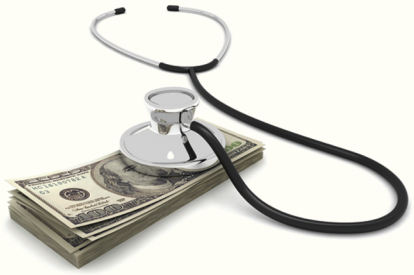
When Being #1 Means We Have to Think Differently:

The Future of Healthcare in New Jersey



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"We must have substantially
new manners of thinking to
enable mankind to bridge
the gap between
the things that have been
and the things which will be."

Julius A. Rippel
Founding President, 1969
FANNIE E. RIPPEL FOUNDATION

The Fannie E. Rippel Foundation
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to achieve better health,
better care and lower costs.
Through our ReThink Health initiative,
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working with them to explore
and implement innovative initiatives
in order to improve health outcomes
for all Americans.

Introduction

For all who care about the future of New Jersey, healthcare costs, delivery and quality warrant increasing focus and attention.

NATIONAL HEALTHCARE REFORM will certainly influence the future of New Jersey healthcare. But it will not address many of the most pressing and fundamental issues facing the state's healthcare system. Prominent among them is the issue of cost. With costs among the highest in the nation—combined with only average overall quality results—New Jersey is on a trajectory that is unsustainable. The increasing impact across sectors is evident as government, businesses, and individuals struggle to cope with the implications of rising costs. Unless addressed, the impact of this trajectory will increasingly spill over into other aspects of New Jersey society. Yet, surprisingly, this has not been a subject of historic or sustained interest in the state. For all who care about the future of New Jersey, healthcare costs, delivery and quality warrant increasing focus and attention.

To better understand the state's healthcare challenge, we examined available data on New Jersey and interviewed more than 25 health leaders selected because of their knowledge about and experience with the state. They represent a broad cross section of stakeholders, including providers, former and current state officials, hospital representatives, patient advocates, insurance company executives, delivery system analysts, and health policy experts. The intent was to develop a high-level overview of New Jersey healthcare, identify important themes, and generate ideas about the future.[1] These are reflected in this report.

The consensus among those interviewed: the current trajectory for the system will only lead to more discord and poorer performance overall—higher costs, marginal quality improvements, and fragmented care. Healthcare costs are already crowding out other critical investments in education, infrastructure, and the environment, as well as making New Jersey less attractive to new business. Can we afford to envision a future where increased health costs have even greater negative impact on our state?

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New Jersey Healthcare Costs and Utilization

New Jersey healthcare costs and healthcare utilization are among the highest of any state in the nation. Dartmouth researchers produced a national atlas reporting data on Medicare beneficiaries with severe chronic illness in the last two years of life that compared New Jersey costs with those in other states.[2] Total per capita spending in 2007 for New Jersey beneficiaries in those last two years averaged $59,379, the highest of any state, and 28% higher than the national average of $46,390.

Table 1: DARTMOUTH ATLAS MEASURE/NEW JERSEY RANK

Total Medicare reimbursements per enrollee during the last two years of life	1
Total Medicare reimbursements during the last six months of life	1
Inpatient reimbursements per decedent during the last two years of life	1
Inpatient reimbursements per decedent during the last six months of life	1
Outpatient reimbursement per decedent during the last two years of life	1
Hospital days per decedent during the last two years of life	1
Total ICU days per decedent during the last two years of life	1
High-Intensity ICU/CCU days per decedent during the last two years of life	1
Total physician visits per decedent during the last two years of life	1
Medical specialist visits per decedent during the last two years of life	1
Primary care physician visits per decedent during the last two years of life	1
Percent of decedents seeing 10 or more different physicians during the last six months of life	1
Number of different physicians seen per decedent during the last six months of life	1

Source: Dartmouth Atlas Web site; Tracking Care of Patients with Severe Chronic Illness, state tables.

The most important reason for the higher costs in New Jersey is greater healthcare utilization. The Commonwealth Fund's State Scorecard on Health System Performance ranked New Jersey 48th out of all 50 states on avoidable hospital use and costs.[3] As Table 1 shows, the Dartmouth Atlas ranks New Jersey first in the nation in days in the hospital, number of physicians seen, and high intensity care, among other measures. In several key measures, New Jersey's utilization is more than 50 percent higher than the national average (Table 2).

