New Jersey Society for Healthcare Consumer Advocacy
www.njshca.org

NJSHCA Newsletter

President's Pen

March 2012

We are two months into a new year, and there is already a lot of activity and work being done within our group following the Executive Board meeting that was held in January. Teresa has been very busy putting together some great programs and speakers for our quarterly meetings in 2012. When all arrangements have been finalized, more details will be available. Ellen continues to work on the nomination process to be followed by a special election for the position of President-Elect, which is part of the Executive Board. The results of the election will be announced at our March meeting. Debbie has received almost everyone's membership dues for 2012, and I think we set a record this year in accomplishing this very early in the year. Kudos to all of you who made the arrangements with your hospital to have your yearly dues paid by the end of January. We all appreciate what a challenge this is.

Gerry and Sr. Marion are also working on plans for our annual conference/ retreat, which will again be held in June at the beautiful Maris Stalla Conference Center in Harvey Cedars on Long Beach Island. Gerry is working on finalizing details for a speaker – and the information so far sounds very interesting. I'll give just a small hint to pique your interest – Is there anyone among us who does not find the topic of "dreams" interesting?? Sr. Marion will be providing us with a fun and meaningful group activity that in some way will tie in to the same topic. More to come on this also as arrangements are finalized

While I am on the subject of the conference, I want to again express my hope that those members who would normally attend the meetings at the NJHA, but who have not participated in the annual conference/retreat give serious thought to coming to the meeting in June on Long Beach Island. I can not convince you of what a worthwhile and truly enjoyable event this is – you have to experience it for yourself by attending. The date will be Friday, June 8th and the option is yours to either make it a day trip (in which case your yearly membership dues will cover all expenses), or stay overnight to extend the fun, beautiful surroundings and friendships within our group for a cost of $50 that would be payable to Maris Stella.

There are several members who will be attending the annual SHCA Conference that will be held in Austin, TX in April. As these are "paperless" events, the content of all sessions are provided to attendees on flash drives, and I will once again, make sure that all of the program content is shared with every one. I am confident of another successful year for our group, and I look forward to seeing all of you in March.

Linda

Inside this issue:

2012 Meeting Dates

Mar. 15, 2012

June 8, 2012 Retreat

Sept. 20, 2012

Nov.15, 2012

Welcome New Members

Christine Beckett

Oscar Leon

Kay Sweet-Springs

Congratulations to Nikki Mederos on being inducted as the New President Elect for her district's Rotary International Club.

NJSHCA Meeting

March 15, 2012

New Jersey Hospital Association Conference Center
760 Alexander Road
Princeton, NJ
(609) 275-4035

Communication Access to Healthcare for People who are Deaf and Hard of Hearing

Jointly presented by:

- *Traci Burton, Specialist in working with people who are hard of hearing;*
- *Jason Weiland, Specialist in working with people who are deaf; and*
- *Cathy Grehlinger, Coordinator, Interpreter Referral Unit*

Please inform the treasurer, Linda Flanagan
by March 12, 2012 your intention to attend.

lflanagan@virtua.org
Phone # (609) 914-6555

SHCA Society for Healthcare Consumer Advocacy of the American Hospital Association

News You Need

A BI-WEEKLY NEWS AND INFORMATION RESOURCE FROM THE SOCIETY FOR HEALTHCARE CONSUMER ADVOCACY

Biggest Medicare Fraud in History Busted, Say Feds – ABC News

By JACK CLOHERTY (@jjclo) and PIERRE THOMAS (@PierreTABC) Feb. 28, 2012

Federal officials say they have taken down the largest Medicare fraud scheme investigators have ever discovered: a $375 million dollar home healthcare scam operating in the Dallas, Texas area.

The alleged "mastermind" of the fraud, Dr. Jacques Roy, is charged with certifying hundreds of fraudulent claims for Medicare reimbursement, and pocketing millions in payments for services not needed, or never delivered. Prosecutors say the 54-year-old Dr. Roy, who was arrested today and could be sentenced to life in prison, operated a "boiler room" to churn out thousands of phony Medicare claims and recruited homeless people as fake patients.

