care fellowships, including providing support for the Palliative Care and Hospice Education and Training Act (HR 1676 and S693).
- ✓ Continue to work with individual institutions (as identified in this poster) to explore the feasibility of developing palliative care fellowships in NJ hospitals.

## Project #6 | Design a plan to integrate the best practices of palliative care into the ER.

### Team:

*Alison Dorsey, MPH*

*Marc Levine, MD*

*Kenneth Sable, MD, MBA, FACEP*

### SHU Faculty:

*Ning Jackie Zhang,*

*MD, PhD, MPH*

Due to the lack of integration of Palliative Care in the Emergency room, there should be an established protocol which enables hospitals to implement policies to better address EOL issues upon admission; subsequently enabling proper referrals to skilled nursing facilities, long term care and assisted living facilities. By integrating palliative care into the ER, ER physicians can serve as a palliative care consultant so that appropriate care can be coordinated.

This executive learning team researched and identified best practices that could freely be shared in New Jersey. *The group designed a standardized and brief palliative care screening tool for use by ED physicians to identify older adults who have palliative care needs upon admission to the ED. The group should also develop a mechanism that maps out decision trees to provide high-quality, integrated, patient centered, and family- oriented outcomes of care while also developing a clear, transparent process for health care decisions to be made for patients who have no one to represent them.*

**Outcomes:** Based on the findings, the team prepared *a detailed business case/proposal that outlines a program that would require Emergency Departments to develop and implement palliative care programs.*

### Action Steps: Identification of Individuals with Palliative Care and Hospice Needs Who Are Present In the Emergency Department

- ✓ Work with commercial health plans and NJ Department of Human Services to identify codes for billing palliative care services on both Medicaid and commercial side, potentially mirroring Medicare.
- ✓ Additional training may be needed to help providers become effective communicators with regard to palliative care and end-of-life issues. One potential guide to improving conversations about end-of-life, “Serious Illness Conversation Guide” is available through Ariande Labs.
- ✓ Work with EHR vendors to build workflows and screening tools directly into EHR applications.

## Project #7 | Improving Access to Homecare

### Team:

*Mary Ann Christopher, MSN, RN, FAAN Christopher Gribbin, MD  
Gail Kosyla, CPA, MBA/MS, FACHE*

### SHU Faculty:

*Terry Cahill, EdD, FACHE*

Design methods for residential providers to support residents that become terminally ill. This could include a waiver or application to an insurer or program to increase medical supports in the person's home, especially if the need comes to receiving hospice services in the home as well with patient- centered supports that include staff, housemates and others.

This executive learning team researched both public and private payer policies on supporting residential based care through palliative care support or hospice services. The goal being to make palliative care and or hospice services available to seriously ill beneficiaries earlier in the disease trajectory and before hospitalization.

**Outcomes:** Based on the findings, the group prepared a detailed report and recommendations that outline a mechanism for temporary increase in Medicaid or private insurance payments to residential providers to cover medical support in a residential setting as a means to improving access to homecare and decreasing hospitalizations at the end of life.

### Action Steps: [Home Based End-of-Life Care](#)

- ✓ An inter-professional palliative care team is proposed to include a board certified or equivalently experienced palliative care physician, advanced practice nurse, physician assistant, nurse, social worker, nutritionist, pharmacist, and other relevant ancillary supports.
- ✓ Insurance coverage for palliative services should not prohibit continued pursuit of potentially curative, or ameliorative therapy.
- ✓ Models for delivering palliative care on a per member per month basis (e.g., Medicare's CMMI project, Aetna's project) are suggested as a method for providing these services.
- ✓ Professional associations to advocate at the State and Federal level for legislative and regulatory changes that allow for the fullest implementation of home-based palliative care and expand eligibility for care.
- ✓ Engage HRET in establishing a learning collaborative among payers, physicians and providers to implement these recommendations including appropriate Pilots



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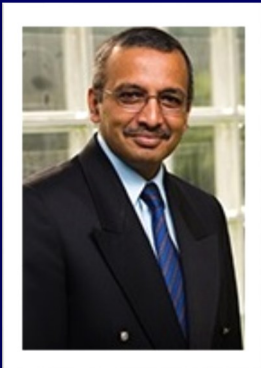


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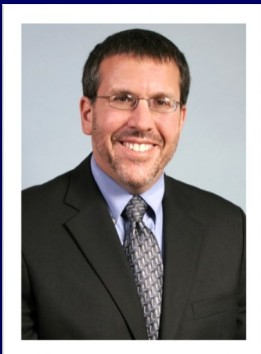
## Faculty

- **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.



## Faculty

- **Ning Jackie Zhang, MD, PhD, MPH**, is a professor in the Department of IHSA at SHU. His research centers on long term care, health informatics, health outcomes, quality and efficiency of healthcare delivery. Jackie has worked with hospitals, cancer centers, LTCs, pharmaceuticals and governments on disease management, comparative effectiveness, market access, and big data analytics projects. He is also the Executive Editor of International Journal of Healthcare Technology and Management.
- **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 Care 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.





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