The Dartmouth Atlas data, organized at the regional level as well as the state level, use what they refer to as Health Referral Regions or HRRs that generally represent natural market areas and include at least one significant hospital. These regional data reveal whether the New Jersey state data are caused by a few unusually high-cost regions. The Dartmouth Atlas data divides New Jersey essentially into seven regions, and five of them are in the top 17 (out of 306 nationally) in Medicare expenditures per recipient: Newark ranks #7 in the nation on expenditures, Hackensack is #10, Ridgewood is #11, New Brunswick is #14, and Paterson is #17. Camden and Morristown complete the New Jersey profile ranking 30th and 41st respectively.

Table 2: SELECTED U.S. AND NEW JERSEY HEALTHCARE UTILIZATION RATES

Measure (last six months of life)	U.S. Average	New Jersey
Intensive care days per decedent	3.40	5.50
Physician visits per decedent	30.50	48.50
Medical specialist visits per decedent	14.40	29.00
Ratio of specialist to primary care visits	1.04	1.76
Percent patients seeing 10 or more physicians	30.40%	46.80%

Source: Dartmouth Atlas Web site; Tracking Care of Patients with Severe Chronic Illness, state tables.

Clearly, these regional data indicate costs are high in all regions—and at the state level, New Jersey is #1. Recognizing that these spending data are not adjusted for price differences, one explanation could be New Jersey's higher cost of living. While prices do contribute to New Jersey costs, along with special payments for medical education and care for the poor, this alone cannot explain New Jersey's national status. Only when combined with the high utilization evidenced in Tables 1 and 2 does the overall effect drive New Jersey costs to be among the nation's highest.[4]

The state's difficulties with managing its healthcare resources are reflected in the establishment of the New Jersey Commission on Rationalizing Healthcare Resources in 2006. While prompted most directly by the financial struggles of some hospitals, the Commission report analyzed the healthcare system's key components (hospitals, physicians, imaging and ambulatory care facilities, etc.) and how the workings of the overall system contributed to higher healthcare costs.[5] The Commission found:

- A large number of hospitals in poor financial health;
- An oversupply of hospital beds;
- High use of hospital services;
- Conflicting financial incentives for physicians and hospitals;
- Limited physician accountability for use of hospital resources; and
- Limited transparency for prices of services provided by physicians and hospitals.

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Quality of Healthcare in New Jersey

Specific findings on the quality of healthcare in New Jersey are mixed, but an overall assessment indicates quality is average, or perhaps slightly better than average, when compared to other states. That leaves significant room for improvement, since on average people in the United States get the recommended care only about 55% of the time.[6]

In the most recent comprehensive assessment by the federal Agency for Healthcare Research and Quality, New Jersey's summary rating is "average" on their state quality dashboard. New Jersey has, however, improved its rank among states through better hospital performance.[7] As an example, ten years ago, New Jersey was ranked 43rd on a set of hospital quality measures, but New Jersey's 2010 Hospital Performance Report documented that the state's hospitals' provision of recommended care, using those same measures, is now above the national average.[8] Quality problems in New Jersey's ambulatory surgery centers, however, illustrate that quality varies across settings. In a recent survey, more than 50 percent of facilities did not meet Medicare Conditions of Participation, due to problems such as drug administration, infection control, and maintaining a sanitary environment.[9]

Using a broad indicator of quality, New Jersey's adjusted death rate for Medicare beneficiaries in the most recently reported data was slightly below the national average. (This rate takes account of the population's age distribution so that it can be compared to other state rates.) In addition, patient ratings of hospital quality in New Jersey were about average. In a nationally representative study of 12 communities, the quality of care in Northern New Jersey was about average for most measures.[10] Overall, New Jersey's quality of care is typical for the nation.

New Jersey Attributes and History

The basic findings from available New Jersey data—very high costs and average quality of care—were no surprise to the health leaders interviewed. Indeed, they offered a number of ideas to explain how New Jersey has come to its current crossroads. These ideas clustered into two broad categories: attributes of New Jersey in general, which set the context for, and contributed to, health system performance; and, attributes of the healthcare system itself, including how it has evolved over the last several decades.

The proliferation of small municipalities has reinforced a wasteful duplication of services that is mirrored in the healthcare system.

New Jersey's Distinctive Character

In commenting on New Jersey's unique attributes that affect the healthcare system, the leaders highlighted its unique geography as a "corridor state" with high density (highest in the nation), high average income (second highest in nation), high tax burden (highest in the nation), and high unionization rate (5th highest). As a corridor state, New Jersey is dominated by New York City and Philadelphia, which influence all sectors of the New Jersey economy, including healthcare. The influence of these two urban centers is reinforced by the lack of large cities within New Jersey—no city in New Jersey is among the largest 50 in the nation, and only four have a population over 100,000.

