Appendix 8.6: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 6: Hospital/Physician Relations and Practice Efficiency

Executive Summary

- The present report represents the work of the Subcommittee on Hospital/Physician Relations & Practice Efficiency, one of six empanelled to advise the Commission on Rationalizing Health Care Resources in New Jersey Commission established under Executive Order 39, promulgated by Governor Jon S. Corzine on October 19, 2006.
- The Subcommittee on Hospital/Physician Relations and Practice Efficiency was charged to:
  - Identify and characterize the most significant factors and aspects of the relationship among New Jersey's acute care hospitals and physicians.
  - Focus on high-cost high reward aspects of physician practices and performance.
  - Evaluate the importance and application of available standards and metrics.
  - Report findings and recommendations to the full Commission.
- The Subcommittee met in plenary session four times with additional workgroup meetings, considered expert opinion and information, raised issues and discussed possible initiatives and action in the following four areas:
  - Payment System
  - Institutional infrastructure
  - Metrics and Reporting
  - Regional Coordination
- The Subcommittee's attention was drawn to several areas that bear critically on hospital and physician relationships but which are too broad to fit within its charge. Reform and change in these areas is vital to the long-term improvement of New Jersey's health care system.
  - Regionalization of health care resource allocation and utilizations.
  - Tort reform.
  - Medical Malpractice insurance reform and relief.
  - Alternative concepts for delivery of acute care services.
- The Subcommittee proposes ten recommendations specifically addressed to improving hospital and physician relations and improving practice efficiency.
  - These recommendations are especially relevant and essential for financially stressed institutions.
  - These ideas also have general applicability to and offer value to all acute care institutions.
  - These recommendations are summarized below for ready reference and discussed in detail in the body of this final report.

Summary Recommendations

1. **Encourage alignment-oriented payment systems** or models for acute hospital care that financially impact, engage and involve physicians.

   Structural non-alignment of financial incentives invites abuse and rewards medically irrational and counter-productive decisions.

2. **Promote physician accountability** through a physician report card of evidence-based acute care performance and outcomes measures.

   Evidence-based medicine standards are under-utilized and un-enforced in the acute care setting.

3. **Coordinate care** from admission through post-discharge with standards and incentives based on quantitative metrics and results.

   Coordinated patient care from admission through in-patient treatment to discharge and follow-up treatment and services is not the standard of care in New Jersey.

4. **Increase institutional transparency for acute care costs,** utilization and care alternatives to enable cost and treatment-effective decisions.

   Imperfect knowledge of acute care costs and resources inhibits informed, rational choices, decreases trust and confidence and disables accountability.

5. **Establish 365 day standards of operation** for an expanded range of services that optimize acute care resources utilization.

   Service and coverage reductions on weekends and off-hours inhibit best practices and cost-effective resource utilization.

6. **Set standard and parameters for physician on-call obligations** for emergency department service regionally and state-wide.

   Hospitals cannot impose ED service call obligations on physicians, and often pay significant fees to secure essential coverage.

7. **Make "intensivist model" the standard of ICU care** and a priority for all hospitals, especially financially distressed institutions.

   Intensive Care Units provide patients with life-sustaining medical and nursing care on a 24-hr. basis but are not typically staffed with optimally trained personnel.

8. **Leverage scarce physician services** through the expanded use of practice-extenders and other means to increase effective access and availability.

   Scarcity of key medical specialties can create service bottlenecks and inefficiencies.

9. **Exploit existing IT systems** and technology to enhance physicians-hospital interaction, improve access to in-patient data, and take greater advantage of information resources.

   Hospitals do not to take advantage of IT to increase interaction with physicians.

10. **Create an acute care data warehouse,** hospital network, and uniform data standards and formats.

    Comparative hospital performance metrics, data compatibility and exchange capabilities are lacking in New Jersey.

Subcommittee Membership

Anthony C. Antonacci, M.D., SM, FACS, *Co-Chair*
Vice President for Medical Affairs & Chief Quality Officer, Christ Hospital

Risa Lavizzo-Mourey, M.D., *Co-Chair*
President and CEO, Robert Wood Johnson Foundation
Member, Commission on Rationalizing Health Care Resources

Fred M. Jacobs, M.D., JD, EX-OFFICIO
Commissioner, Department of Health and Senior Services
Member, Commission on Rationalizing Health Care Resources

Henry Amoroso, CEO
Cathedral Healthcare Systems

Carolyn E. Bekes, M.D.
Senior Vice President, Academic and Medical Affairs, Chief Compliance Officer, Cooper Health System

Darlene Cox
President, CEO, University Hospital

William B. Felegi, D.O.
Past President, American College of Emergency Physicians, New Jersey Chapter

Linda Gural, R.N.
President, New Jersey State Nurses Association

Gary S. Horan
President, CEO, Trinitas Hospital

John V. Jacobi, J.D.
Senior Associate Counsel, Office of the Governor

Michael J. Kalison, Esq
Kalison, McBride, Jackson & Murphy, P.A.

Fr. Joseph W. Kukura
President, Catholic Health Partnership of New Jersey

Ira P. Monka, D.O.
President, New Jersey Association of Osteopathic Physicians and Surgeons

Charles M. Moss, M.D.
President, Medical Society of New Jersey

Richard G. Popiel, M.D., MBA
Vice President, Chief Medical Officer, Health Affairs, Horizon Blue Cross Blue Shield

Gregory J. Rokosz, D.O., J.D.
Senior Vice President for Medical and Academic Affairs, Saint Barnabas Medical Center

William A. Rough, M.D.
President, American College of Surgeons

Michael Shebabb, CPA, COO
North Hudson Comm. Health Center, New Jersey Primary Care Association

Robert Spierer, M.D.
Past President, New Jersey Academy of Family Physician

Virginia Treacy, R.N.
Executive Director, JNESO, District Council 1 IUOE

Ann Twomey
President, Health Professionals and Allied Employees, AFT, AFL-CIO

Sara Wallach, M.D.
President, New Jersey Chapter, American College of Physicians

Benjamin Weinstein, M.D., Ph.D.
Senior Vice President/Medical Dir, New Jersey Hospital Association (CentraState Healthcare System)

Administrative Personnel

Michele Guhl, Executive Director
The Commission on Rationalizing Health Care Resources in New Jersey
Department of Health and Senior Services

Cynthia McGettigan
The Commission on Rationalizing Health Care Resources in New Jersey
Department of Health and Senior Services

Gabriel B. Milton, J.D., LL.M.
Staff to the Subcommittee On *Hospital/Physician Relations & Practice Efficiency*
Office of the Commissioner
Department of Health and Senior Services

Introduction

On October 19, 2006, Governor Jon S. Corzine promulgated Executive Order #39, identifying the need to examine the availability and delivery of health care services in New Jersey, and develop recommendations toward the creation of a state wide health plan. The Commission on Rationalizing Health Care Resources in New Jersey, chaired by Dr. Uwe E. Reinhardt, Professor of Economics and Public Affairs, Woodrow Wilson School, Princeton University was established to implement the Order.

The work of the Commission was assigned to six subcommittees, each addressing a particular topic relevant to the overall mission. The present report represents the efforts of the Subcommittee on Hospital/Physician Relations & Practice Efficiency, co-chaired by Risa Lavizzo-Mourey, MD, Co-Chair, President and CEO, Robert Wood Johnson Foundation, and Anthony C. Antonacci, MD, SM, FACS, Co-Chair, Vice President for Medical Affairs & Chief Quality Officer, Christ Hospital. Fred M. Jacobs, M.D., J.D., Commissioner, Department of Health & Senior Services, also served on this subcommittee.

