Appendix 8.1: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 1:
Access and Equity for the Medically Underserved

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I. Subcommittee Charge

The Subcommittee on Access and Equity for the Medically Underserved was charged with developing recommendations to address the breadth of needs of low-income and medically underserved New Jersey residents. More particularly, this subcommittee examined the systemic gaps and other access barriers that now exist, which often interfere with the availability and provision of quality primary, specialty and inpatient care, including inpatient and outpatient mental health and substance abuse care. In the context of the full Commission's final report, and in the environment of increasing numbers of hospital closures, the Subcommittee's work focused on identifying potential solutions and alternative approaches to the provision of healthcare.

The gaps and access barriers identified by the Subcommittee included the following: over-reliance and/or inappropriate use of hospital emergency rooms, in the absence of other appropriate venues for the delivery of healthcare services; disparate and/or disconnected local health planning, in connection and in cooperation with community-based partnerships; a dearth of primary and specialty healthcare providers (doctors, nurses, nurse practitioners, physician assistants, dentists and other oral healthcare practitioners) and related workforce availability issues; transportation; cultural and communication barriers, including access for individuals who have mobility impairments, or are deaf, hard of hearing, blind or visually impaired; access issues for persons for whom English is not a primary language; medical and dental care needs for individuals with developmental disabilities; availability of healthcare insurance; and historically low Medicaid reimbursement rates.

II. Overview of Subcommittee Process

The Commission members and State agency staff conducted two planning meetings prior to convening the full subcommittee, in order to identify data that would be helpful to subcommittee members during their deliberations, including maps and charts that identify the location of hospitals, federally qualified health centers, mental health, and other state and federally funded agencies located in medically underserved areas. This data was made available through the New Jersey Department of Human Services.

The Subcommittee held three meetings with the full membership: July 25, August 8, and August 30, 2007. A final meeting with Commission members and State agency staff was then held on September 6, 2007.

During the first full meeting, the Subcommittee was initially divided into subgroups and tasked with answering two fundamental questions:

(1) What are the basic and essential health services that should be available for New Jersey residents?

(2) Who constitutes the "medically underserved"?

For the purposes of this initial discussion, the subgroups intentionally operated under some very artificial assumptions: that insurance coverage, costs of providing such services, financial viability of neighborhood hospitals, access to transportation, and availability of primary and specialty care were issues of no consequence. Instead, the task was more narrowly focused on the services themselves in order to identify essential core services.

III. General Approach to the Issue

After much discussion regarding services to which New Jersey residents must have access, the Subcommittee decided that basic and essential services could, for the purposes of this report, be defined as those services covered by Medicaid Plan A, with some caveats. These services, while not entirely all encompassing, covered the broadest range of needs, and included specialty care populations such as individuals with developmental disabilities.

The Subcommittee also grappled with defining the medically underserved population. Was one "medically underserved", for example, if one needed to travel a significant distance in the state for a mammogram? Or for bariatric surgery? After much deliberation, the Subcommittee agreed to use the definition of "Medically Underserved Areas" as used by the U.S. Department of Health and Human Services when it determines areas for funding programs and services for medically underserved populations: http://bhpr.hrsa.gov/shortage/muaguide.htm This geographic narrowing appeared to satisfy concern that a particular healthcare service, while essential to some, may not necessarily be readily available to all New Jersey residents.

As the Subcommittee delved more deeply into its charge, it became apparent that barriers to care can be broadly categorized as either economic or environmental, or both, in nature. Economic barriers included access to health insurance, hospital finances and Medicaid reimbursement rates. Environmental barriers included geographic proximity to some other locus of care as a viable alternative to a hospital emergency room, transportation availability, language and other cultural or communication difficulties, physical access barriers for individuals with mobility impairments, well-established behavior (one may be accustomed to accessing care through a hospital emergency room), and traditional focus on and funding of acute versus preventative care. In addition, three points of agreement emerged as a backdrop against which the group's work took shape:

(1) Most fundamentally, the relationship between the community and its hospitals was recognized as complex. A lack of services within a community, for example, often results in inappropriate or over-reliance on a given hospital, which strains the hospital's finances and overall capacity. Conversely, hospital closures frequently strain community services and negatively impact capacity. What would ideally be a symbiotic relationship is often fraught with tension. The proliferation of ambulatory care centers across the state, which are arguably better able than hospitals to control payer mix, additionally strains hospital resources. It should be noted that while the Subcommittee did discuss this issue, it will be explored at greater length in the Commission's full report.