Due to a long history of creating new local governments, New Jersey has more municipalities per square mile than any other state. The proliferation of small municipalities has reinforced a wasteful duplication of services that is mirrored in the healthcare system. This complex array of jurisdictional entities not only frustrates reasonable policy efforts and complicates community and regional development, but reflects a culture of disputation and division as an accepted pattern for dealing with conflict generated by thorny societal issues.[11]

Several of those interviewed commented on the limited engagement of business and industry leadership. They also noted an anemic social sector devoted to healthcare. This is consistent with New Jersey's ranking of 46th among states on an index of civic life,[12] and the observation that New Jersey healthcare nonprofits often reflect the interests of particular stakeholders rather than provide venues for broad-based discussions focused on the public interest and interactions among those holding diverse views.

In addition, greater emphasis seems to be placed on issues such as education, environment, housing, and transportation, than on health.[13] This underscores an unusual absence of public discussion about healthcare, including the values and overall system performance that matter most to the people of New Jersey.

New Jersey's Healthcare System

Interviewees also pointed to a number of attributes of the healthcare system itself that help explain why New Jersey's healthcare is so expensive, yet produces only average quality. A critical factor has been the waxing and waning role of state government in overseeing the system.

From 1978 to 1992, the state had an all-payer rate-setting system for hospitals.[14-16] This payment mechanism, which was well-funded, reinforced the structural arrange-

ments existing in the 1970's system, including a predominant reliance on local community hospitals.

As a result, the delivery system evolution that occurred in other parts of the country did not happen in New Jersey. In addition, it set patterns of relationships oriented towards state government payments, contributed to contentious relationships among entities in the system, and resulted in local political representatives acting at the state level to solve local resource disputes.

When the state ended the all-payer system in 1992, the market competition model reinforced the contentious aspects of the system, but the reduced role of the state government in overseeing the system left a vacuum. As a result, opportunities to come together and generate cohesive thinking and discussion about the system overall became scarce.

Today's healthcare system is influenced by this legacy, and those interviewed described it as fragmented, balkanized, uncoordinated, competitive, and poorly integrated. As one put it, "New Jersey has a 1970's healthcare delivery system trying to deliver 21st century healthcare."

Those interviewed also noted other factors that contributed to this overall picture:

- The market structure of physician practice, with few large groups and a high proportion of practices with one to four physicians;
- The proximity of hospitals that allows physicians to use their market power in admitting patients;
- The combination of physician and hospital market structures that constrains cooperation and organizing together to improve quality and efficiency;
- The culture of distrust among stakeholders;
- The division of the state's responsibility for healthcare among multiple agencies;
- The mal-distribution of physician specialties, skewed towards a highly specialized physician workforce;
- The excess hospital capacity;
- The "medical arms race" environment, in which the competition to have the latest equipment results in excess capacity in the system of the most advanced (and often costly) technology; and
- The high percentage of physicians who graduated from an international medical school (highest for any state in the nation).

The dynamics of the system's development over the years was described by one leader as a continual process of resource accretion: many of the factors reinforced one another, as all the stakeholders—providers, hospitals, patients, insurers, suppliers, etc.—used the system to their own advantage, fostering overall growth while externalizing the costs. As a wealthy state, New Jersey has, until now, accommodated this process better than most.

There was consensus among those interviewed that continuing on the current pathway is unsustainable.

There was consensus among those interviewed that continuing on the current pathway is unsustainable. The current trajectory for the system is viewed as leading to more discord and poorer performance overall—higher costs, marginal quality improvements, and fragmented care. These outcomes could provoke, unintentionally, more intensive efforts to force the system to behave differently via rules and oversight, especially if New Jersey falls farther behind in terms of utilization, cost, and quality outcomes achieved in other states. These problems, especially ever-increasing costs, will spill over into other sectors of New Jersey society. Healthcare costs are already crowding out other critical investments in education, infrastructure, and the environment, as well as making New Jersey less attractive to new business.

The Future of New Jersey's Healthcare System

Coming to grips with this bleak consensus may be a necessary prelude to the stirrings of constructive change. Leaders noted that the growing awareness of New Jersey's problems is changing expectations about being able to continue with "business as usual". As a result, many in the system are beginning to be open to new ideas and directions. Knowing that ever-higher healthcare costs are unsustainable and that change is inevitable can free up stakeholders from long-held assumptions about their roles and relationships.

