



Bending the Health Care Cost Curve in New York State:

Implementation Plan to
Expand Palliative Care

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Prepared by The Lewin Group



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KATHY KUHMERKER and **JIM TEISL** of The Lewin Group led development of this implementation plan. The following individuals also contributed valuable input to the plan:

JULIA DONNARUMA
Hospital Association of New York State

KAREN LIPSON
New York State Department of Health

DIANE MEIER
Mount Sinai School of Medicine

CHUCK MOWLL
The Joint Commission

MOLLY POLETO
Healthcare Association of New York State

LORRAINE RYAN
Greater New York Hospital Association

ZEYNEP SUMER
Greater New York Hospital Association

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Overview

The following high-level implementation plan is presented as a follow-up to the New York State Health Foundation's (NYSHealth's) July 2010 report, "Bending the Health Care Cost Curve in New York State: Options for Saving Money and Improving Care." The report was designed to inform a State-level discussion of health care savings opportunities in New York, and outlines the estimated impact of 10 scenarios that could help to contain escalating health care costs in New York State over the next decade while also improving health care quality.

While the report demonstrates that New York State's health care cost curve can be bent through policy options that better coordinate care and improve health care outcomes, significant effort on the part of a variety of stakeholders is required to actually achieve these savings. With the assistance of a Technical Advisory Panel, four of the modeled scenarios were selected for high-level planning to identify the action steps, timeframes, and resources required for implementation. The following four scenarios were selected based on a combination of their savings potential, feasibility, and impact on quality of care:

- ▶ **Expanding Palliative Care.** Require hospitals to establish a palliative care program to promote better coordinated, higher value care where appropriate.
- ▶ **Integrating Care for Dual Eligibles.** Enroll New York's Medicaid/Medicare dual eligibles into a fully integrated coordinated care setting.
- ▶ **Adopting Bundled Payment Methods.** Make prospective payments for entire episodes of care, potentially encompassing inpatient care, physician services while hospitalized, and post-acute care services, including short-term rehabilitation and home health care.
- ▶ **Rebalancing Long-Term Care.** Restructure New York State's Medicaid programs for long-term care, examining both residential and community-based settings for a large population of beneficiaries with extensive functional and cognitive impairments, and behaviorally and medically complicated needs.

With the exception of the managed care for the dual-eligible population scenario, each of these opportunities can be advanced by the State of New York through the Medicaid and the State employee benefit programs, with minimal Federal involvement other than routine program oversight. While more significant savings are associated with adoption of these scenarios beyond these State-operated programs, implementation by New York State is a major first step toward more widespread adoption. In the case of managed care for the dual-eligible population, however, full implementation of the modeled scenario requires a change to Federal Medicare statute, which guarantees "freedom of choice" under the Medicare program.

For each of the four scenarios, we convened a group of stakeholders that included New York State officials, policy experts, and representatives of payers, providers, and patients. Stakeholders were not asked to endorse any of the scenarios, but were asked to comment on implementation requirements necessary to achieve each of the scenarios. Those involved in the planning process acknowledged that implementation of these scenarios will require a great deal of effort.

It is our hope that the following implementation plans can serve as a roadmap for policymakers seeking to contain costs while improving care coordination and quality. Achieving substantial improvement in the delivery of health care is neither quick nor easy, and requires active participation by government, providers, and payers working together, and not shifting costs. The potential improvements in efficiency and quality of care associated with these initiatives make it worthwhile to initiate implementation efforts as soon as possible.

Expanding Palliative Care Implementation Plan

SCENARIO SUMMARY

Palliative care is a process in which patients and families meet with providers to identify patient goals at a given stage of illness and to adopt a treatment plan that is consistent with these goals. The process typically results in “advance directives” that identify the type of life-prolonging care that a patient is willing to receive. Palliative care also includes developing a plan for “pain management” and other instructions designed to improve quality of life. While this scenario is focused on care provided in hospitals, palliative care is often provided in a variety of care settings, including nursing facilities and in community settings.

Under this policy scenario, the State would require, as a condition of licensure, that all hospitals have a palliative care consultation program for adult patients with extended hospital stays of seven or more days, regardless of payer. Hospitals with existing programs would be required to expand them, if necessary, to meet minimum requirements. This policy would apply regardless of payer because it would be a condition of licensure.

