Long Term Care Subcommittee
Evelyn Dooley-Seidman, MD, Chair
Steven Kaner, MD
John Ostuni, MD
Jay Slotkin, MD
Joan Cincotta, Alliance

MSSNY Staff:
Moe Auster, Esq., MSSNY Staff, Division of Governmental Affairs
Pat Clancy, MSSNY Staff, Division of Governmental Affairs
John Belmont, MSSNY Staff, Division of Governmental Affairs.
Anna Cioffi, MSSNY Staff, Division of Governmental Affairs.

John Belmont was introduced as our new staff person. He will be working with Pat on this Committee.

1) Welcome/Introductions: Dr. Dooley-Seidman welcomed the subcommittee and guests.

2) Approval of Minutes from September 21, 2016: Approved as written.

A question was raised about the May 18th minutes. At the end of the minutes there was a description of what happened with the resolution calling for collaboration with the VA. The Long Term Committee was charged with developing a report for the House of Delegates.

Presentations:
Paula E. Lester, MD, FACP, CMD, Associate Director, Winthrop Transition Level of Care Program at Sunharbor Manor; Associate Program Director for the Geriatric Medicine Fellowship at Winthrop University Hospital and Assistant Professor of Clinical Medicine at Stony Brook University Hospital.

Dr. Lester provided slides and discussion on palliative care which is a relatively new concept and it's more new in the nursing homes. There is growing recognition about the value of palliative care for quality and to reduce costs in both hospital setting, and true more so, in the nursing home setting.

Dr. Lester indicated that there was a New York state law a few years ago (2011) about requiring physicians to provide palliative care to patients with terminal conditions of six months or less and has been added to the Palliative Care Access Act. The law is actually for the agencies, for health care facilities, nursing homes, home care agencies, assisted living, as well as individual providers, actually have to now offer information and counseling to facilitate access to appropriate palliative care, including pain management. This applies to patients or residents with advanced life limiting conditions or illnesses that might benefit from palliative care and not just those who are terminally ill.

Dr. Lester indicated that she and Dr. Stefanacci conducted a nationwide survey of directors of nursing about what kind of palliative care and nursing care they have in their facilities. This survey showed that for-profit facilities were more likely to have a palliative care program and more likely have a medical director for palliative care, not to say that not-for-profit facilities don't care about profit because everyone needs to run a profit. Nursing homes with religious affiliations were less likely to have a formal palliative program. Sometimes there was a long period and it seems there are still some people who think palliative equals hospice, or palliative equals death panels, or that palliative equals no treatment. What was interesting also was that in the nationwide study social workers and nursing staff were more likely to be the ones to inform patients and families about palliative care programs, rather than coming from the physician.

When we asked people what their palliative care program included:
• 42% had a consultation provided by a physician certified in hospital/palliative care and almost half of them did have a palliative certified person, but more than half of them didn’t, so what does palliative mean in those settings;
• 28% has a designated palliative medical care director;
• One-third had interdisciplinary rounds;
• 60% included bereavement or memorial services; and
• 56% incorporate nursing training/education program into their staff.

It took a while to publish this survey but there was a follow-up study in NYS and the results accepted yesterday by the American Journal of Hospice and Palliative Medicine. This survey was only New York State and we did not survey only physicians, but we also surveyed nurses, social workers and other staff members and it is now a few years later and it shows some growth within palliative. We conducted the survey in 2015. We had almost 150 respondents - a lot of medical directors and physicians. What is interesting was there was a higher percentage of comfort care programs.

Dr. Lester indicated that questions about people’s perception to that palliative care, there were specific differences between doctors and other ordering nursing and others. Doctors agreed more that palliative care makes it more likely for patients to die in the nursing homes instead of the hospital. Physicians agreed more that palliative can be provided at the same time as these modified treatments such as chemo and radiation. Doctors agreed less that palliative care meant giving up medical treatment and doctors agreed more that palliative care can be provided along with rehab services. It seems like the physicians understand the goal that palliative can recognize play in the nursing homes and that more education needs to be done even in the places that have services.

The survey also asked if palliative care was only for patients that were dying soon. The survey found that the statistical difference based on how long people had a palliative program and the longer someone had a program, the more they realized that wasn’t true that palliative care could be earlier in illness and can help along the process. Palliative is not only end of life and that is a big difference from hospice.

**Developing a Palliative Care Program in the Nursing Home (See Slide Sets presented to the Subcommittee Members).**

Dr. Ostuni said that in his nursing home the average age is 83 so we consider every patient palliative care. There are a lot of benefits to nursing care as decrease in hospitalization, but also putting patients on hospice or acute hospice at least they don’t have to pay room and board which is through Medicare.

Dr. Slotkin said that Paula’s presentation is really terrific about all the elements. Dr. Lester added that the problem is that people who are on a committee are all geriatric doctors, either by training or experience, who understand it and get it and work in places that recognize it and value that so there are still a lot of facilities that are internists and go in for their monthly, don’t want to be bothered.

There was also discussion about a resolution for the MSSNY’s 2017 House of Delegates supporting a palliative care with reimbursement. The consensus was that the committee will continue to think about this.

Al Cardillo, Vice President, Home Care Association of New York State (HCA), also offered some information related to the State Palliative Care Education and Training Council. The Council has drafted a report that examined the opportunities through education and training in palliative care in all health care settings so that all respective sectors with the goal of looking at creating clinical competence on the part of staff.

Pat Clancy suggested to Dr. Dooley that Dr. Jeffrey Berger, who serves as the MSSNY representative to the Council, may be someone to address the committee. Dr. Berger has been significantly involved in palliative medicine and palliative care efforts in the state. Al Cardillo said that the next meeting of their palliative care committee is on January 25 and Dr. Beth Popp from Maimonides is planning on being there to give an update on this report. Pat Clancy will reach out to Dr. Berger to assess his availability.

Al Cardillo gave an update on the Task Force of MSSNY and the Home Care Association met several times over the course of the fall and discussed issues and tried to prioritize those issues related to home care and physician engagement and partnership together. One large category that was a priority focus involved the various regulatory levels and logistics which really form impediments in terms of the timely turn-around of physician signatures, the mountain of duplicative
paperwork that ends up on physicians' desks and just look at the ways that that has created for timely signed records, just the logistics that go along with that. One particular aspect is the federal face-to-face requirement that requires a face-to-face encounter between the patient and the physician. Documentation in the patient's record of eligibility based on that face-to-face encounter in order for home care to be covered for recipients. The ACA legislation required a face-to-face encounter and that needed to be documented by the physician within 90-days of the start of care. Mr. Cardillo said the task force has talked about what could be done federally. With the change in administration, there clearly are signals about a cultural change with respect to regulation to society.

The second piece which is at the state level on the Medicaid side, Mr. Cardillo said there was a meeting with the Department of Health discussing what the department would envision and what would have to be put in place in order to comply with requirements. The department invited us to put together a draft outline of what we would think would be some streamline guidelines. Mr. Cardillo and Mr. Auster are putting together a document that we could co-brand and co-endorse and send to the department indicating that here are some recommendations for what would be a mitigated approach to face-to-face under the Medicaid side that would minimize the crossovers. Additionally, MSSNY will develop articles in MSSNY publications that have alerted our membership to the activity that is taking place through this collaboration with the home care association and to help educate and to also get ideas on what we can be working on and set the foundation for folks to pay more attention to this issue. Dr. Dooley said that Moe was very helpful in developing that article that was published in the MSSNY News.

**Next Meeting:** Next meeting will take place on May 10, 2017.