Charge

The Subcommittee on Hospital/Physician Relations and Practice Efficiency will:

- Identify and characterize the most significant factors and aspects of the relationship between New Jersey's acute care hospitals and physicians affecting institutional viability and financial integrity, cost-effective use of resources, physician relations and practice efficiency, and the delivery of quality health care.
- Focus on high cost-high reward aspects of physician practices and performance. Examine key criteria, including: length of stay, prescription drug charges, procedure charges, consults, etc.
- Evaluate the importance and application of available standards and metrics, e.g., best practices, Leapfrog, "report cards", etc., paying special attention to the impact and importance of these issues to the situation of New Jersey's most financially stressed acute care hospitals.
- Report findings and conclusions to the full Commission and recommend institutional, legislative and policy initiatives that will positively impact the financial and care crisis affecting New Jersey's acute care institutions.

Membership

The Subcommittee on Hospital Physician Relations and Practice Efficiency consisted of 23 individuals who freely contributed their time and energy to achieving its goals. Candidates were identified and selected through a painstaking process undertaken by the Commission, its Executive Director and the Governor's Office of Appointments. The membership of the subcommittee now represents a wide range of interests, backgrounds and perspectives relevant to many of the shared concerns and issue affecting hospitals and physicians. A list of members and administrative personnel appears immediately before the introduction to this report.

Meeting Schedule:

The Subcommittee held four meetings in the course of its operations. The initial meeting was held at the Department of Heath and Senior Services, the Robert Wood Johnson Foundation provide meeting space, conference facilities and amenities for the second and third meetings, and the final meeting was hosted by the Medical Society of New Jersey. The Subcommittee gratefully acknowledges the organizations and their staff for making the required arrangements. The schedule of meetings held appears below:

- July 5, 2007
- July 24, 2007
- August 21, 2007
- September 10, 2007

Methodology

The Subcommittee convened its initial meeting under the co-chairship of Drs. Risa Lavizzo-Mourey and Anthony C. Antonacci on July 5, 2007. Fifteen members attended in person and 7 by conference call. The meeting proceeded in open discussion resulting in a decision to develop and circulate a conceptual framework that would guide the work to be done.

A second meeting was held on July 24, 2007 with 20 members present and one call-in. The conceptual framework was reviewed and a decision made to divide the work of the Subcommittee among four areas of strategic focus:

- **Payment System** – addressing issues of discontinuities and disparities among payors, individual providers and institutions, in compensation, reimbursement and their relationship to abuse and medically irrational and counter-productive decisions.

- **Institutional Infrastructure and Support Systems** – addressing the unmet needs of acute care institutions for systems and procedures that incorporate best practices and make optimum use of available resources to minimize excess costs, delays and waste.

- **Institutional Reporting and Metrics** – addressing the potential for improving adverse event and outcome reporting and quality metrics throughout New Jersey's acute care facilities.

- **Regional Coordination of In-Patient and Out-Patient Care** – addressing deficiencies in pre-admission and post-discharge care and follow-up to minimize admissions, maximize clinical progress, and reduce readmission rates.

Each member picked an area of interest and contributed in subsequent work sessions.

Workgroup assignments were as follows:

WG1 - PAYMENT SYSTEM

Gregory J. Rokosz, D.O., J.D
William A. Rough, MD
William B. Felegi, D.O.
Robert Spierer, MD
Ira P. Monka, DO
Richard G. Popiel, MD, MBA
Michael J. Kalison, Esq.

WG2 – INFRASTRUCTURE

Carolyn E. Bekes, MD
Linda Gural, R.N.
Benjamin Weinstein, MD, PhD
Virginia Treacy
Sara Wallach, MD

WG3 - REGIONAL COODINATION

Anthony C. Antonacci, MD, Co-Chair
Henry Amoroso
Ann Twomey
Joseph W. Kukura, Rev.
Michael Shebabb, CPA
Gary S. Horan

WG4 - METRICS AND REPORTING

Risa Lavizzo-Mourey, MD, Co-Chair
Darlene Cox
Charles M. Moss, M.D.

These work groups each produced a brief report and recommendations which provided the basis for further discussion and comment and formed the foundation of this report.

On August 21, 2007, the Subcommittee held its third meeting. Sixteen members attended, with three call-ins and 4 members unavailable. The work groups shared their discussions, findings and recommendations with the entire subcommittee. Comments and suggestions where noted. Core recommendations were prepared and circulated prefatory to submission of a draft report to the membership for review and revision.

All input was collected and incorporated in a draft report sent to the membership in advance of the final meeting of the Subcommittee held on Monday, September 10, 2007 at the Medical Society of New Jersey. Twenty-one members attended with three call-ins and one member unavailable. Comments, changes and editorial suggestion were made and a final report sent by email for approval. The present final report represents the end-product of that process.

General Observations and Comments

The New Jersey Commission on Rationalizing Healthcare Resources is focused on the situation faced by New Jersey's most financially distressed hospitals and the critical factors contributing to their distress. The tasks of its subcommittees are aimed at identifying problems and issues and developing recommendations that will aid institutions in crisis regain a sounder financial footing, improve management and efficiency, enhance the delivery of quality health care, and maintain essential services in light of current and future health care needs.

The Subcommittee on Hospital Physician Relations and Practice Efficiency has made a number of specific recommendations which it believes may together or separately contribute to improving elements of the relationship among New Jersey's acute care hospitals and their physicians. While many of these recommendations will require the agreement and collaboration of different stakeholders and may take considerable time and energy to implement, the governors, trustees and senior management of each acute care institution bear direct and ultimate responsibility for the fortunes of facilities under their collective direction and control.

Management, oversight and direction of the State's acute care institutions must start from within, be driven from the highest levels of executive authority, and carry the weight of organizational commitment. Each individual holding a senior position of responsibility must understand his or her role as an active and engaged participant in the life of the hospital, and understand that role as one for which they can and will be held accountable.

The Subcommittee is also aware that its recommendations cannot be considered apart from larger issues affecting health care in New Jersey. Issues such as the state's fiscal crises, medical insurance and tort reform, economic and life-style pressures on physicians, the needs of New Jersey's highly diverse population, and the growing number of under- or non-insured persons all contribute to and complicate the present crisis.

Acute care facilities in New Jersey share a responsibility to deliver a comprehensive range of care to all persons, regardless of their ability to pay. Notwithstanding, it is impossible and irrational, medically, economically and otherwise to maintain identical capabilities at all acute care institutions. Some form of regional coordination is essential to rationalize the utilization of scarce resources and provide essential services to all populations in the state. Regionalization of scarce health care services must play a key role in rationalizing health care in New Jersey.

Medical malpractice insurance costs and the threat of costly, even devastating litigation is a powerful disincentive to systemic reform, practice improvement, and innovation. It dissuades physicians from practicing in this state and contributes to shortages in key specialties. Tort reform is a politically charged, legislatively challenging but essential component of a long term solution to New Jersey's health care crisis.

Declining revenues are as much a cause of the financial distress experienced by many of New Jersey's Hospitals as rising expenses. In a long-term trend, both private and public payors have reduced payments and reimbursements for medical services, consumables and resources, and have adopted more restrictive authorization standards. The financial squeeze is exacerbated by the growing impact of non-paying users – the uninsured or under-insured.

It is beyond the scope of this report to examine or comment on the implications, justifications and rationale for the present state of affairs – it may be enough to observe that even as the base of adequately insured, paying patients weakens, the weight of uninsured care grows unabated. This is a questionable recipe for a sustainable system of care.

Physician-owned for-profit ambulatory care centers have made significant inroads into the traditional profit base of many acute care institutions. It is increasingly difficult for traditional acute care institutions to derive sufficient income from insured patients and high-value procedures to offset the costs of uninsured charity care. State charity care payments defray only a portion of those costs. While ambulatory care centers undoubtedly meet a growing market demand and often offer a cost- and quality effective alternative to acute care institutions, there are pragmatic as well as ethically grounded reasons that argue these centers should share some of the charity care burden.