Based on modeling of this scenario, it is estimated that health spending could be reduced by \$11.9 billion over a 10-year period.

CURRENT ENVIRONMENT

While such programs are not currently required, estimates show that approximately 57% of hospitals in New York State currently have a palliative care program of some size. However, research indicates that, even in hospitals with a palliative care consultation program, not all eligible patients are offered palliative care services.

Palliative care programs have been the subject of recent New York State legislative activity. For example, New York Public Health Law (Section 2807-n) provided grants for undergraduate programs and faculty development related to palliative care and established the New York State Palliative Care Education and Training Council. Grant announcements are forthcoming, and funds will be available for physician educators and champions, and to establish an Institute for Palliative Care that will provide mentoring and technical assistance and disseminate best practices. Funds were also allocated to establish several Centers for Palliative Care Excellence. Standards for these Centers have been approved by the Council. Finally, in August 2010, legislation was enacted that will require physicians to counsel patients with less than six months to live.

The New York State Health Foundation (NYSHealth) has funded a program with the Center to Advance Palliative Care (CAPC) to broaden the reach of existing palliative care programs in New York State hospitals. Several New York hospitals currently have ACGME-accredited palliative care fellowship programs (e.g., Mount Sinai and the University of Rochester). In addition, the Kaiser Permanente Palliative Care Project is a multidisciplinary care management approach for home-based end-of-life care and treatment, designed to ease the transition from acute to palliative care through various means.

A recent study published in the August 19, 2010 edition of the *New England Journal of Medicine* found that early palliative care not only improved quality of life among lung cancer patients, it resulted in

¹ Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010;363:733-742.

Expanding Palliative Care Implementation Plan *(continued)*

their longer survival.¹ Findings such as these should help to refute the notion, among both patients and providers, that palliative care is an “end of life” alternative to life-prolonging treatment.

OBSTACLES TO IMPLEMENTATION

The most significant obstacle to implementation is the lack of trained palliative care practitioners. This is primarily due to the lack of training programs and the fact that Graduate Medical Education (GME) slots, capped by the Balanced Budget Act of 1997, are typically used to fund programs for more profitable specialties.² As a result, hospitals that wish to expand or establish a palliative care program may not have the necessary staff or resources available to sustain their programs.

A second potential obstacle is that national certification standards for palliative care programs are not currently available. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) has, however, developed palliative care program standards that could be rapidly deployed once a decision is made to do so. Should New York State mandate palliative care standards in all hospitals in the State, JCAHO would likely release the standards.

Another potential obstacle is that palliative care policies can be politically controversial and can be construed as “denying” people treatment rather than assisting them with understanding care options, and helping them to make decisions about their quality of life. Palliative care should be considered not only within the context of end-of-life issues, but with recognition of its value in the context of longer-term chronic conditions. Mandating palliative care programs as a condition of licensure may require New York State statute and, therefore, may need to be addressed through an education campaign to effect a social culture change related to palliative care. Culture change will also be required at the provider level. Intensivists, for example, may consider end-of-life care to be their area of responsibility, and may be less likely to refer a patient for palliative care consultation.

A final potential obstacle is that under existing reimbursement policies, only doctors and nurse practitioners can bill directly for palliative care services. Despite the fact that an effective palliative care program requires an interdisciplinary team, all other related services need to be incorporated in general administrative and overhead costs. Moreover, establishing additional certification requirements may lead to increased provider overhead costs and a portrayal of the new policy as an unfunded mandate. Access to additional seed money may need to be explored to address this potential obstacle.

ACTION PLAN

Baseline Assessment

Department of Health Activities

- ▶ Catalogue existing programs and characteristics.
 - Determine the nature of the data currently available on each program and what data should be collected for future analysis and reporting.
 - ▶ Note that the Center to Advance Palliative Care (CAPC) has a palliative care registry (getpalliativecare.org) that is updated annually based on American Hospital Association data. Data include staffing, funding, types of patients, referral source, payer, etc.

² Slots are allocated for geriatric care, but not specifically for palliative care.