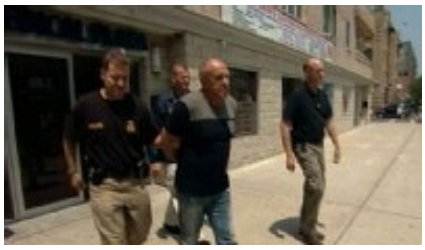
"Today, the Medicare Fraud Strike Force is taking aim at the largest alleged home health fraud scheme ever committed," said Assistant Attorney General Lanny Breuer. "According to the indictment, Dr. Roy and his co-conspirators, for years, ran a well-oiled fraudulent enterprise in the Dallas area, making millions by recruiting thousands of patients for unnecessary services, and billing Medicare for those services."

The New Face of Health Care Fraud

The government charges that Dr. Roy was planning to take the money and run. He allegedly hid much of his Medicare money in an offshore account in the Cayman Islands, and in documents filed in court today, the government charges that Dr. Roy was planning to change his identity and flee the country to avoid prosecution. In a motion opposing bail for Dr. Roy, prosecutors claim that he had created a false Canadian identity under the name Michel Poulin, had a copy of a book called "Hide Your A$$ET$ and Disappear," and a guide to yacht registration in the Caymans.

The Biggest Medicare Bust in History

Dr. Roy's scam was clever, wide-ranging, and very, very profitable, according to prosecutors. He allegedly exploited the Medicare regulation that requires a doctor to "certify" that Medicare services are legitimate – that they are needed and are being delivered to the patient. Dr. Roy allegedly sold his certification as "a commodity" to nearly 500 home health care companies in Texas, certifying patients for Medicare services regardless of whether they needed them or received them. In return, the government charges, Dr. Roy would receive a portion of the fraudulent Medicare payment.



Grand Theft Tax Dollars

Between 2006 and 2011, according to the 13-count indictment unsealed today, Dr. Roy certified more Medicare beneficiaries for home health services and had more patients, than any other medical practice in the United States. He allegedly even had a "boiler room" where employees worked all day signing his name on Medicare claims. Roy's company, Medistat Group and Associates, received hundreds of claims per day, and Dr. Roy allegedly instructed employees in the company's "485 Department," named for the "Plan of Care" form, to sign his name by hand or affix his electronic signature. Since 2006, according to prosecutors, Medistat Group and Associates has "certified more than 11,000 unique patients from over 500 home healthcare agencies in the Dallas-Fort Worth area." Medistat and the home health care agencies billed Medicare for more than $350 million and Medicaid for more than $24 million for these patients.

Homeless 'Patients' Recruited in Alleged Medicare Fraud

Seventy-eight companies associated with Dr. Roy will have their Medicare eligibility suspended immediately as a result of this indictment, the Justice Department says, and six associates of Dr. Roy's alleged scheme were also charged as co-conspirators. Operating under the company names Apple of Your Eye, Ultimate Care and Charry Home Care, among others, the associates allegedly fed a steady stream of fraudulent clients to Dr. Roy to be certified as Medicare eligible. In some cases, the indictment charges, Medicare patients were recruited by offering cash and groceries in return for signing up for home health care. These fraudulent "patients" were then allegedly certified by Dr. Roy for services. Some of those recruits didn't even have a home to visit according to sources close to the investigation: they were recruited from homeless shelters.

For example, the indictment charges that Charity Eleda of Charry Home Health services "visited The Bridge Homeless Shelter" in Dallas to recruit Medicare patients. She allegedly sat in a parked vehicle outside the shelter, and hired recruiters to send prospects to her car. She allegedly paid the recruiters $50 per new "patient." "Any treatment that Charity Eleda provided was either in her vehicle, in the courtyard of the Bridge, or on a park bench," said the indictment.

Dr. Roy's business manager, identified in the indictment as J.A., allegedly recorded phone calls with Dr. Roy in which he objected to working with the coconspirators to drum up phony business, and suggested that the company "invest in legitimate marketing" to attract business instead. According to the indictment, Dr. Roy responded, "I've done enough marketing to know it's b___sh__, and I don't want to do it."

Federal sources say investigators have been looking into Dr. Roy's operation for years, and he was suspended from the Medicare program in 2011. But according to documents filed today, Dr. Roy found a way around the suspension by creating a new company, "Medcare HouseCalls," and working through his associated companies.

Last summer, investigators searched his home and found evidence that Dr. Roy had stashed some of money he alleged stole from Medicare in a secret account in the Cayman Islands. There was also evidence that Dr. Roy had created a false identity for himself -- he had a fake driver's license and a birth certificate in the name of Michel Poulin, and applications for Canadian citizenship. Investigators also found bank deposit slips from Cayman Island banks, a guide to yacht registration in the Caymans, a book titled "Hide Your A$$et$ and Disappear: A Step by Step Guide to Vanishing Without A Trace," and a copy of "The Offshore Money Manual."