In some localities, the state is now virtually supporting certain acute care institutions. Close scrutiny and oversight of performance and management are required in circumstances where significant public funds are being spent. The imposition of these controls, however, is creating something very like virtual public hospitals. This unintended consequence begs the question of whether, assuming the prospects of these institutions is unlikely to change, instituting some more formal and explicit system of public health care ought, in some cases, be examined as an alternative.

Regardless of which recommendations may be selected for further study, the Subcommittee strongly urges that all "stakeholders" be involved from the earliest planning stages through implementation and ongoing management and oversight of initiatives. Only if all parties affected understand the crisis, are assured their interests are represented and viewpoints considered, and have confidence that needed changes and compromises further the common good and not a private or partisan agenda will there be reasonable prospects for success. Private, not-for-profit and public entities can play a vital role in the necessary process of public education, discourse and debate.

Much use of the term "stakeholders" is made in this report and elsewhere in discussing the healthcare system. In the interests of clarity the Subcommittee offers its own, non-exclusive list of "essential" stakeholders and potential participants:

New Jersey's acute care hospitals and health care systems
Medical Society of New Jersey (MSNJ)
The New Jersey Association of Osteopathic Physicians and Surgeons (NJOAPS)
New Jersey Hospitals Association (NJHA)
Catholic Health Partnership of New Jersey
New Jersey Council of Teaching Hospitals (NJCTH)
State Board of Medical Examiners
New Jersey State Nurses Association
Physicians' professional associations
Private medical insurers and payors
Health care worker's unions and associations
Public Sector payors (Medicaid, Medicare)
New Jersey Department of Health and Senior Services (NJDHSS)
New Jersey Department of Banking and Insurance (NJDOBI)

Issues, Findings and Recommendations

The Subcommittee has selected what, in its view, are the most critical issues for New Jersey's acute care hospitals and physicians. While many of the recommendations made in this report can be expected to make a significant impact on financially distressed institutions, they also have broad relevance for the relationships among New Jersey's acute care hospitals, physicians and payors, as well as the communities they serve.

The relationship among New Jersey's acute care hospitals and the physicians who provide essential care is complex, and no one factor or solution can be identified as either the cause or cure for all problems and risks. Some of the more salient aspects of the situation are mentioned below:

- Hospitals and physicians do not operate on a common or compatible set of practice-oriented and financial concerns with respect to the medical management of patients and the provision of in-patient services.
- Hospitals have not provided financial details and transparency on the cost of services or care. It is not surprising that physicians have little appreciation of the cost implications of their care and treatment decisions on hospitals.
- Physicians face little accountability for consumption of hospital resources, consults, length of stay, etc. Over-utilization of medical resources and "defensive medicine" is common practice at many institutions.
- There are no accepted standards of measurement for hospitals and physicians and consequently no means to compare or evaluate performance, quality, effectiveness and efficiency.
- New Jersey physicians have not, in many instances, been quick to adopt even the most widely recognized and accepted evidence-based protocols, guidelines, and best practices.
- There are no financial incentives to coordinate care or assure patients have access to continued care once they leave the hospital.
- Economics of small practice groups which characterize the New Jersey market makes broad-based innovation and change more difficult than in markets characterized by larger specialty group and multi-specialty group practices

The Subcommittee on Hospital Physician Relations and Practice Efficiency believes its findings and recommendations provide insight and guidance for the better management of acute care facilities in general and especially those facing financial challenges.

Payment System

Closer alignment of hospital and physician financial incentives for hospital care almost certainly holds significant potential for improving cost efficiency and rationality of health care resource utilization. There are several strategies that may be employed to help achieve such a goal including goal-based incentives, reimbursement systems for physicians based on severity-adjusted Diagnosis-Related Groups (DRGs) or Relative Value Units (RVUs), or other means of sharing gains in productivity and cost-savings. Detailed study and evaluation of plans and strategies for improving alignment of payors[1], hospital and physician financial incentives is a key recommendation.

Certain physician practices and behaviors can have a significant impact on the effectiveness (quality) and the efficiency (resource consumption) of outpatient and inpatient care resulting in waste, inefficiency, delay and unfunded inpatient care. For example, a commercial payor may deny or downgrade a hospital stay as medically unjustified, but nonetheless reimburse the physician responsible for the decision. Medicare payors pay hospitals a fixed rate, but hospitals remain at risk if a physician is an inefficient user of hospital resources. Presently, hospitals have no effective means available to correct, discipline, or exclude outliers and even outright abusers.

On the other hand, New Jersey physicians receive some of the lowest reimbursement rates in the nation for treating Medicaid patients, while hospitals are paid at considerably higher rates. Such a misalignment of incentives is regarded as a key reason for lack of physician availability in hospitals serving a large proportion of Medicaid patients.

Better alignment of financial and practice incentives among hospital systems, physicians and payors will help close service gaps, reduce counter-productive attitudes, and encourage more cost-effective practices. Any such initiative must take measures to avoid the risk that, as physicians and hospitals payments are more closely aligned, patients' interests may be unduly constrained. For example, patients who, for medical reasons, should receive extended or more intensive care may be faced with increased or more complex barriers. Safeguards including procedural checks, rights to second opinions, and a swift and straightforward route of review and appeal are essential to assure fairness and protection of patient rights as the economic interests of physicians, hospitals and payors are brought into alignment.

Institutional Infrastructure and Support Systems

Hospital infrastructures and support systems are in many cases ill-adapted to present institutional needs, financial realities and physician practices. Attempts by physicians and hospital staffs to compensate for these deficiencies can result in practices and behaviors that can weaken the institution and diminish the quality of care.

Unlike some hospital resources, sickness, disease and trauma do not diminish on weekends and holidays. Service and coverage reductions on weekends and off-hours impact more than patient care and convenience. They can result in needlessly extending hospital stays, may place patients at greater risk for hospital related complications, and cause waste and delay. New Jersey's acute care institutions should consider the economic feasibility of providing a more comprehensive range of services every day of the week to ensure timely and effective care, optimize resource utilization, and control costs.

Physician availability, particularly among certain specialties and especially in the ED, is a major limiting factor in improving the overall performance of ED services and optimizing the use of physical and human resources on a daily basis. There is a growing disinclination among some physicians to accept traditional on-call obligations, an increasing trend toward limiting care for charity cases to the initial ED encounter, little apparent interest in innovations such as the increased use of practice extenders, or receptivity to improvements in practice and practice models.

[1] "Payors" as used here refers to public and private third party payers, and excludes self-insured individuals or co-payees.

Reductions in public and private physician reimbursements, increasing concerns over medical liability, life-style issues, and increasing numbers of under- or uninsured individuals all play some role in creating and perpetuating this situation. Physicians must become active partners and be convinced of the value to themselves and their patients of making practice changes and working with their institutional partners to achieve desired changes.

Metrics and Reporting

Establishment of standards and measures of quality, outcomes and efficiency for physicians and hospitals is a key to strengthening the acute care system. It is well established that measurement improves performance among hospital staff, physicians, and institutions in general. Tracking resource utilization, length-of-stay, end-of-life issues, and performance on key clinical indicators associated with the most frequently used DRGs, among other metrics, is a key to raising quality, efficiency and performance.

Lack of confidence in and acceptance of performance criteria, collection methods, data analysis and reporting have been major hurdles to agreement on the meaning and interpretation of results, their relevance and validity, identifying problems, and deciding on action steps and solutions. The logistics, IT resources, expertise and costs involved in developing establishing and maintaining state-wide metrics and reporting are significant. No one institution can or should bear this cost. The source of funds to defray expenses and provide the necessary resources requires serious and careful consideration. Unless these issues can be resolved, they will mean defeat for any effort to establish quantitative standards.