Expanding Palliative Care Implementation Plan *(continued)*

- Determine how data will be collected in the future.
 - ▶ New York State could potentially require hospitals to participate in the CAPC data collection effort or establish additional reporting requirements and vehicles.
- ▶ Identify statutory and regulatory provisions related to provision of program and reimbursement.
 - Review existing statute and regulations to identify provisions specifically affecting palliative care programs, including for use of controlled prescription medications and GME program provisions.
 - Identify, for each type of statute or regulation, the steps that would need to be taken if changes were required, as well as projected timeframes for initiating such changes (e.g., statutory change will likely require drafting of a Governor's Program bill; and regulatory changes will likely require approval of the Public Health and Health Planning Councils (PPHCs)).

Palliative Care Council Activities

- ▶ Identify characteristics of existing palliative care workforce.
 - Develop agreed upon definitions of palliative care workforce (e.g., types of professionals and primary work locations).
 - Gather data on existing palliative care workforce from existing sources.
 - Determine whether additional reporting or data collection is needed for ongoing workforce assessment.
- ▶ Catalogue existing training programs.
 - Identify different types of training programs within New York State (school-based, residency-based, etc.) and competencies developed by these programs.
 - Determine slots/openings/funding/etc. available and recent historical participation levels/rates.

Program Design

New York State Department of Health Activities

- ▶ Establish stakeholder group to assist in the development and vetting of program design and related activities.
 - Identify potential members.
 - ▶ Hospital/home care/medical/allied health professional associations and representatives
 - ▶ Palliative care providers
 - ▶ Patient advocacy groups
 - ▶ State regulators
 - ▶ JCAHO or other certification bodies

Expanding Palliative Care Implementation Plan *(continued)*

- Develop proposed scope of stakeholder activities.
 - ▶ Assist in developing program design.
 - ▶ Gather feedback from the field.
 - ▶ Champion program changes.

New York State Department of Health Activities Informed by Stakeholder Group

- ▶ Determine whether to focus palliative care efforts on individuals other than those with stays of at least seven days (e.g., particular diagnoses) and/or whether to include children.
- ▶ Determine certification standards that hospitals will be required to meet.
 - Review JCAHO draft standards to determine whether they are appropriate for use in New York. Contact other certification bodies (e.g., the Healthcare Facilities Accreditation program and Det Norske Veritas) to determine whether these organizations have draft standards that should be considered.
 - Identify New York State-specific variations, if any, that should be considered (for example, it may be desirable to allow hospitals with fewer than 100 beds to meet less comprehensive certification standards).
 - Determine the appropriateness of promoting tiers of certification (similar to National Committee for Quality Assurance medical home levels) and, if so, whether these differing tiers should be considered steps to full certification or acceptable levels of certification in and of themselves.
- ▶ Determine timeframes for mandated hospital attainment of the various types and tiers of certification established, taking into account such issues as availability of a trained workforce.
- ▶ Develop standards or “triggers” for screening and referral to promote consistency in application across the State, including:³
 - Whether the requirements for palliative care consultation should be applicable to both adults and children, specific disease conditions or diagnoses, or all adults/children who have hospital lengths of stay of a certain duration.
 - Whether there are methods to promote the integration of these “triggers” into hospital operations, such as requiring that hospital electronic medical record systems have the ability to issue alerts in such cases.
- ▶ Determine whether revised reimbursement approaches are necessary to promote adoption.
 - Review existing reimbursement policies to identify potential disincentives.
 - Determine the extent to which these disincentives can be modified.

³ CAPC is close to publishing “triggers” for palliative care referrals and these could be used to frame any New York State requirements.

Expanding Palliative Care Implementation Plan *(continued)*

- ▶ Determine the need for enhanced training programs to support the palliative care program.
 - Identify gaps in existing training programs (number, capacity, and type) based on assessment of the number and types of providers necessary to support enhanced palliative care programs.
 - Review programs available in other states that could be used to support New York’s palliative care program or that could serve as models for New York State training programs.
 - Develop approaches to supporting training programs, such as loan repayment programs, modification of GME program parameters, opportunities to generate seed money, inclusion of ACGME-accredited fellowship programs (at a cost of about \$75,000 per fellow).
- ▶ Determine whether workforce limitations necessitate changes to the program design.
- ▶ Consult with Palliative Care Council (to the extent that council members are not also included in the stakeholder group) periodically throughout development of program design.