(2) Recognition was paid to the fact that health disparities associated with income, race, ethnicity and disability are closely intertwined with the issue of health access and quality. Indeed, barriers to accessing quality health care are at a least a contributing factor to the grim reality that death rates from heart disease are more than 40 percent higher for African Americans than for whites and that Hispanics are nearly twice as likely as non-Hispanic whites to die from complications of diabetes.

(3) Last, but certainly not least, there was an acknowledgment that one of the most significant predictors of access to health services and treatment is health insurance coverage. As the solutions to this factor are entangled with political, financial and philosophical differences, and therefore exceedingly complex, the Subcommittee did not devote any time to solutions concerning this topic.

IV. Key Findings and Recommendations

A. There is an over-reliance and/or inappropriate utilization of hospital emergency rooms

Hospitals are in trouble, at least in part, because they are inappropriately serving patients. Hospitals in low-income areas all too often report a large volume of cases

that come to their emergency departments with late stage illnesses such as cancer and kidney failure or come repeatedly for chronic conditions such as asthma, diabetes, and congestive heart failure. Indeed, a September 2007 Rutgers Center for State Health Policy report (Rutgers Study) noted that emergency department visits are on the rise in New Jersey and that a significant percentage of the visits might have been avoided through better access to primary care.

Recommendation:

Successful patient case management models should be supported and replicated in order to address the large volume of ambulatory care sensitive utilization. For example, certain case study hospitals included in the September 2007 Rutgers Study have developed "fast track" systems to separate emergent from other cases in the emergency department. Under this model, patients are routinely referred to outpatient clinics for non-emergent care. Other hospitals are having success as a result of developing elaborate case management and chronic disease management systems within the emergency department itself. While this is a clear departure from the traditional role of the emergency department, these facilities have decided that community need and patient preference have made the departure necessary. (This report can be accessed in full at: http://www.cshp.rutgers.edu/Downloads /7510.pdf).

Additionally, New Jersey should seek to replicate and implement emergency room (ER) diversion programs. Under such programs, hospitals employ a nurse to care manage patients after their ER visit. For Medicaid clients enrolled in an HMO, after the ER visit, the care manager works with the patient and the HMO in order to ensure that the proper follow-up care is coordinated with the patient's medical home and primary care physician. In cases of Medicaid fee-for-service, the care manager connects the patient with the FQHC, as it will become the patient's medical home. The purpose is to provide primary care as part of the continuum of care needed to prevent increased acute episodes.

B. Local health planning is disparate and/or disconnected from community-based partnerships

B1. FQHC/Community-Based Clinic Issues

Through a network of ninety-six satellite sites located statewide, New Jersey's nineteen Federally Qualified Health Centers (FQHCs) provide high quality preventive, primary, and acute care medical services for its medically underserved population. In addition, community-based health centers, such as Volunteers in Medicine, family planning centers, and the like provide similarly necessary services.

While the FQHCs and community health clinics are models for providing high quality primary and preventive care services, most of these sites are not equipped to provide specialty care services for a wide range of specialty care needs of their patient population. At present, for example, most FQHCs provide specialty care services through referrals to specialists affiliated with local hospitals or specialty care clinics as needed. Only a handful of these health centers have on-site specialty care services for selected specialties.

Since many of the medically underserved areas also suffer from severe shortages in health care providers, in many instances, the current referral system fails to provide timely treatment for the health center patients often resulting in harmful health effects, high number of emergency department visits, and costly hospitalizations. (For a fuller discussion of recommendations related to the FQHCs' role in New Jersey, go to: http://www.njpca.org/Medical%20Home%20Document.pdf). It should be noted that support for Federal legislation increasing the number of FQHCs across the country would provide meaningful impact on the medically underserved community.

Recommendation:

Increase the primary care infrastructure and supply of specialty care to patients served by FQHCs and community-based clinics.

It is important to note that the Subcommittee generally agreed that community-based health clinics and FQHCs were equally critical to providing primary and specialty care. One solution proffered to accomplish the above recommendation was to encourage the New Jersey Primary Care Association (NJPCA), in collaboration with the Medical Society of New Jersey (MSNJ) and New Jersey Hospital Association (NJHA), to work to establish an expanded network of specialty care providers and hospitals to provide additional specialty care support for the health centers. By negotiating letters of agreement with specialists and participating specialty care clinics and hospitals, health centers could refer their patients as needed.

A related solution would encourage FQHCs and other clinics to focus primarily on providing on-site specialty care. The NJPCA has identified three approaches to providing on-site specialty care. Since case overload is a major reason for backlog in the existing system of specialty networks, the first approach would be to recruit retired specialists to provide volunteer specialty care services on-site at the health centers.