The implementation of professionally endorsed, evidence based, and unbiased institutional and physician metrics and reporting would be a major step forward in realizing the benefits of evidence-based medicine on a broad scale in New Jersey. Active engagement of all key stakeholders in the endeavor is essential.

Regional Coordination of Health Care

Regionalization can be an important strategy in achieving a more rational and sustainable health care system. Coordination of care on a regional basis involves redefining acute care “market areas” within a broadened conceptual framework. Such a framework must take into consideration a range of economic and demographic factors and an evaluation of the “essentiality” of both institutions and key services modules.

Regionalization is one way hospitals may achieve the goal of providing a comprehensive range of services on an everyday basis. It is very likely some institutions will find it impossible to provide all such services in the face of shortages of key specialists, or simply because it is economically unfeasible to do so. In such cases, providing certain services on a regional basis may be the best workable solution.

The concept of Centers of Excellence is not new in the health care field but is one that can be readily adapted to provide enhanced service and quality, sounder financial management, and improved utilization and efficiency on a regional basis. New Jersey has already made a significant move in this direction with the establishment of its Level 1 Trauma Centers. Conditions of a non-emergent nature could be candidates for similar programs.

The subcommittee is aware this topic is receiving in-depth consideration by other subcommittees advising the Commission and is confident their recommendations will be in accord with its own concerns.

Critical Areas for Structural Reform

Regionalization of health care resources, tort reform, restructuring medical malpractice insurance within New Jersey and consideration of alternatives to traditional concepts and patterns for delivering acute care will have profound and far-reaching impact in and outside the health care system. While specific recommendations for change and reform in these areas are outside the charge and scope of this Subcommittee, these issues are regarded as so crucial to the long-term resolution of New Jersey’s health care crisis they demands mention

here, even in summary manner. The Subcommittee is confident these subjects are being thoroughly studied by other subcommittees advising the Commission and that well-considered recommendations will be forthcoming.

Regional Coordination of Health Care

Regionalization of scarce health care services offers some of the most challenging and potentially rewarding opportunities to rationalize New Jersey's acute care system. There is a wide disparity across the state in the scope, quality and availability of acute care services. Acute care facilities in New Jersey vary considerably in their economic resources, physician and staff availability, scope of physical plant and in-house capabilities and services.

Many institutions are essential to their service areas but cannot, for financial or other reasons, provide all needed services on a sustainable basis. Conversely, there are other institutions with ample physical plant and medical resources which would benefit from increased utilization. Nevertheless, they all have an equal responsibility to deliver a comprehensive spectrum of care to all persons, regardless of ability to pay.

Regional coordination will require either regulatory or legislative action and in any case will not be immediately attainable. An effective plan of regionalization must take into account a thorough assessment of community needs on a local and regional basis. Such a plan may need to encompass adding or expanding essential services where gaps are identified, as well as combining capabilities and eliminating or reducing clinical redundancies. Support will be required to assist institutions transitioning operations from non-essential to essential services, and relocating under-utilized resources and capabilities to more robust institutions. Above all, hospitals (and other key stakeholders, such as unions) must be persuaded such far-reaching structural changes are in their best long-term institutional and financial interest.

The following points represent some of key issues and concerns that will arise in considering how regionalization can be realized:

- What is the structure envisaged? Vertical (acute, rehab, LTC, etc.)? Horizontal (new shared service entities)? Hybrid?
- Community needs must be balanced against institutional viability and rationality at every point in the process of regionalization.
- Are physical, intellectual and human resources being rationalized, re-used, recycled, retooled and restructured wherever possible?
- Is there a net positive impact on quality care, access and cost? How does this break down by patients, physicians, communities, payors, and caregivers?
- How well are logistics, transportation, and community needs addressed?
- Does the regionalization plan serve a broad range of patient needs efficiently and effectively?

Regionalization should be the initiated on a demonstration or pilot basis, with the involvement and oversight of the Commissioner, Department of Health and Senior Services. Such an initiative should engage and involve all key stakeholders, including community groups, payors, physicians, institutional staff and management and focus on meeting service gaps in critical specialties and redirecting utilization of scarce resources. Hudson County may be especially well-suited for such a demonstration project.

Reformation of Tort Liability Law

There is now a serious lack of key specialties in New Jersey (e.g. obstetrics, neurosurgery, mammography services) driven in part by the reputation of New Jersey's courts as "plaintiff-friendly" and the steep rise in medical liability insurance rates. Action by the legislature will undoubtedly be needed if meaningful tort reform is to become a reality in New Jersey. Comprehensive tort reform represents a formidable political and legal challenge but remains one of the key objectives for improving the long-term viability and vitality of New Jersey's health care system.

A crucial objective is ensuring the continued availability of essential on-call specialties and reducing the disparity in tort liability between acute care institutions and physicians providing ED services. This could be accomplished by raising the tort standard from simple negligence to gross negligence/willful misconduct for all care rendered for such services by on-call physicians.

Medical Malpractice Insurance Relief

Increases in medical liability premiums in New Jersey have contributed to a crisis in both the availability and affordability of mandatory medical liability insurance Moreover, recent court decisions suggest a continuing judicial bias in favor of plaintiffs, notwithstanding contractual and other legal barriers. A key long-term objective should be to ameliorate the burden of medical liability insurance first on specialists in high risk practice areas to ensure New Jersey residents continued access and availability to these vital services, and then more generally to physicians in all lines of practice.

The state should explore affordable, alternative means of obtaining insurance at appropriate levels, while maintaining the right of injured individuals to recompense for damages. It may also be feasible to condition such preferred liability coverage to approved programs that incorporate compliance with well-validated and widely recognized, evidence-based standards of care and treatment.

Comprehensive medical malpractice insurance and tort liability reform must be part of long-term plans to rationalize health care resource utilization in New Jersey. Targeted tort reforms aimed at retaining key acute care specialties and services must at a minimum receive serious consideration.

- On-call/ER physician services
- Obstetrics
- Neurosurgery
- Critical care and trauma physicians
- Oral/maxillofacial specialists
- Primary Care

Alternative Concepts for Delivery of Acute Care Services

For-profit ambulatory care centers are a growing presence on the health care landscape. Many physicians have significant financial interests in these centers and often refer their patients to them in preference to hospitals providing the same services. Procedures done at these centers are typically high value, and even if not "cherry-picked," divert an important revenue stream away from acute care hospitals. If New Jersey is to have a unified system of care, these centers should be required to shoulder some portion of the burden of charity and uncompensated care which now falls entirely on the hospitals and the physicians providing that care.

In other markets, the payer mix, demographics, access, and population density may be insufficient to sustain the necessary level of care and services, even with the best management, processes and oversight available. Some hospitals in these areas seem chronically resistant to change, have persistent issues of fiscal crisis and mismanagement, and suffer from consistently sub-standard quality and patterns of misuse and abuse.

Regionalization, service initiatives, programs and mandates may not be enough to address the problems these hospitals face. While these same institutions are often vital and "essential" to the communities they serve, they may only continue to operate with massive long-term financial support from the state.

The necessity for oversight and accountability for public funds is creating in some of the most severely stressed institutions something approaching a de facto public hospital status. In view of this, it may be prudent to consider a broader range of options, including but not limited to the creation of a formal public hospital designation or perhaps a state-funded public hospitals corporation with the mandated requirements of performance, transparency and accountability. Obviously, such a step is not to be undertaken lightly, but it should be borne in mind that such systems can work and in fact have long records of meeting vital public health needs.