Implementation

New York State Legislature

- ▶ Amend State statute (Article 28 of the Public Health Law) as necessary.

New York Department of Health Activities

- ▶ Amend State statute (Article 28 of the Public Health Law) and State regulations as necessary.
 - Prepare information materials and briefing sessions for involved legislative staff and legislators, as well as Public Health and Health Planning Council members.
- ▶ Develop hospital licensing and survey and certification procedures.
 - Identify staffing and training needs.
 - Develop enforcement procedures, if necessary.
- ▶ Establish evaluation program to assess impact on costs, quality, and quality of life as programs are implemented.
 - ▶ Determine the appropriateness of quality guidelines that have been developed previously (e.g., National Quality Forum standards) and that may already be used (e.g., by the Centers for Medicare and Medicaid Services).

Stakeholder Group Activities Led by Provider Associations

- ▶ Develop promotional and educational campaigns to inform the public of the benefits of palliative care and to overcome the stigma of such programs.
 - Highlight the value of making choices about how one wants to receive care, aspects that are important, and ability to identify needed (or desired) treatment in cases of end-of-life and chronic condition management.
 - Educate consumers regarding the distinction between palliative care and hospice care.
 - Consider public service announcements, news stories, billboards, etc.

Expanding Palliative Care Implementation Plan *(continued)*

- ▶ Promote overall provider culture change in hospitals.
 - Develop leadership and technical assistance programs to support the establishment of new and expansion of existing programs.
 - ▶ Identify champions who can guide relative newcomers; identify and promote opportunities for them to provide support.
 - ▶ Identify and provide technical assistance needs required by new or expanding programs.
 - Consider incorporating palliative care continuing education requirements for license renewal for specific specialties.
 - Meet with medical schools to promote increased incorporation of palliative care in curriculum.
- ▶ Educate providers about upcoming requirements and related topics including decision-making and patient autonomy, advanced directives, hospice, and end-of-life care.
 - Conduct regional training sessions focused on different constituencies (e.g., hospital administrators, physicians, nurses, other allied health professionals, and post-acute care providers).
 - Make presentations at various conferences.
 - As appropriate, publish guidelines, program updates, etc.
 - Update website.

Hospital Activities

- ▶ Participate in State-based activities noted above (likely through associations).
- ▶ Develop internal champions among both clinical and medical staff to educate hospital staff on the benefits of palliative care and encourage referrals to the palliative care team. These efforts will likely require technical assistance that may be available through a number of sources:
 - Grant funding and program information is available through the New York State Palliative Care Education and Training Council and the Institute for Palliative Care created through the recent palliative care legislation.
 - CAPC is also available to provide technical assistance and the Greater New York Hospital Association (GNYHA) has indicated a willingness to work with CAPC to help grow programs.
 - NYSHealth is supporting CAPC's efforts to extend technical assistance for program development.
- ▶ Modify policies and procedures to meet palliative care program requirements.
 - Engage physicians and other health professionals in determining how and when palliative care program components should be incorporated.
 - Address areas that may be of specific concern (e.g., intensive care unit operations and discharge planning).
 - Determine the appropriateness of incorporating internal hospital incentives and disincentives to promote palliative care programs.

Expanding Palliative Care Implementation Plan *(continued)*

- ▶ Determine whether systems modifications will be needed (e.g., electronic medical records and quality monitoring programs).
- ▶ Enhance relationships with post-acute providers, as necessary.
 - Meet with post-acute providers to discuss program and gather input.
 - Assess whether current post-acute providers can provide the same level of care as the hospital's palliative care program.
 - Consider whether a mandate is needed to promote post-acute providers establishing palliative care programs.
 - Expand number and type of post-acute providers available for coordination with hospital.