The Current Climate for Change

The national health reform legislation contributes to this climate of changing expectations. Health reform brings focus to some aspects of system change (for example, health information technology), along with resources devoted to implementing those changes. In addition, it will expand and change the state's private health insurance market and Medicaid program through a health insurance exchange, and it will provide federal funds to subsidize care. It will stimulate pilots and demonstrations. And it brings an urgency driven by legislatively specified implementation deadlines. Health reform does not, however, lay out a blueprint for delivery system changes that lead to better health, better care, and lower costs—and particularly costs. In short, health reform can help establish the conditions for positive change, but it will not solve New Jersey's problems of high costs and utilization, nor improve the health of the population. Those challenges fall to New Jersey itself.

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New Jersey's Strengths

New Jersey has, of course, many strengths on which to build. It does reasonably well in state comparisons based on infant mortality, mortality rates for particular diseases, and smoking prevalence, as well as on measures of prevention, access to care, and system equity.[3,17] The leaders interviewed also saw emerging opportunities that may point to a way forward, including pilots and innovative programs being planned or started by stakeholders and patient care advocates. Among those innovations highlighted were:

- The efforts of Dr. Jeffrey Brenner, a social entrepreneur in Camden, NJ, who is developing systems of care for chronically ill, high-utilizing, Medicaid patients;
- The establishment of a new subsidiary, Horizon Healthcare Innovations, by the state's largest insurer, Horizon Blue Cross and Blue Shield, that is expressly focused on building new models of care and testing them in pilots;
- A new model clinic, the Special Care Center, in Atlantic City, NJ, with a unique approach to patient-centered care for patients with chronic disease, primarily unionized employees of casinos; and
- Cooperation among the New Jersey Hospital Association, the Medical Society of New Jersey, and the New Jersey Bar Association to foster the adoption of state-wide efforts to improve end-of-life care.

Yet what is lacking is a common vision, widespread awareness, and a shared will and commitment to innovation and change.

Ingredients for Charting a New Path

While there is no single best way to move forward, interviewees suggested what is needed for New Jersey to fundamentally improve:

- Leadership and vision—Leaders within the health sector should help set the vision, tone and direction for fundamental change. In addition, public and private leadership outside the health sector—especially from the business and civic communities—is needed to bring healthcare into the overall discourse on New Jersey's future.
- Public engagement and discussion—The people of New Jersey need to engage on the tough issues that changing the healthcare delivery system raises. What outcomes are most important? How should inevitable tradeoffs be handled? How should public input be organized? The media can play an important role in highlighting these discussions. The nonprofit sector, including philanthropy, should increase its capacity to foster ongoing dialogues. Overcoming New Jersey's balkanized structure will be the first priority, and this needs to be addressed at all levels—in communities, in regions, and in the state overall.
- Delivery system experimentation and innovation—Absent a blueprint, experimentation and innovation are a reasonable way to begin to change the system. These could include new cross-stakeholder collaborations focused on system-wide efficiencies and redesign, as well as building on planned or existing activities around, for example, medical homes, chronic disease management, high-utilizing patients, health disparities, payment reform, and accountable care organizations (ACOs).[18] Recent efforts to develop Medicaid ACOs in five urban communities and planning underway for six additional ACOs throughout the state are promising steps.
- Mechanisms for coordination and integration—Some coordination will occur as actors in the system work together and develop new relationships, consortia, and agreements. However, more concerted efforts are needed by governmental, business, citizen and nonprofit organizations to foster effective coordination and governance structures within the system, as well as between the system and the larger society.
- Data on system-wide costs and performance—New Jersey needs much better information on system-wide costs and performance that is timely, accurate, and useful. State government should play a leading role, working with all payers and providers, in assuring that this information is available. These data are essential for improvement and accountability and should be made easily accessible.
- Systemic learning—The healthcare system needs the capacity to assess performance and learn how to improve. That requires sharing information, creating a culture that rewards improvement, and fostering systemic learning that builds on existing evidence to support quality improvement and lower costs at the same time.[19]
- System thinking and analysis—The elements above must be developed in tandem within the context of a widespread collective dialog about the future of New Jersey healthcare in order to lay a foundation for the development of new institutional arrangements that foster health and care outcomes that New Jersey residents want and deserve.

The people of New Jersey need to engage on the tough issues that changing the healthcare delivery system raises.

Conclusion

New Jersey's state budget challenges contribute to an atmosphere in which significant changes are anticipated.[20] Healthcare, in the form of state funding of retirees' costs, current employees' costs and various government public insurance programs, especially Medicaid, is central to these challenges. The combination of national health reform, state budget deficits, and an unsustainable trajectory of healthcare costs produces a climate for change and underscores the need for leadership to begin to grow a new vision for the future.