Costs associated with this approach include the cost of maintaining a valid license for retired physicians, the cost of registration for Continuing Medical Education (CME) credits and the cost of malpractice liability coverage for retired specialists. Legislative support at the national level is also needed to extend medical malpractice liability protections to volunteer physicians at community health centers. (H.R. 1313, the "Community Health Center Volunteer Physician Protection Act of 2005" was introduced in November 2005 to amend the existing Public Health Service Act to provide liability protections for volunteer practitioners at health centers.) A New Jersey alternative to this Federal legislation was introduced in 2003. While these bills would act as a catalyst to help bolster the infrastructure of physicians who volunteer service, both have been stalled in the process.

A second option would be to hire retired specialty care physicians on a part-time basis at the health care centers. Once employed, these physicians would be eligible for malpractice coverage under the Federal Tort Claims Act of 1992.

Under a third approach, health centers would contract with practicing specialists to provide on-site services for a few hours each week in high priority specialty areas. A related recommendation in this area was to encourage FQHC and community clinic physicians to join the medical staff of a single local hospital in order to encourage patient care through a team approach.

B2. Mental Health and Substance Abuse Services

Local hospitals are an integral part of the community mental health and substance abuse systems with much of the emphasis on meeting the most acute, serious needs of these populations. Many hospitals offer a continuum of psychiatric and substance abuse services, which function as acute care diversion services, as well as step down options from more intensive services. As they are embedded in the community, these hospitals are critical in responding to the needs of the community members. When hospitals close, it is imperative that these critical services remain available to the community at the same level of accessibility and clinical intensity.

While hospitals serve as an important part of the mental health and substance abuse treatment system, some patients seeking emergency room treatment present signs of mental health or substance abuse treatment needs. According to the 2007 Rutgers Study, New Jersey hospitals have increasingly become providers of care for mental health and substance abuse patients, particularly through the emergency department. A number of emergency department physicians have attributed this rise to a decrease in the number of psychiatric beds and detoxification services and insufficient funding for community-based mental health and substance abuse care. Many admissions to emergency rooms are often related to drug or alcohol misuse. Best practice indicates that substance abuse-related emergency room visits represent an opportune moment for screening, brief intervention, and referral to treatment services. Currently, this practice is not widely implemented.

Additionally, the Subcommittee noted that the continuum of preventative, non-acute care provided by community-based and hospital providers is less expensive, effective, and preferable to costly emergency-based care. Available services and funding sources from hospital closures could be transitioned to replacement community or hospital-based services, and when possible, to more wellness and recovery-oriented services.

Recommendation:

State health policy should expand mental health and substance abuse capacity in the community, prioritize funding for mental health and substance abuse services, and insist on tailoring services to patients' wellness and recovery needs. In addition, it is also critical that acute psychiatric and detoxification services, emergency and acute hospital inpatient care continue to be available in a hospital setting. As noted above, this could be funded through a reallocation of resources available once a hospital closes. Similar resource shifts should likewise occur for substance abuse services, now available on an inpatient basis in only limited parts of the State.

B3. Disconnect between community needs and the Certificate of Need process

The Subcommittee noted that the existing Certificate of Need (CN) process, which, in relevant part, examines availability and continuity of community resources when a hospital is considering closure, is ripe for examination and can be strengthened.

Recommendation:

Institute a community-based health planning process that encourages partnerships and includes community resources so that access to basic and essential healthcare services is a proactive, rather than a reactive endeavor. To that end, the Subcommittee is recommending that four regional focus groups be convened over the next year to ensure that input into health system redesign is focused on a consumer-driven system of care. If a hospital must ultimately close, county-based planning can buttress the Department of Health and Senior Services' monitoring of the availability of sustained, alternate resource development.

C. There exists a dearth of primary and specialty healthcare providers (doctors, nurses, nurse practitioners, physician assistants, dentists and other oral healthcare practitioners) and related workforce availability issues.

C1. Historically low Medicaid reimbursement rates

New Jersey's historically low provider reimbursement rates for Medicaid are well documented, and have been directly associated with adversely impacting access to a variety of healthcare services. Indeed, the abysmally low reimbursement rates have so severely impacted the availability of healthcare professionals who are willing and/or financially able to offer services to Medicaid patients in some cases, that meaningful access can be compromised by any reasonable level of geographic proximity to clients for care or may result in wholly inaccurate listings of practitioners willing to participate in such care.