Required Resources

As with any new program, resources will be required to achieve implementation and to sustain the program into the future. The following resources are expected to be needed:

New York State

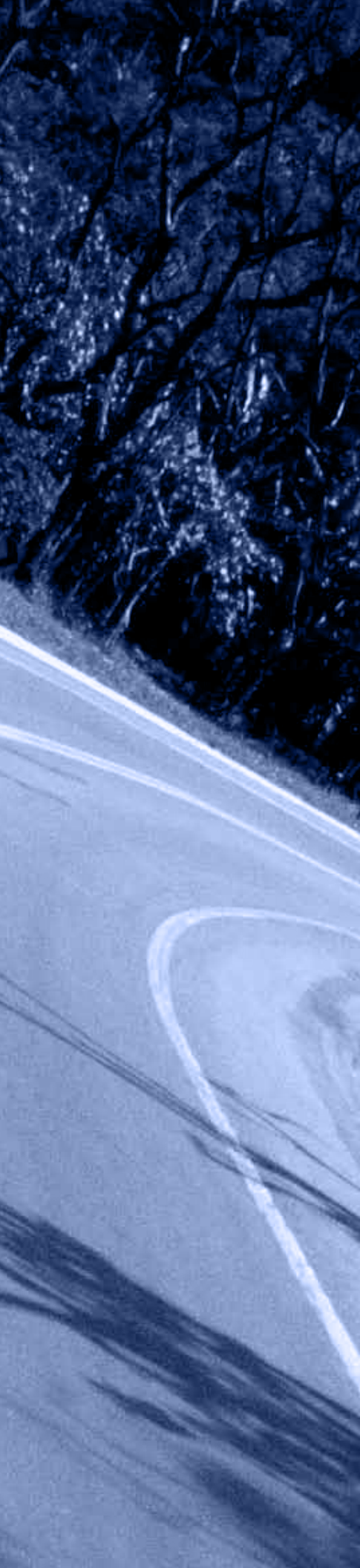
- ▶ Policy staff to develop and analyze program design options, coordinate stakeholder meetings, draft legislative and regulatory changes, and develop program materials.
- ▶ Funding to support technical assistance activities and training enhancements and incentives.
- ▶ Funding for public educational campaign and leadership development.
- ▶ Funding to support enforcement infrastructure.

Providers

- ▶ Capital for technical assistance and program start-up.
- ▶ Staff to develop new policies and procedures for palliative care consultations.
- ▶ Additional discharge planning staff or other resources to manage potential increase in discharges to hospice and other community-based care settings.

Expanding Palliative Care Implementation Plan *(continued)*

ESTIMATED IMPLEMENTATION TIMELINE FOR EXPANDING PALLIATIVE CARE													
Policy Option: Expanding Palliative Care	2010	2011				2012				2013			
ACTION STEP	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Identify stakeholders to participate in policy development	Program Design												
Conduct baseline assessment, including programs, workforce, standards, and regulatory	Baseline Assessment	Baseline Assessment											
Determine program parameters (e.g., mandate, target population, certification standards, phase-in, etc.)	Program Design	Program Design	Program Design										
Hospitals conduct leadership development and collaboration efforts		Implementation	Implementation	Implementation	Implementation	Implementation							
Identify needed changes in statutes and regulations			Baseline Assessment										
Identify needed changes in provider reimbursement rates/methodology			Program Design										
Develop/modify program standards for incorporation in licensure surveys/reviews		Program Design	Program Design										
Submit proposed changes to PHHPC for review and input			Program Design	Program Design									
Draft/enact proposed changes through Legislature, including incorporating funding needs			Implementation	Implementation	Implementation	Implementation							
Amend provider reimbursement policies (if necessary)				Implementation	Implementation								
Develop/enhance provider training programs				Implementation	Implementation	Implementation	Implementation	Implementation	Implementation	Implementation			
Hospitals system changes and policy updates						Implementation	Implementation	Implementation	Implementation	Implementation			
Develop consumer and provider education and promotion campaign						Implementation	Implementation						
Conduct consumer and provider education and promotion campaign								Implementation	Implementation	Implementation	Implementation		
Go live												7/1	



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VOICE: 212-664-7656

FAX: 646-421-6029

MAIL: 1385 Broadway,
23rd Floor

New York, NY 10018

WEB: www.nyshealth.org