SHCA 2012 Annual Conference

April 17 - 20 ★ Austin, TX

★ Be a Patient Advocate Star! ★

SHCA
Society for Healthcare Consumer Advocacy
of the American Hospital Association

American Hospital Association

In This Issue

2012 SHCA Annual Conference
Austin, Texas
April 17-20

Renaissance Hotel
Attendee Rate: $160/night

Annual Conference Website

Register Now

Hotel Information

Airfare and Ground Transportation

Follow Us

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Take a Leap - Register for the SHCA Annual Conference!

Early bird registration extended to March 2 !

Be empowered - learn from your peers and expert faculty how to become a more effective and efficient patient advocate!

Click Here to register online and receive the Early Bird rate

Download the complete conference brochure and start planning your educational experience. Visit the 2012 conference website for all of the updated details including travel, learning sessions and events. Specific registration details can be found on pages 14-15. You can also fax your registration form to (312) 422-3609.

Hotel Deadline: Reserve your hotel room by March 25 in order to receive the group rate. Call (512) 343-2626.

Do you need help getting support to attend the conference?

SHCA has created a tailored and customizable economic justification toolkit that will build your case to attend the conference.

Planning Reminders...

- Book your hotel accommodations by calling 1.512.343.2626. Ask for the SCHA block. The room rates are $160/night. Government rate is $104/night. All conference events and educational events will be held at the Renaissance.
- Book your flight. SHCA has secured discounts from the following airlines United, American, and Delta airlines. For code details, refer to the SHCA conference website.
- Review, print, and pack your conference program, speaker bios, and session handouts; make a list of what you need/want to learn and experience while you're there; review speaker & session details to ensure you have selected learning opportunities that will challenge and increase your patient advocacy tool kit; don't limit your learning by sitting with those that you already know or keep you in your comfort zone; and pack your business cards.

SHCA
Society for Healthcare Consumer Advocacy
of the American Hospital Association

Domains of Practice
Certificate Program

American Hospital Association

In This Issue

Module 3: Healthcare Management: Administrative

March 21, 2012
1:00 p.m. CST

Module Prices:

Individual Module

$140 - Member Price

$240 - Non Member Price

Register Now

2012 Curriculum Season Pass:

$1400 - Member Price

$2500 - Non Member Price

Register Now

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Register for the SHCA Domains of Practice Curriculum

Module 3: Healthcare Management - Administrative

Wednesday, March 21, 2012 - 1:00 p.m. CST
Single module member price- $140

Directing a patient advocacy program calls for having superior conflict resolution skills, problem-solving abilities, and great empathy. The patient advocate must master fundamental management functions and be pro-actively involved in quality improvement efforts, bringing into focus the patient at all times. Join us for this 75 minute webinar which includes real world perspectives and tips with a live Q & A segment.

Module 3 Learning Objectives:

• Define the elements of the strategic planning process.

• Articulate the fiscal responsibilities of a healthcare patient advocate.

• Define the steps of an effective budgeting process.

• Analyze the financial status of a department or strategic business unit based on its budgetary projections and actual performance.

• Define the advocate's role and responsibilities as it relates to quality improvement and institutional accreditation.

Module Faculty:

Brenda Radford, Director of Guest Services, Duke University Hospital

*Mindy Raymond, Vice President of Human Resources, Boca Raton Regional Hospit*al

Click here to learn more about registering your facility for the Season Pass. If you think you may need to convince your supervisor, check out the justification toolkit tailored to help build your case.

Continuing Education Contact Hours

This program has been recognized by the Illinois Nurses Association for 1.5 contact hours.

Department of Health and Senior Services
News Releases

P.O. Box 360
Trenton , NJ 08625
CONTACT: Office of Communications
609-984-7160
RELEASE: February 02, 2012

Department of Health and Senior Services and University Medical Center at Princeton Convene End-of-Life Roundtable Announces New Jersey Hospital Association to Develop New Standardized POLST Form

(Princeton) On Friday, February 3, New Jersey Health and Senior Services Commissioner Mary E. O'Dowd will join with University Medical Center at Princeton (UMCP), the acute care hospital of Princeton HealthCare System (PHCS), to convene a roundtable discussion about end-of-life care and the Physician Orders for Life-Sustaining Treatment (POLST) law recently signed by Governor Christie. She will be joined by physicians, nursing home industry leaders, hospital association representatives and a family member of a nursing home resident. The roundtable will be held in Ground Floor Conference Room A at University Medical Center at Princeton at 11am.