Notes

1. This research project, "Exploring opportunities to bring new thinking to health and healthcare in New Jersey," was supported by the Fannie E. Rippel Foundation. See: www.rippelfoundation.org/our-approach/

2. Wennberg JE, Fisher ES, Goodman DC, Skinner JS. *Tracking the Care of Patients With Severe Chronic Illness: The Dartmouth Atlas of Health Care* 2008. Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice.

3. McCarthy D, How SKH, Schoen C, Cantor JC, Belloff D. *Aiming Higher: Results from a State Scorecard on Health System Performance,* 2009. New York, NY: The Commonwealth Fund; 2009.

4. Specifying the relative importance of factors that contribute to higher costs is the aim of ongoing health services research, especially explaining variations across regions and states. Dartmouth Atlas researchers have found significant variation and documented relationships with supply-side characteristics, i.e., provider supply and behavior. Recent analyses under the auspices of the Institute of Medicine (iom.edu/Activities/HealthServices/GeographicVariation/DataResources.aspx), using somewhat different methods, found that after adjusting for local wages, graduate medical education and other payments, and for patient conditions, New Jersey ranked 21st in costs. However, new research (Welch, et al., "Geographic variation in diagnosis frequency and risk of death among Medicare beneficiaries", Journal of the American Medical Association, pp 1113-1118, March 16, 2011) suggests these risk adjustments, based on diagnoses, may themselves be a consequence of provider behavior. Better research using better data is needed. In the meantime, we know New Jersey costs are high.

5. New Jersey Commission on Rationalizing Health Care Resources. *New Jersey Commission on Rationalizing Health Care Resources, Final Report 2008*. Trenton, NJ: New Jersey Department of Health and Senior Services; 2008.

6. McGlynn EA, Asch SM, Adams J, et al. *The quality of health care delivered to adults in the United States*. N Engl J Med. 2003;348(26):2635-2645.

7. Agency for Healthcare Research and Quality. *New Jersey dashboard on health care quality compared to all states*. Available at: http://statesnapshots.ahrq.gov/snaps08/dashboard.jsp?menuld=4&state=NJ&level=0. Accessed on October 1, 2010.

8. *Hospital Performance Report: A Consumer Report: New Jersey 2010*. Trenton, NJ: New Jersey Department of Health and Senior Services; 2010.

9. *Ambulatory Surgery Center Survey Activity Update*. Trenton, NJ: New Jersey Department of Health and Senior Services; January 20, 2011.

10. Kerr EA, McGlynn EA, Adams J, Keesey J, Asch SM. *Profiling the quality of care in twelve communities: results from the CQI study*. Health Aff (Millwood). 2004; 23(3): 247-256.

11. Karcher AJ. *New Jersey's Multiple Municipal Madness*. New Brunswick, NJ: Rutgers University Press; 1998.

12. *Volunteering in America: 2007 State Trends and Rankings in Civic Life*. Washington, DC: Corporation for National and Community Service, Office of Research and Policy Development; 2007.

13. Salmore BG, Salmore SA. *New Jersey Politics and Government: The Suburbs Come of Age*. 3rd ed. New Brunswick, NJ: Rivergate Books; 2008.

14. Siegel B, Weiss A, Lynch D. *Setting New Jersey hospital rates: a regulatory system under stress*. Univ Puget Sound Law Rev. 1991;14(3):601-631.

15. Volpp KG, Siegel B. *State model: New Jersey. Long-term experience with all-payer state rate setting*. Health Aff (Millwood). 1993;12(2):59-65.

16. Cantor JC. *Health care unreform. The New Jersey approach*. JAMA. 1993;270(24):2968-2970.

17. United Health Foundation, American Public Health Association, Partnership for Prevention. *America's Health Rankings: A Call to Action for Individuals & Their Communities*. 2009 ed. Minnetonka, MN: United Health Foundation; 2009.

18. A medical home is an approach to delivering primary healthcare through a team partnership in a high quality, comprehensive manner—including acute, chronic, and preventive care. An Accountable Care Organization (ACO) is a group of healthcare providers who give coordinated care and chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving healthcare quality goals and outcomes that result in cost savings.

19. Weeks WB, Gottlieb DJ, Nyweide DE, et al. *Higher health care quality and bigger savings found at large multispecialty medical groups*. Health Aff (Millwood). 2010;29(5):991-997.

20. *Facing Our Future*. Trenton, NJ: Council of New Jersey Grantmakers; 2011.

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