Recommendation:

To improve the availability of quality care, the Subcommittee recommended that New Jersey should set provider reimbursement rates for Medicaid and other state-funded health care services at 75% or more of current Medicare reimbursement rates. The Subcommittee did note that Governor Corzine's 2008 Budget Initiative to include $5 million (a $20 million figure once annualized and matched with federal dollars) to increase Medicaid rates for services to children was a first and meaningful step to address this long-standing concern.

C2. Workforce issues and Graduate Medical and Dental Education

According to the New Jersey Council of Teaching Hospitals, New Jersey's teaching hospitals provide 70 percent of the medical care to the uninsured and underinsured. Faculty medical staff and physician residents are key care providers to New Jersey's medically underserved. New Jersey ranks 18th in the nation as to the number of physicians in training relative to the State's population. Furthermore, New Jersey has a particularly high percentage (39.7%) of practicing physicians who are International Medical Graduates (IMG), ranking us 2nd in the nation.

According to the Medical Society of New Jersey, our State is currently experiencing a shortage of physicians in the fields of obstetrics and gynecology, pediatric subspecialties, neurosurgery, anesthesiology, family practice, and general surgery. There is a similar shortage of dentists and other oral health practitioners. A September 2000 GAO report, "Factors Contributing to Low Use of Dental Services by Low-Income Populations" (http://www.gao.gov/archive/2000/he00149.pdf), discusses not only the low Medicaid reimbursement rates for dentists but also the short supply of dentists in many areas.

Recommendations:

- Loan forgiveness and scholarships. New Jersey should provide loan forgiveness and scholarships for professionals willing to serve in medically underserved areas or in professional specialties experiencing workforce shortages. Targeting incen-

tives to areas of greatest need is important for making health care services available where they are needed most. For example, Medicaid could focus its Graduate Medical Education (GME) funding to the specialties experiencing the greatest workforce shortages. Advocacy is also needed on the federal level to increase annual awards to physicians by the National Service Corps to encourage more doctors and dentists to practice in under-served areas while addressing rising medical/dental student debt.

- Boost class sizes in existing medical schools and establish new medical schools.

- Advocate increasing the number of residency training positions funded by Medicare to accommodate additional medical/dental school graduates.

- Minority recruitment and training. The percentage of minority enrollees in medical schools remained essentially unchanged between 1970 and 1996, and continued at a rate lower than minority representation in the general population. Addressing this trend is important because minority physicians most often serve in minority communities and under-served areas. State policy should establish goals to encourage the recruitment and training of health care providers whose race, ethnicity, and language reflect the composition of the state and communities in need.

- Telemedicine for remote areas. Telemedicine approaches enable the transfer of medical information – including medical images, two-way audio and videoconferences, patient records, and data from medical devices – for diagnosis, therapy and education. New Jersey should make use of currently available technology to develop and support telemedicine systems that provide medical expertise to underserved geographic areas of the state. Specifically, New Jersey could explore exercising Medicaid options for reimbursing telemedicine services and protect patients by requiring out-of-state physicians to be licensed to provide telemedicine services.

D. Lack of practical transportation options hinders access to care.

For those individuals who are not Medicaid eligible, transportation was noted as a significant barrier to accessing healthcare – especially in rural communities and other areas where a robust transportation infrastructure for seniors and those with disabilities is unavailable. In addition, the lack of coordination among existing systems that serve special populations creates duplication and increased costs.

Recommendation:

- The Subcommittee noted that transportation needs are best resolved through local planning and should figure prominently in the community and regional planning noted above. The federal government has initiated a "United We Ride" initiative that requires states to enhance access to transportation to improve mobility, employment opportunities, and access to community services for persons who are transportation-disadvantaged, including seniors, individuals with disabilities, and low income households. (New Jersey's Department of Human Services manages this initiative.)

- When available, transportation for persons who are Medicaid eligible may be coordinated with existing county Paratransit trips. This will increase cost efficiency and reduce duplication of trips routing.

- The federal regulations that govern the United We Ride initiative require that each state develop a local planning process whereby the needs of the target populations are examined and addressed. Localities who fail to develop transportation plans risk losing Federal Transportation Administration (FTA) funding.

- The United We Ride initiative offers the health care community an opportunity to incorporate the transportation needs of the medically underserved into the local planning process. Since the planning process in ongoing, the health care community should verify that a member from their community is participating on the local transportation steering committee. This will ensure that, as transportation needs of the population change, they are identified on the plan updates.

E. Cultural and communication barriers exist for a number of special needs populations, including access for individuals with disabilities, including persons who are deaf, hard of hearing, blind, or visually impaired, or those for whom English is not a primary language.