"End-of-life care raises many difficult and emotional issues for patients and their families and is often complicated by inadequate planning," said Commissioner O'Dowd. "The POLST form can improve end-of-life care by clearly outlining an individual's decisions on what type of medical care they desire, making it easier for health care providers to honor a patient's wishes."

The standardized POLST form, which is signed by a patient's attending physician or advanced practice nurse, provides orders for health care personnel to follow for a range of life-sustaining treatments such as feeding tubes, ventilators and medication. The POLST form is designed to outline the wishes of those who have a terminal illness or a compromised medical condition.

This new law directed the Commissioner to designate a Patient Safety Organization to develop a standardized POLST form for which the New Jersey Hospital Association (NJHA) Institute for Quality and Patient Safety was selected. The NJHA will prescribe this form, as well as, promote awareness among health care professionals and the public about the option to complete a POLST form. Additionally, NJHA will provide ongoing training of health care professionals and emergency care providers about the use of the POLST form.

"POLST empowers patients to discuss their end-of-life wishes with their physicians – and then ensures that those wishes are documented in a standardized form recognized across the healthcare spectrum," said Betsy Ryan, NJHA President and CEO. "As longtime supporters of POLST, we'll continue our intensive work with hospitals, physicians, post-acute providers and others to improve end-of-life care and to honor all patients' care goals in their final days."

Dr. David Barile, director of the Acute Care for the Elderly (ACE) unit and Palliative Care Program at UMCP, and executive director and chief medical officer of New Jersey Goals of Care will open the event with a presentation outlining a Partnerships for PIECE (Patient-Centered, Integrated Elder Care and Empowerment) initiative to improve older adults' transition from the hospital to the community. Princeton HealthCare System is piloting a version of a POLST form at University Medical Center at Princeton and nine skilled nursing facilities in the region as part of a two-year Robert Wood Johnson Foundation grant initiative.

At the roundtable, the need to improve care for seriously ill patients and ways to promote conversations about end-of-life will be discussed. The roundtable will also focus on bringing greater attention to the enactment of POLST legislation in New Jersey and how it will benefit those who have a terminal illness or a compromised medical condition.

The Department of Health and Senior Services website provides forms, tools and guidance to help residents plan end-of-life decisions. The Department's online resources, available at www.nj.gov/health/advancedirective, include more information on the POLST legislation, advance directive forms, educational materials, toolkits for completing an advance directive and links to web sites with additional information on hospice and palliative care.

NJ SPOTLIGHT
WHERE ISSUES MATTER

Easing End-of-Life Care

2011 WINNER ONLINE JOURNALISM AWARD
GENERAL EXCELLENCE
ONA ONLINE NEWS ASSOCIATION

Pending legislation would make it easy to bring together patients, their physicians, and their families to map out how patients want to spend their last days

By **Beth Fitzgerald**, **November 29, 2011** in **Healthcare**

End-of-life care is always a difficult issue.

In New Jersey it's also one that is both costly and aggressively pursued: The latest Medicare study by the nonprofit Dartmouth Atlas, which analyzes nationwide variations in healthcare, found that nearly 25 percent of New Jerseyans spent a week or more in the hospital intensive care unit in their last six months, compared with the national average of 15 percent. In that time they saw an average of 11 doctors, compared with eight for the nation. Medicare spending averaged $65,436 in the last two years of life in New Jersey, compared with $53,441 for the U.S., according to the Dartmouth Atlas review of 2003 to 2007 Medicare data.

Experts say the cost of end-of-life treatments can be reduced if patients diagnosed with a terminal illness were encouraged to write an end-of-life plan in consultation with physician and family. Legislation now on track in Trenton would bring to New Jersey a relatively new model of end-of-life planning known as the "Physician Orders for Life Sustaining Treatment," or POLST. Starting with Oregon in 1995, POLST laws are now on the books or under consideration in more than half the states.

Related Links
NJ's POLST Legislation
POLST Website

Lawrence Downs, chief executive officer of the Medical Society of New Jersey, said "we are long-time supporters of POLST and we support the legislation." He noted that New Jersey's shortcomings with end-of-life care are well-documented. New Jersey "does not do as good a job of referring patients and their families to hospice care as other states -- and we know that care delivered at home is less expensive and more comfortable for patients in their last days."