Recommendations

1. Alignment of Hospital and Physician Financial Incentives

Issue

Structural misalignment among payors, individual providers and institutions, and inadequate reimbursement invites abuse and rewards medically irrational and counter-productive decisions. Inefficient patterns of practice, misuse of scarce resources, denials or delays in coverage or payment, unduly burdensome pre-certification processes, and panels with too few participants may serve short-term financial interests, but have lasting adverse effects on physicians' willingness to provide care, institutional strength and patient health and well-being.

Acute care institutions are often caught between conflicting demands for service by physicians and coverage decisions by payors. The absence of a coherent framework of incentives for providing and compensating cost-effective medicine and care is at the root of the problem.

Discussion

Admissions and discharges are typically driven by physician decisions. However, where such decisions do not meet reimbursement criteria for medical necessity or level of services, it is irrational and inimical to institutional financial health for payors to deny reimbursement to the hospital while continuing to compensate for physician services.

There are also instances where a payor may cover an ED visit, but deny payment for physician services. For example, it is common for a payor to require referral to an "in-network" provider for a patient stabilized in the ED service. But if a patient cannot locate such a specialist promptly, and requires subsequent follow-up in the ED, coverage may well be denied for the treating physician's services.

Misuse and overuse of consultants is a significant problem in many institutions. Presently, hospitals have little or no control over this aspect of physician practice which can lead to sharply increased expenses without an improvement in patient care. Beyond instances of outright abuse, there is a large opportunity to improve practice and reduce costs by eliminating unnecessary and extended consults.

Examples of irrational decisions and counter-productive results could be multiplied, but the lesson to be drawn is the same. Payment and coverage decision-making is deeply and often critically disconnected from care-giving and medical decision-making, often to the detriment of patients and providers. While payor decisions are clearly a major factor, it is a dangerous oversimplification to place the blame entirely on insurers, or for that matter, any other single player or stakeholder group. New paradigms of care, payment, accountability, and patient involvement and responsibility are clearly needed.

If a medical or treatment decision, admission, continued stay or discharge is not medically necessary, both the institution and physician should bear similar financial and legal consequences. Both the physician and the hospital should be at risk for non-payment if a medically inappropriate decision (i.e. one not supported by an agreed treatment algorithm) is made, and conversely be equally exposed to (or protected from) litigation for the consequences. Institutions, physicians and patients alike should have ready access to review and revision if such any decision results, or is likely to result, in patient harm. This would stimulate better working relations among physicians, the hospital, physician advisors and case managers to improve overall efficiency in operations and rational utilization of resources, while assured patients rights are maintained, protected and defended.

However, not every medical decision translates readily into increased or decreased costs or impacts length of stay, nor can desired change in all cases be achieved by placing pressure on the primary care physician. For example, if a treatment or test is postponed because a service is closed or a specialist unavailable, it is both unfair and ineffective to penalize the primary care physician for the delay. Thus, an across-the-board system of rewards and correction cannot be applied to all physician decisions that may result in additional in-patient days.

One solution to avoidable delays and extensions of stays may lie in achieving seven-day per week operations as

discussed elsewhere. Another approach may involve innovative ideas regarding compensation of physicians for in-patient care that increase alignment of financial incentive among physicians, hospitals and payors.

Alignment-oriented payment schemes that provide physicians appropriate incentives for cost-efficient case management through case-rates or severity-adjusted payments but that do not unduly impose penalties for unavoidable or unintended consequences should be thoroughly examined. This is an area requiring careful study of alternatives and demonstration projects before widespread implementation can confidently be recommended.

Physician education is a key to rationalizing proper use of consultants. The process should begin in medical schools and continue through training programs and CME. Demonstrating that cost-effective medicine has a positive financial impact and that over-utilization neither improves outcomes nor reduces lawsuits is an available strategy that may reduce the use of non-essential consults.

Public payors and private insurers must adopt uniform standards of review and consequences so physicians and hospitals can make consistent and rational decisions without regard to the source of payment.

Benefits and Risks:

- Educate and incent physicians to practice cost-effective medicine, reward physicians based on system cost savings, and eliminate or reduce incentives to over-utilize resources and continue defensive medicine tactics.
- Rationalize the appropriate use of consultants and consulting practices through physician and medical student education.
- Align financial interests and liability exposure for hospitals and physicians to improve physician accountability for appropriate use of hospital resources.
- Establish uniform hospital and physician payment criteria for all payors (public and private sector.)
- Alignment-oriented payment systems must not actually or apparently improperly incentivize hospitals, physicians or payors to withhold, curtail, or deny medically necessary care.

Recommendation

- Establish, enable or support the implementation of alignment-oriented payment models or systems for acute hospital care that financially impact, engage and involve physicians.
  - Funding for the incentives required to implement such a system must come from savings generated within the present scope of payments and reimbursements.
  - Payor fees schedules should be completely and publicly disclosed.
  - Safeguards must be built-in to protect patient rights to all medically necessary care and provide percentage-based payment for out of network services.
  - A carefully designed, geographically limited and closely monitored pilot or demonstration project would be a prudent first step.

2. Physician Accountability and Evidence-Based Practice in Acute Care Institutions.

Issue

The value of evidence-based medicine standards is well-recognized for producing improved case management, better patient outcomes and cost-efficiencies in the acute care setting. This is especially true for some of the most common and costly diagnoses where such standards have been extensively researched and promulgated.

Even where such standards are widely recognized, however, New Jersey hospitals and physicians have made little progress in agreeing how to implement them, measure results, or how to reward, induce or coerce compliance. This has made it nearly impossible to assess the level of practice, identify leaders and outliers and implement any system of evidence-based rewards and corrective action within a given institution.

Discussion

Though hospitals have a vital interest in physicians practicing the most cost-effective medicine, their ability to induce such behaviors is limited. Collection and dissemination of information on physician performance, whether available to the public at large or a more limited

peer group can promote physician accountability and adherence to evidence based practice guidelines.

Many physicians regard such measures with suspicion as unwarranted intrusions into their professional prerogatives. Some find the mere suggestion of standards and the threat of publicity offensive, if not threatening, and move business to less aggressively managed hospitals. Unless the effort is based regionally or state-wide, attempts to use metrics and peer-pressure will put all but the strongest institutions at increased competitive disadvantage and potential financial risk.

Physician report cards can work only if they are designed so that the information is valued and used by the physicians themselves. Standards of measurement must be widely accepted and validated if ratings and rankings have the desired effect of motivating and modulating behavior in positive directions. Implementation of such tools demands a cooperative and collaborative effort, as well as agreement on shared goals and outcomes.

Many insurers have access to demographic and clinical data that can be used to produce performance metrics at the physician and patient level. New Jersey insurors should be strongly urged to cooperate in developing standardized quality performance reports for New Jersey similar to those developed in New York (MetroPlus) and Minnesota (HealthPartners). Such reports could represent an important component of an acute care report card initiative.

Benefits and Risks

- Broad participation in standards development encourages buy-in and reduces bias concerns.
- Regional implementation of physician report cards levels the playing field for weak and strong institutions and encourages best practices, especially in key specialties.
- Implementation may disadvantage institutions dependent on marginal providers and possibly divert business elsewhere.

Recommendation

- A properly validated, well-accepted, independently complied, and publicly available physician report card system that measures performance and outcomes on critical, evidence-based standards of acute care practice should be developed and implemented on a regional or state-wide basis.
  - Priority and focus should be first placed on key specialties and high-cost, high-risk conditions and diagnoses.
  - Insurors, MSNJ, NJHA and other state-wide organizations should participate in the study, research and validation required for this effort.