E1. Special Needs Populations

E1a. Individuals who are Deaf or Hard of Hearing:

Generally speaking, the healthcare access needs for this population are similarly affected by the access and equity issues noted above. One obvious complication, however, is the ability of healthcare professionals to meaningfully communicate with persons who are deaf or hard of hearing, so that the quality of care rendered is not compromised. A 2005 study published in the Journal of General Internal Medicine examined healthcare system accessibility issues of deaf people found communication to be pervasive healthcare access problem. This report can be found at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1828091

Technological advancements are increasingly available, as are traditional resources such as American Sign Language interpreters, although in diminishing supply. These resources can readily provide meaningful communication for those with special needs, as appropriate. Access remains largely dependent, however, upon a healthcare facility's investment in and commitment to ensuring adequate availability of human or technological resources for those who require such assistance.

E1b. Individuals who are Blind or Visually Impaired:

Sensitivity and transportation issues permeate the access and equity issues for blind and visually impaired individuals. The ability to access health care is often dependent on the ability to complete health forms. Lack of alternative media for medical forms and the availability of staff to read forms creates a major barrier for sight impaired individuals. A 2007 study conducted by the National Council on Disability points to the importance of providing health care forms and information in alternative formats for those with visual impairments. As with other populations, accessing barrier free transportation is also an important issue. A full copy of the National Council on Disability report can be found at: http://www.ncd.gov/newsroom/publications/2007/implementation_07-26-07.htm

E1c. Individuals with Physical Disabilities:

Generally speaking, the healthcare needs of individuals with physical disabilities are similarly affected by the access and equity issues noted above. Two complications, however, are barrier-free access to the locus of care and meaningful access to transportation. The above mentioned National Council on Disability report identified access to transportation as a significant barrier to accessing healthcare. One example of an important healthcare issue for this population is the lack of availability of accessible examination tables for persons who are non-ambulatory.

E1d. Individuals with Developmental Disabilities:

The medical needs of individuals with developmental disabilities range enormously in their complexity. A 2002 publication by the Surgeon General titled "Closing the Gap: A National Blueprint to Improve the Health of Persons with Disabilities" (http://www.surgeongeneral.gov/topics/mentalretardation/retardation.pdf) underscores the challenges in obtaining these services.

For those whose disability is mild to moderate, access to traditional hospital venues and/or community care clinics may suffice for routine medical or dental needs. For those with significant developmental disabilities, however, access to specialty medical and dental care, as well as mental health care (if needed) is critical. Additional behavioral supports may be required for consumers with challenging behaviors in order to facilitate the exam and treatment provided by the physician or dentist. A 2005 report by the Special Olympics highlights the gaps in health care for those with developmental disabilities. This report can be accessed via the Special Olympics website, www.specialolympics.org, and visiting their research link. The issue of transportation, akin to that which was noted for individuals with physical disabilities, is also a barrier to accessing health care services. The Subcommittee also noted that the recently-enacted Danielle's Law has imposed some unintended stressors upon hospital emergency rooms, as the frequency of such visits has increased.

Recommendations:

While it is difficult to generalize the accessibility concerns of special needs populations, basic accommodations such as communication support, barrier-free access, and specialized care are not always costly and should be prioritized. One example of an important and low-cost effort towards effective communication is the Communication Picture Board, prepared through a collaboration of the New Jersey Department of Health and Senior Services/Office of Minority and Multicultural Health and the New Jersey Hospital Association. This board utilizes a variety of pictures to enhance one's expression of needs, and is designed for use by emergency service personnel and frontline intake staff to better enable effective communication with the public.

For individuals with developmental disabilities, the dearth of medical and dental specialists is particularly acute. Articles at http://rtc.umn.edu/nhis/ and http://www. Pubmedcentral.nih.gov/picrender.fcgi?tool= pmcentrez&artid=1783697&blobtype=pdf cite accessibility and communication as barriers to medical and dental services. As such, the establishment of Centers of Excellence for medical, mental health and dental care for individuals with developmental disabilities should be explored. Finally, the recruitment and retention issues noted above for medical and dental professionals exist as well for those individuals with developmental disabilities.

E2. Language

The increase in immigrant groups in New Jersey, coupled with higher incidence of chronic health care conditions requiring regular health care monitoring, argues strongly for health care services that can adequately serve linguistically, ethnically and culturally diverse families.

Recommendation:

To provide better access to healthcare and prevent unnecessary complications due to language and cultural barriers, New Jersey should provide translation and outreach and educational materials in the language of the patient populations. This can best be achieved by local planning efforts, outlined above.