New Jersey's initial POLST bill has passed the legislature and been amended to reflect a conditional veto by Gov. Chris Christie, whose veto message expressed concerns that the original bill would have allowed the patient's wishes to be overridden by the physician or the patient representative, without the patient's prior consent. The amended version, which supporters hope to see adopted by the lame duck session that ends in January, provides for the patient's POLST instructions to be

adhered to unless the patient expressly gives the physician or the healthcare representative, also known as the healthcare proxy, the authority to override the POLST in the event the patient is incapacitated and no longer able to make decisions.

In 1991 New Jersey enacted a "living will" or advance directives law enabling individuals to designate a proxy and give instructions for the intensity of treatment in the event their health is compromised by an accident or sudden illness, or they are diagnosed with a terminal condition. The individual's advance directive might request cardiac resuscitation, for example, but reject being kept live on a ventilator or feeding tube.

But people typically create advance directives when they are healthy, said Jessica Cohen, director of governmental affairs for the New Jersey Hospital Association. She said POLST is designed to allow patients diagnosed with a life-limiting illness to express their specific goals for the remainder of their days.

Unlike advance directives, POLST must be signed by a physician or advanced practice nurse; consent is obtained either directly from the patient, if the patient is able, or from the proxy, legal guardian, spouse, or parent. POLST carries the authority of a medical order. It is part of the patient's medical record, and it follows the patient from one healthcare setting to another: home, ambulance, hospital, nursing facility, rehabilitation hospital, long-term care, hospice.

Supporters argue that POLST has the potential to be more effective in end-of-life care than advance directives. According to the bill, in many cases advance directives "are designed simply to name an individual to make healthcare decisions for the patient if the latter becomes incapacitated . . . and are often locked away in file drawers or safe deposit boxes and unavailable to health care providers."

In contrast, POLST will eventually guide first responders like ambulance squads, who arrive at the home of a critically ill individual and must decide whether or not to resuscitate from cardiac arrest. Electronic medical records are still years away for most individuals, but eventually the patient's EMR will include the advance directives and POLST.

"The purpose of POLST is to get patients and doctors talking about what patients want if they are no longer able to voice their preferences," said Don Pendley, president of the Hospice and Palliative Care Association of New Jersey. He said New Jersey ranks lower than other states in the use of hospice, where palliative care is administered, usually at home, to alleviate pain and suffering, and the focus is on providing comfort to the patient and emotional support to the family. Pendley said in New Jersey, "the average patient spends only 17 days in hospice, and that is not enough time for us to support the patient and the family during this awful crisis." He said nationally, the average length of hospice care is 26 days. "In New Jersey, patients get referred later to hospice, if they get referred at all."

Cohen said POLST encourages patients to make very specific plans for their last years or months of life. POLST ideally is used "while the patient is still able to communicate for themselves what they really want. So if I have stomach cancer and I have a year to live, I might say, "I don't want to be resuscitated for my cancer, but if I get hit by a bus, please resuscitate me because I'm trying to make it to my son's wedding."

People shun conversations about death; POLST aims to get this conversation started, Cohen said. "By normalizing this conversation we are saying 'look, it's okay to talk about it and you can have plans set forth to end a really great life."

Cohen said when the time comes to follow the instructions outlined in POLST -- which may or may not include resuscitation or a ventilator -- "Healthcare professionals have a greater level of comfort because they know that it [POLST] carries the weight of a physician's order, as opposed to the standard advance directive that in many cases does not have medical professionals involved in any way."

The legislation doesn't specify how New Jersey's POLST will read. A pilot began in March using a POLST form developed by a team led by Dr. David Barile, medical director of the acute care for the elderly unit at the University Medical Center of Princeton; participants in the pilot include UMCP and nine skilled nursing facilities in the Princeton area. The POLST pilot is part of a two-year initiative to improve the transition of older adults from the hospital to the community, which is funded by a $300,000 grant to UMCP from the Robert Wood Johnson Foundation. Barile said hundreds of patients have used the pilot's POLST form so far and once the legislation is passed, the experience gained by the pilot will help create a standard form that healthcare providers and their patients will use statewide.

Barile, who is board-certified in geriatric medicine and palliative care, is also executive director of New Jersey Goals of Care, a foundation whose aim is to empower healthcare teams and patients "to make specific treatment decisions that focus on achieving a specific goal that is determined by the patient," according to the foundation's mission statement.