3. Coordinating the Continuum of Care

Issue

New Jersey's health care system does not adequately ensure the management of a patient from admission through in-patient treatment to discharge and follow-up treatment and services. Lack of organizational structures and financial incentives for such a continuum of care adversely affects medical outcomes and increases the total cost of medical care. Discontinued care or lack of follow-up can result in a readmission which might have been avoided by a more timely intervention.

The problem is made worse by the practice of some physicians who restrict their engagement with charity care patients to a single ED encounter, limit the range of services they are willing to perform, or fail to manage the clinical condition to conclusion. Reimbursement and liability concerns are likely drivers, but fall short of excuses, for such behaviors, which in extreme cases can amount to the virtual "abandonment" of the patient. This increases clinical costs, creates liability exposure, may place patients at increased risk and degrades health care quality.

Discussion

There are at least three key components to establishing a continuum of care that are within the existing capabilities of New Jersey's acute care facilities. Hospitals can establish guidelines to assure patients are admitted to the most medically appropriate service, insist ED physicians manage patients to an appropriate point of transfer, and ensure discharge procedures provide for appropriate follow-up, after-care, or outpatient services.

Hospitals traditionally do not question admission to a primary care provider's service or make an independent

determination whether another service or specialist care would be more appropriate and efficient. However, procedures that ensure patients are admitted to the appropriate service will increase their likelihood of receiving well-managed treatment from the onset of care through discharge or transfer. Consultation and/or recruitment of other providers should be coordinated by the appropriate admitting physician. In situations where hospitals lack needed specialty resources, regional relationships could fill the gap.

Hospital policies must clarify the scope of physician responsibility for all ED cases, and articulate unambiguous professional, ethical and legal standards to ensure patients receiving treatment in the ED service are managed through to clinical resolution and appropriately stabilized, discharged or transferred. Stronger inducements, including legislative mandates may be necessary if such encouragements prove insufficient.

Utilization of appropriate post-discharge care can mean better outcomes, more compassionate care, and greater cost-efficiency. This may include local or regional access to long term ventilation units, vent/dialysis units, long-term acute care facilities (aka LTACs), nursing homes, and hospice care. Discharge procedures should encourage such choices and efforts should be made to reduce or eliminate any financial barriers that may inhibit considering such alternatives.

Managing the continuum of care for the highest cost diagnoses (DRGs) may offer the best opportunity for realizing a measurable benefit from a coordinated approach. CHF (congestive heart failure) is a good example, representing one of the most common and costliest DRGs. Coordination of in-patient care and outpatient support through specialists, anticoagulation and/or CHF clinics is likely to prove a readily available, cost-effective strategy.

In all cases, incentives or other forms of encouragement are needed to achieve better management of patients throughout the continuum of care.

Benefits and Risks

- Ensure optimal management of all patients from admission to post-discharge treatment to conserves the benefit of treatment, reduce readmission rates, and forestall clinical deterioration.
- Ensure involvement of the appropriate specialist from admission through discharge or transfer.
- Restructuring significant aspects of the physician-patient relationship and ED practice patterns will require engagement and commitment by senior management and institutional governance.

Recommendation:

- Encourage coordinated care through a system of appropriate incentives and standards for achieving measurable results, that will at a minimum:
  - Assure patients are admitted to the most medically appropriate service
  - Require ED physicians to manage patients to an appropriate point of transfer, and
  - Establish discharge procedures that provide for appropriate follow-up after-care or outpatient services.
- Study and development of specific guidelines for implementing coordinated care on an individual institutional basis is a likely necessity and strongly urged.

4. Transparency & Accountability for Acute Care Resource Utilization Costs

Issue

Imperfect or non-existent knowledge of the cost of care and resources inhibits physicians and consumers from making informed, rational choices, decreases trust and confidence and disables accountability for decisions.

Discussion

The cost of hospitalization and associated resource utilization is not widely appreciated by treating physicians, much less by the public at large. Without such information, physicians and patients may make unwarranted or inappropriate demands for non-essential services, over-use or misuse hospital resources, and fail to appreciate justified denials or consider alternatives to such services. These factors tend to raise the overall level of dissatisfaction in and distrust of many aspects of the health care system.

Greater financial transparency would increase comprehension of the financial impact of treatment

decisions and make creation and adoption of quality and cost performance expectations for physicians rational and equitable.

Benefits and Risks

- Financial transparency engages physicians in resource utilization decisions
- Removes elements of uncertainty contributing to suspicion and distrust
- Empowers consumer-directed health care choices.
- May threaten marginal institutions dependent on higher cost services to offset uncompensated care.

Recommendation

- Increase institutional transparency for acute care costs, utilization and care alternatives to enable cost and treatment-effective decisions.
  - Hospitals should explore ways of publishing and communicating accurate, relevant and timely information on the cost of care, resource utilization and alternatives to inform and help guide physician decision toward the most cost and treatment-effective choices.

5. 365 day Optimization of Hospital Resources

Issue

Hospitals maintain emergency department and other essential services at all hours of the day or night, providing vital and life-saving resources to their communities. However, hospital staffs and ancillary in-patient services are reduced or limited on weekends and off-hours which, while saving money, can mean important diagnostic tests or treatments must be delayed, sometimes for days.

Consequences of this may include medically unnecessary stays, patient inconvenience and exposure to infection risk, and associated waste, delay and cost. While some service capabilities should undoubtedly be provided on a 365-day basis, it is unclear whether and to what extent non-essential services would be cost-justified if available on a similar basis.

Discussion

Optimizing hospital resource utilization throughout the year is not formulaic and will require study, tailored recommendations and well-managed implementation for each institution's unique situation. The importance and role of institutional governance in such an endeavor cannot be too strongly emphasized.

While it may not be possible for a hospital to provide every service at all hours throughout the day, there are identifiable aspects of effective coverage that all hospitals can and should maintain every day throughout the year. These include the implementation of specially trained coverage for ICU units, physician extenders and actions to address any deficits in on-call coverage.

Benefits and Risks

- Enhanced patient care, improved outcomes.
- Incremental implementation can start with highest cost units.
- Spread work load to normally less productive hours.
- Reduce unjustified (and unreimbursed) LOS

Recommendation

- Hospitals management should be encouraged to define and adopt standards of operation for an expanded range of services that optimize utilization of physical plant and human resources on a 365 day basis.
  - Where essential in-house resources or specialized services are unavailable or not cost-justified, management should seek to form and/or participate in regional networks to address the identified deficiencies.
  - Hospitals should invest in and incent programs such as Intensivist and physician extender programs that are proven to have a measurable impact on cost-savings, resource optimization, efficiency and effective patient care.
- Funding of such programs must be internally cost-justified. The State should provide assistance in developing economic and business modeling for financially distressed hospitals.

6. Standardization of Emergency Department Service Call Requirements

Issue

New Jersey is one of the few states in the Union that has foregone creation of public hospitals in favor of a state-mandated requirement that all acute care hospitals provide medical care to all persons regardless of ability to pay – the so-called "Charity Care" system. As a practical matter, this often means the Emergency Department must provide an extensive range of comprehensive care and services.

In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the patient anti-dumping law, encompasses emergency care in the ED (including on-call specialists as required), OB care for women in labor, and psychiatric emergencies. The law provides for an appropriate medical screening examination for any person requesting examination or treatment for a medical condition at an emergency department. It is the hospital's obligation to determine if there is an emergency medical condition and if so, to stabilize the patient or arrange transfer him to another appropriate facility.

Many hospitals can no longer enforce Emergency Department (ED) service call obligations on physicians, and in a growing trend, must pay significant fees to physicians in order to secure urgently needed and essential coverage. While this may not be a burden to some institutions, it is undoubtedly problematic for others.