Barile said the POLST form he and his team wrote for the pilot begins with the patient's goals.

The idea, Barile said, "is to align the available therapies with patient goals. So we ask that senior patient, that 70-, 80-, 90- or 100-year old patient, 'what are your hopes for the future?' and then simply organize all the medical care to help them achieve that particular goal. Health goals are different when you reach 85. For some it's longevity; for some it's quality: 'I want to be able to read again'; 'I want to live independently', 'I want to die a peaceful death at home'. Everybody's different." The goal of POLST, he said is "just to do one thing: get the entire medical team at the bedside to find out what the hopes are for the future for that patient--and then align those goals with any available therapies to help them achieve their goals."

Barile said most POLST forms in use around the country emphasize the patient's medical status, rather than the patient's goals. "Our form starts with the goals of care. The doctor simply asks, 'what are your goals for the future' and based on the answer to that question they complete the rest of the form."

Barile said if the patient's goal is to live as long as possible, the physician will make certain suggestions; if the goal is palliative care, the physician will make other suggestions. That conversation is then reflected in a medical order dealing with questions of resuscitation, ventilators and feeding tubes.

"A very common pitfall in medical decision-making is to spend too much time on [the patient's] code status—'what do we do when your heart stops?'" he said. Barile advocates starting with the end-of-life experience the patient desires, then creating a medical order that spells out the care designed to achieve that experience.

He especially objects to language in a POLST form that juxtaposes "full treatment" with "comfort care only." He said "this is lousy language because what it suggests is that hospice is not treatment. And that just reinforces this mutually exclusive relationship that palliative medicine has had with so called 'treatment.'"

Dr. Fred Jacobs, former state health commissioner and now head of the health care quality institute at Barnabas Health, said POLST is a good idea, but he said it remains to be seen if it will significantly increase the amount of end-of-life planning in New Jersey. He estimated that as few as 15 percent of Jerseyans have advance directives, which have been available for 20 years. But he said the key advantage of POLST is that it is a medical order that follows the patient after discharge from a hospital or other health care facility. "It enables the patient or the physician to know with some clarity what the wishes of that patient are under the circumstances outlined in the document."

Jacobs said POLST won't eliminate bedside disputes over an unconscious patient among relatives who either insist on aggressive medical treatment or letting nature take its course --regardless of what the patient spelled out in the POLST form.

Jacobs noted that advance directives never became popular and "a lot of it is a basic human feeling that 'who knows- maybe if I can live a little longer there will be a breakthrough, maybe something will happen. I don't want to give it up quite yet.'"

And he said many doctors "believe they need to offer extraordinary care in almost every situation. Doctors hate to lose, and if they allowed the patient to die and didn't do absolutely everything, then there would be a sense of guilt. And they are concerned about legal liability for not going as far as they felt the patient wanted them to go."

Education of the general public and the medical profession is essential to get New Jerseyans engaged in end of life planning, Jacobs said, and he urged the Medical Society of New Jersey to take this on as a major initiative. "This is a public health measure that goes to the heart of what being a physician is all about -- caring for your patient as an autonomous individual. The health department and the governor should be champions in providing education" about POLST, Jacobs said. He urged public officials to take a neutral posture on the issue of how much care should be delivered at the end of life, and simply "provide educational opportunities for the public to understand this."

Dr. Alan R. Pope, chief medical officer of Lourdes Health System in Camden, said "Decisions about limiting end-of-life care are personal, often difficult and may change with the medical condition." He said Lourdes' physicians have been collaborating with patients for years to help them make fully informed decisions, without a POLST form, but he said POLST "can be a useful tool to help ensure patients' end-of-life wishes are always sought, have clarity and are honored."

Jacobs said the POLST role in assisting first responders will be critical. "It would be appropriate and humane if there was some clarity which enabled these first responders to not go into maximum life saving mode [if that] is not what the patient wanted -- if it is not what was agreed to in a more reasoned discussion that was done with cool heads before the emergency developed. So I think [POLST] is a good step in the right direction. It gets the medical profession and their patients back to a common feeling of what is in the patient's best interest." Jacobs said it could take 30 minutes or more for patient and physician to complete the POLST form, and one issue that needs to be addressed is how the physician will be paid for this time. "I think it will be hard unless Medicare, which is the major payer here, decides they are actually going to pay for it."