In some cases, the lack of ED on-call physicians means patients have limited access to needed medical care and lack of appropriate follow-up or continuity. Change is needed to ensure all acute care institutions have the access to critical specialty physicians needed to fulfill their obligations.

Discussion

Physicians (specialty physicians in particular) are increasingly disinclined to accept on-call obligations, resulting in strains on access and availability of key medical services to the particularly vulnerable populations for whom the ED may represent the only means of access to the health care system. "On-call" physicians are (unlike hospitals and their employees) fully exposed to tort liability and risk not being compensated for treating the uninsured (unless, as is increasingly the case, the hospital has contracted them to do so.)

Historically, ED service obligations were more or less expected from physicians in consideration of attending privileges. A return to the former "soft" system of obligation is not anticipated. One option is a mandatory on-call requirement for all physicians. However, making on-call service "mandatory" for all physicians via regulation, legislation or hospital policy raises difficult questions of equity, bargaining power, legality and enforcement.

Fines and licensure actions seem too extreme, while suspension or curtailment of privileges is not a realistic option for many institutions. Moreover, the institutional landscape is not uniform. Requiring obligatory on-call service would be far less burdensome on physicians in suburban hospitals due to the relatively small number of charity care and Medicaid cases. Urban hospitals, in contrast, would face difficulty recruiting and retaining physicians who could expect to shoulder a substantial burden of uncompensated care. (There is also a widespread but largely anecdotal perception that charity care patients pose a higher medical liability risk than other patients.)

Paying for on-call services is a poor but in some cases necessary strategy, inasmuch as hospitals are mandated to provide certain services under EMTALA. Where such arrangements provide for flat fees only and do not pay for each episode of care, there is a built-in bias toward under-delivery and over-payment. Moreover, flat fees are paid independent of any reimbursement or other compensation a physician might receive. A better system might tie payments to services actually rendered on some equitable pre-determined basis.

Initiatives considered elsewhere in this report and perhaps by other subcommittees may provide a partial solution. Establishment of and participation in a comprehensive system of regionalized care or Centers of Excellence and expedited transfers may provide a medically responsible and financially sustainable means meeting public expectations of the ED service, as well as the legal demands of Charity Care and EMTALA

mandates. The widespread use of such centers has the potential to change the current paradigm of ED care and alter the traditional pattern of reliance on on-call services.

The crisis in on-call service is exacerbated by the problems and risks, real or perceived, of providing care in the ED setting. The issues of compensation and liability for providing such services need to be addressed to ensure adequate and consistent on-call coverage and continuity of care.

Benefits and Risks

- Increasing on-call service will reduce service bottlenecks and disparities in care for under-served populations.
- Increasing the trend toward payment for "on-call" status is a poor solution that places additional strain on institutional finances.
- Mandating on-call obligations is a controversial and potentially divisive concept that poses major obstacle to implementation, may adversely impact care, and perhaps reduce availability and access.
- Compensation for on-call services is a better approach in principle but presents unresolved issues of funding.
- Regionalization could reduce the need for each institution to have access a wide range of on-call specialties.

Recommendations:

- Physician obligations and expectations with respect to ED service should be standardized (or at least rationalized) regionally or even state-wide to ensure adequate medical coverage and fulfillment of statutory mandates. However, there is lack of consensus on the means to accomplish this end. Several ideas have been proposed:
  - Mandatory (via statute or regulation) call and continuity of care obligations for all physicians at all facilities.
  - Increased incentives for Medicaid and uninsured cases, compensation for taking call in urban areas, and perhaps malpractice premium relief.
  - Compensation for EMTALA-related services on an episode-of-care basis rather on a flat fee basis.
  - Regional Coordination and Centers of Excellence should be examined in light of their impact on demand for on-call services.
  - Lifetime or age cap for on-call service hours.

7. Intensivist Model for ICUS

Issue

Intensive Care Units provide patients with life-sustaining medical and nursing care on a 24 hour basis but are not typically staffed with specially trained personnel. Typically, ICU patients are among the sickest, highest risk and most expensive cases in the hospital.

Discussion

Quality of care and cost-effective treatment in the ICU setting are maximized when they are provided by trained staff whose only responsibility is the care of patients in the unit. Such "Intensivist" programs, when properly executed are recognized as cost-savings measures that also improves the quality of patient care.

A minimum requirement for such a program would provide service on a 365 day basis for at least eight hours per day, preferably during hours of greatest risk and/or limited coverage. In some institutions, telemedicine and remote centers can be a highly effective and cost-efficient means to implement intensivist capabilities in whole or in part. An "Intensivist Model" of ICU care and case management provides multiple benefits.

Benefits and Risks

- Better utilization of resources and ICU beds, organizational throughput and lower LOS,
- Better adherence to practice guidelines and best practices and coordination of care in complex cases
- Better patient outcomes, lower mortality rates, potentially higher patient and family satisfaction, more effective treatment of end-of-life issues, improved organ donation efforts.

Recommendation:

- Adoption or implementation of an Intensivist Model of ICU Care should be a priority for acute care hospitals statewide and especially financially distressed institutions.

- Hospitals should be encouraged, rewarded and/or recognized for implementing intensivist programs and capabilities.
- The State or other organizations should enable and assist program development wherever possible.

8. Leverage Professional Resources

Issue

Physician availability is a critical factor that impacts a hospital's ability to respond effectively to patient need and efficiently utilize its resources. Reduced services, staffs and coverage on week-end and holidays, declines in on-call physician availability and shortages of key medical specialties can limit access and availability.

Even where physicians are available to provide in-patient coverage, the pressure to maximize the use of their professional hours is often extreme, reducing the amount of time available to each case and each situation demanding their attention. These factors contribute to service bottlenecks and inefficiencies, and may result in added costs and increased risk.

Discussion

While there is no short-term means for increasing the supply of specialty physicians in under-served localities in New Jersey, there are other strategies for leveraging scarce physician resources in the acute care setting that potentially offer economic and quality improvements.

In many situations, "practice extenders", such as Intensivists, case managers, hospitalists, physician assistants and advance practice nurses have the potential to provide cost-effective means of achieving quality and efficiency goals in appropriate circumstances. Advanced practice nurses, for example have independent practitioner (IP) status which enables them to be independently compensated. Recognition of and compensation for the services of other practice extenders, such as Physicians' Assistants ("PAs"), would expand their use, helping to realize more effective and cost-efficient resource utilization.

According a class of practice extenders such as Physicians' Assistants IP status might facilitate this, and could allow greater flexibility in matters such as getting orders co-signed within narrow time constraints. On the other hand, this may raise new issues of practice autonomy, training and expertise, and liability. It is also not clear whether and under what circumstances Physicians' Assistants themselves might desire or accept independent status. Any such change will require further study and should not distract attention from the need to expand their utilization through recognition of and compensation for the value added.

Other capabilities such as telemedicine services could, if appropriately compensated, help multiply the effective reach of vital physician services. Financial incentives or support from the state or other organizations may be required to overcome cost barriers to acquiring the IT infrastructure needed for telemedicine and remote monitoring.

Extensive implementation of leveraging strategies will impact and alter the practice model of individual physicians in important and perhaps radical ways. Institutional priorities must reflect and embody the commitment of the governing board and senior management to the needed change and establish clear goals. Practice leaders, staff and employee representatives must be brought into and "buy into" the process.

Benefits and Risks

- Reimbursement for the services practice extenders more generally would expand their use and enable more cost-effective leverage of scarce physician resources.
- Patients will receive a net increase in care, hospitals will gain greater coverage at reduced cost, and physicians can make better and more profitable use of billable time.
- Various combinations and patterns of practice extenders, intensivists, case managers, hospitalists, advance practice nurses, remote and telemedicine capabilities can be combined to augment the delivery of care and expand physicians' availability.
- Solutions can and should be tailored to meet the needs and capabilities of each individual particular institution and health care system.
- Initiatives in this area must be undertaken and endorsed at the highest levels of hospital governance in cooperation with payors, physicians

and representatives of the various groups of practice extenders to succeed.
- Hospitals (and especially financially stressed institutions) may need guidance to make cost-effective selections among the wide range of available options.

Recommendation

- Hospital management should explore and expand the use of practice extenders and other options for leveraging, extending and augmenting the professional presence and expertise of physicians.
  - Provide enhanced compensation for the use of selected practice extenders, such as Physician Assistants, even if not separately compensated as "Independent Practitioners".
  - Hospitals should work closely and cooperatively with its physicians and regional hospitals to optimize the benefit of such efforts for patients, doctors and the institution itself.
  - The State should assist financially-distressed institutions in identifying qualified consultants and solution providers who can help define and implement such initiatives.

9. Exploit Existing Electronic Capabilities and IT

Issue

Electronic data, communication and information technologies continue to evolve and proliferate through the economy and society, but so far these tools are underutilized by the healthcare system. There are significant efforts already underway, notably NJHA's efforts to enable a Regional Health Information Organization (RHIO) in New Jersey which promise to dramatically improve connectivity and communication among physician, hospital facilities and staff. These efforts require long-term commitment, substantial investment, support and encouragement. Nonetheless, it may be possible to realize more modest gains sooner, and with much less effort and cost.

Discussion

There are many ways to make use of advances in information technology that are far less complicated and more readily attainable than the widespread implementation of electronic medical records or the creation of broad-based health information complexes. The web is an existing resource that could dramatically enhance the relationship and communication between physicians and hospital staff without major reengineering or capital investment. Existing hospital IT systems could be used to provide physicians' offices with the ability to remotely monitor hospital patients to achieve more timely, quality- and cost-effective decision on interventions, treatment, discharge or other dispositions.

On-line information, consultation and reference resources for physicians and hospital staff are within reach of existing technology and could be implemented at comparatively low cost. Electronic sharing of information, case histories, and best practices could be a cost effective means of education and promoting better medical and cost-efficient management. Intranet messaging may prove a useful and readily accessible means of communication as it has in other contexts.

The discharge and transfer process could be better handled through electronic means and as discussed elsewhere, may help ensure continuity of care. Electronic means could be used to obtain real or near-time information on discharge and intermediate care options, hospice, palliative care, rehab, LTC, etc., to shorten discharge time. The state might be able to offer assistance in locating consultants and solution providers.

Finally, institutions, payors and other stakeholders, perhaps pharmaceutical firms or insurers might be find it in their interest to support aspects of the effort to improve connectivity and communication among target groups of practitioners and selected institutions, even on a limited basis.

Benefits

- Improve physician-hospital communications to increase efficiency and productivity.
- Near or real-time remote access to patient records can improve accuracy and timeliness of clinical decisions.
- Distance learning technologies can enhance access to reference resources, learning and enable information exchange.
- Private sector support and/or funding are worth exploring.

- Legal and regulatory issues (HIPAA, Stark, IRS, etc.) must be considered and addressed.

Recommendations:

- Utilize existing hospital IT systems and standard web access to provide physicians remote, real-time access to clinical monitoring and/or data.
  - Institutional and text messaging, physician home page, etc could be an integral part of such a system
- Establish on-line practice resources and institutional physician information
  - Medical references, research, journals and other library services
  - Institutional and/or healthcare system-specific information on resources, treatment protocols, best practices and other informational bulletins and updates.
  - State IT and library resources may be available to help pool resources and reduce subscription costs.
- Explore feasibility of using on-line discharge information systems or providers to shorten discharge wait times and improve patient placement.

10. New Jersey Health Care Data Warehouse

Issue

Quantitative comparative measures of hospital performance do not exist in New Jersey. Disagreement over whom and what to measure delays or prevents needed action, and can have but one outcome for a failing institution. Beyond agreement on the tools and criteria, there must be confidence in the impartiality and objectivity of the process.

Discussion

A vital task of the Commission is to help determine the viability of hospitals that are currently operating "marginally," and recommend incentives for improvement. The availability of reference standards and measures of performance would inform and benefit all acute care institutions, but is an absolute necessity for the effective management of hospitals in crisis.

The mechanics of such a system – the data collection instruments and evaluation algorithms and criteria - can be developed on a regional or state-wide basis, drawing from good practices, experience and evidence-based guidelines and use quality assurance experts, trained statisticians and data base development experts as needed. Data on patient outcomes and institutional performance would be submitted by New Jersey's acute care hospitals to a central data repository or warehouse.

It is essential that all stakeholders be involved in the process of developing metrics and the methodology of collection, collation and dissemination of the information. The end product should be a comprehensive hospital patient health care and outcomes data set, collectively designed and independently maintained, to serve as a publicly available reference standard.

Such a system may well be implemented as a spin-off of the RHIO initiative mentioned above. However, as the data warehouse concept could be implemented at an earlier date and with less expense. It might also be utilized as a precursor to the more ambitious data collection aims of the RHIO project.

Benefits and Risks

- Increase transparency and metrics for New Jersey's acute care hospitals and health care system
- Wide availability to all payors, healthcare plans, institutions and physicians will encourage broadly accepted metrics and performance standards.
- Serve as the mandatory standard of reference for all institutions requesting or requiring extraordinary (beyond currently authorized Charity Care) state financial assistance for their operations.
- May impose extra costs on institutions, compete with or made superfluous by other public or private efforts.

Related initiatives that may further such a project:

New Jersey Hospital Management Data Network

New Jersey acute care hospitals do not presently have the means for real-time exchange of non-proprietary, non-confidential data. Like many

institutions in the state, hospitals tend to be local and relatively isolated, with limited interaction with peer institutions.

- A hospital management data network, created by the hospital associations and member institutions, could provide managers of acute care institutions non-confidential information to better assess their performance and progress compared with their peers.

Uniform Data Standards and Formats

Uniform data standards and formats would enable much improved oversight, data and best-practices sharing, as well as transparency, measurement and accountability among New Jersey's acute care institutions.

- Standard for forms and data capture and entry should be created and promulgated implemented by all hospitals. Immediate candidates for standardization include a uniform clinical data reporting sheet and a new, customized New Jersey UB Type 04 medical claim form.

Recommendations

- Consideration should be given to establishing a New Jersey Health Care Data Warehouse containing outcomes and performance data from a wide spectrum of participating acute care institutions.
    - New Jersey should assist all acute care institutions in identifying consultants and solution providers to develop the required IT and MIS resources.
    - Standardization (or at a minimum, agreed ways of normalizing) of admission, charting, treatment and discharge procedures should be developed to allow comparative assessments of performance.
    - Contributors must include the Medical Society of New Jersey, the hospital associations, health care insurers, public payors, appropriate professional societies and the final product must bear their unanimous endorsement.
    - The state should explore options to host, support and maintain the database, to assure compliance with HIPAA and other applicable laws and regulations, and provide neutrality.
    - Funding options should be explored, including grants, user fees, subscriptions or subsidies for financially distressed institutions.

Conclusion

The crisis in acute care facing many communities and institutions in New Jersey is profoundly affected by the relationship between the hospitals that provide access to services and the physicians who provide the care. While these stakeholders share many interests and goals in delivering effective and high quality medical care, in too many instances financial pressures, structural inefficiencies, imperfect information and irrational patterns of traditional practice, resource allocation and use defeat or deflect the achievement of these ends.

The recommendations provided in this report if implemented in whole or in part, can be part of the answer to rescuing New Jersey's most at-risk institutions, bringing quality care to underserved communities, and raising the level of health care available to all persons seeking it within the state.