Dr. Gregory Rokosz is chair of a physician executive group at the NJHA, and worked on a white paper issued by the NJHA in July 2010 advocating for POLST legislation. Rokosz is senior vice president for medical and academic affairs at Barnabas Health.

He said POLST should supplement the advance directive, which is normally created "when you are healthy and you are not at the end of life stage." He said POLST is flexible: "the goal could be aggressive care, it could be hospice or palliative care or it could be somewhere in between."

Rokosz noted that, "when patients can speak for themselves they direct their own care; they can change their mind at any time," about decisions they've made in the POLST.

NJ Society for Healthcare Consumer Advocacy
Membership Meeting Minutes
November 10, 2011

TOPIC	DISCUSSION/CONCLUSION
Welcome	
NJHA Legislative Report Sally Roslow	• Voting turn out low • Legislature: New districts; standard election, most incumbents re elected • Assembly- Republicans increased edge, Democrats still hold majority • Senate speculative, Loretta Weinberg may move off – she's an advocate • Annual public meetings 4x a year passed in Senate, hoping not in Assembly • Several merger discussions within State – rumors are that NJ will end up with 5 systems. There is a need for the ability to use technology to get things done. Many hospitals have to re-build. There is also a payroll and benefits cost saving to mergers • POLST Physicians' Orders for Life Sustaining Treatment – Legal document– 2 vetoes. It went back to Senate and to go before Assembly, hopefully to be signed by Gov. Christie.
Decision Making in Geriatric Medicine David Barile, MD	Aging worldwide "Silver Tsunami" Worldwide: • Healthcare systems not prepared USA • In better position to support aging population – babies – immigration Modern Medical Decision Making – Is it adequate? 5 Barriers: **1. Wrong financial incentive** • Reimbursed to do more bedside medicine **2. Estimating prognosis** • How long does the patient have? How can we effectively council? **3. Ageism and stereotyping** • Age alone not a prediction of prognosis – exacerbations, co morbidities **4. Advance Directives** • Failed public experiment • Need more direction from physicians **5. Not addressing goals of care** • Most important barrier Goals – What's important to the patient? Problem Based Care: heart failure, pneumonia, liver failure, etc Goal Based Care: quality, independence, function, peaceful death, specific tasks, events Simply ask: "what are your goals for the future?" **POLST – Physicians Orders for Life Sustaining Treatment** – Dr's order sheet Actionable medical orders based on discussion that doctor had with patient – portable across health care settings. NJ only has out of hospital DNR now - POLST will replace this. • Problem now– most forms start with code status • Created POLST form starts with goals – de-emphasizes code status • POLST compatible with Advance Directive

NJ Society for Healthcare Consumer Advocacy
Membership Meeting Minutes
November 10, 2011

TOPIC	DISCUSSION/CONCLUSION
Retreat – Sr. Marion	Weekend of June 8 open. We will try for the 15th Linda asked everyone to bring list of vendors to meeting or email Gerry McClosky
President- Linda Fauteux	Meeting dates confirmed Membership questions: • Currently one type – "individual"- did away with "hospital" • Group needs commitment from members to be successful – goal is to have people be more committed • Changes were done at Executive Board meeting – if problem we will put on agenda at January Board Meeting • Should we build into process to amend ByLaws? Member need to look at ByLaws because we vote on them in March • Form will remain the same for now. • Hospital can send one representative to each meeting
Membership – Debbie Parrott	2 Checks for 2012 to date
Treasurer Linda Flanagan	Yearly report was passed to membership by President Linda Fauteux in Linda's absence
Secretary Michelle Oleski	Motion to approve minutes from previous meeting. Approved
Vice President Teresa Lawlor	• Keeping Membership with SHCA – will continue to email membership with updates and certification program • We need a voice to push back on 7 day written response requirement • This is last meeting of 2011. We need to think of topics and speakers • Teresa read off list of potential topics from membership
President Elect Dawn Wright	• Email – Tying Hospital Payments to Patient Satisfaction – links on email • Cleveland Clinic having conference • LGBT Community Health Conference- drill down online • Care Partners – orange band – asked about at Registration
Susan Keane Baker HCAHPS Booster	• Dawn Wright and Ellen Stanislaski gave presentation of highlights of the October 14th presentation from Susan Kean Baker
Discussion Reports	• Are categories by perception or what really happened? • Bring category list to next meeting

Prepared by: Michelle Oleski, Secretary