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# ***Council Meeting***

of

## NEW JERSEY ADVISORY COUNCIL ON ELDER CARE

*“Testimony concerning health care and caregiving for the elderly”*

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**LOCATION:** Board Room  
New Jersey Hospital Association  
Princeton, New Jersey

**DATE:** April 9, 1999  
1:00 p.m.

**MEMBERS OF COUNCIL PRESENT:**

Assemblywoman Carol J. Murphy, Chair  
Assemblyman Samuel D. Thompson  
Assemblyman Louis A. Romano  
Susan C. Reinhard  
Theresa L. Edelstein  
John Michael Heath  
Renee W. Michelsen  
Joanne P. Robinson

**ALSO PRESENT:**

Irene M. McCarthy  
*Office of Legislative Services*  
*Council Aide*



*Meeting Recorded and Transcribed by*  
The Office of Legislative Services, Public Information Office,  
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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**ASSEMBLYWOMAN CAROL J. MURPHY (Chair):** Thank you for being here today.

And, Theresa, thank you for the wonderful hospitality and the gorgeous lunch.

MS. EDELSTEIN: You're welcome.

ASSEMBLYWOMAN MURPHY: It was a nice surprise and a real treat. We enjoyed it.

We don't have a long agenda today, but we certainly have one packed with information for us. Joyce Hildenbrand, who is Manager of Social Services at Morristown Memorial; Mike Dennis, Vice-President, Senior Services at Kennedy Health System; and John Gribbin from the Meridian Health System.

If you'll remember, I think what kind of brought this into today was the fact that both Theresa and Dr. Heath were discussing case management or care management, two words that are used sometimes interchangeably in human service agencies. I don't know whether they are necessarily in the hospital, but what it says is that one part of you can't be treated in an isolated fashion. We need to be dealing with the whole, and that that's exactly what we're going to be hearing about today is what happens to you.

My husband had minor surgery this week, and I got three pages of what to do. The nurse told me what to do, and if she hadn't given me the pages, I would not have known. By the time I got halfway home, it had all gone out of my mind. So I got home, and we both read it. And we're arguing today whether or not he could drive for his visit to the doctor, whether I had

to drive. So we had to look at the papers again. We trust our memory because we want to be able to remember the things, but sometimes it doesn't work out as well as I guess you would anticipate.

You have before you, also, minutes. The transcript from the meeting of January 20. That is our second meeting that has been put up, and I'm very appreciative of that.

I think we will begin without further adieu.

So, Joyce Hildenbrand, thank you very much for coming to speak with us and educate us all today.

ASSEMBLYWOMAN THOMPSON: I think I would just like to add--

ASSEMBLYWOMAN MURPHY: Yes, Sam.

ASSEMBLYWOMAN THOMPSON: --that as you speak of this as a care management and information related to being discharged, at an earlier hearing, we did have some individuals in speaking of that this was a problem. That they did feel that they weren't being given adequate information as they left. And when they went home to take care of an elderly resident or something, they really didn't know that much of what they should do. So, if we have some systems that are working well, that's wonderful.

**J O Y C E H I L D E N B R A N D:** I'd be happy to address that and thought that it might be most helpful to me, and hopefully to you, if there is another point from possibly your prior meetings that you'd like to bring up that I could include in my remarks, because if there's other questions-- It was mentioned what's the difference between care and case management or is there

a difference? A concern about what kind of information patients and families are leaving the hospital with. Is it adequate, inadequate?

Are there any other thoughts that any members of the Advisory Committee might have that are questions?

Yes.

DEPUTY COMMISSIONER REINHARD: I've been hearing some rumors that hospitals are downsizing in discharge-planning areas with--

MS. HILDENBRAND: Okay.

DEPUTY COMMISSIONER REINHARD: --especially with PPS, the perspective payment system.

MS. HILDENBRAND: Okay.

ASSEMBLYWOMAN MURPHY: And another issue that was discussed is that ongoing understanding of what you are dealing with is very necessary for caregivers, that the continuing education, if you will, as to how they care successfully and what they are to anticipate. I think some of that came from people who are dealing with dementia-related disorders, which alter, and they felt unprepared for what was coming -- even granted that you only hear what you need to hear at the time it's delivered.

MS. HILDENBRAND: Okay.

As I was so pleased to have the opportunity to address you, I began thinking quite across a wide variety of areas to share with you. But I think that hearing the concern, and it was reiterated by Theresa to me, of how are patients discharged from acute care, and since that's my current place of employ, though I have historical perspective in post-acute, in rehab services, SNF or skilled nursing, until it became sexier and more profitable to call it

subacute and now it's changing to something else, I feel like I have a sensitivity to those issues having worked in those environments.

The thing I most wanted to share with you today about what the challenges are for acute care is just our general perspective towards our health and our well-being. As a generation, there is a tremendous amount of discussion about how we as people are probably the most dedicated generation to fighting aging. We're doing tons and tons and tons of vitamins and exercise and wellness and all of these other things. And we talk about our quality of life at this point in time, but in many of those instances, we talk about our quality of life and our longevity of life, but there really isn't the necessary discussion about the other part of our continuum of life, which is, when we reach a point in time, how can we be prepared? So what we find often in the acute care settings is the challenge of receiving patients in, in not the best scenario. This is not a time where folks have come to collect a lottery ticket and plan what they're going to do with their millions. It's not a time where it's a social gathering. It's a time when it is a sudden, traumatic, devastating, confusing, and frightening situation -- typically, pretty critical.

We do celebrate life. We do celebrate deliveries. But even for persons coming in with the wonderful celebration of having a new life arrive, it is still a huge change. It is a sudden explosion in what was known and familiar and controlled, and that's a really critical term -- is being in control. When patients come to our hospital and have health-care issues or come to the physician's office, they are relatively out of control at that moment, and they are trusting to the institutions to know what to do. Our obligation as institutions is to know what to do but to give advice and guidance and

education and not, as I've affectionately call it, do it to them, but rather be a partner with them. And I think many of the changes that we have seen in recent years with care management -- being teamed with social workers and nursing professionals to comprehensively look at the issues that will be the stepping stones for continuum of care or some of the initiatives that demonstrate how we're coming together as a team to work collaboratively. We have so many initiatives across our continuum and in other health-care settings where we've partnered. We invite educators in to talk to us about different services, assisted living, the foster care programs that are out in the community, the variety of waiver programs that we have. We truly are collaborating.

Certainly, there are gaps. Whenever we have individuals come to the hospital and have such traumatic circumstances, it is not the best time when someone is in such a crisis to begin to talk about and say, "Now, Theresa, in planning for your loved one's care, we need to address some very personal, financial information." Basically, I'm asking you to disclose to me everything about this loved one's personal assets, funding, holdings, personal properties, so that we can begin to build a foundation and structure for not only the next step, which might be subacute, which might be a comprehensive rehabilitation hospital, but we've expanded our vision to provide comprehensive services to look at steps beyond.

There are many criticisms that once you're in the hospital, acute care is so anxious and truly because of payer pressures to move people out and to push them out, and we all know that that's out there. We hear so much the language through our own health-care plans. We are truly trying in this very

condensed time to educate as fully and completely as possible about what are options and alternatives, and we do try to look at those next steps.

I have worked with persons in the acute care setting that have regrettably been victims of car crashes. And I'll help you with saying they are not accidents. They are car crashes. And in that fashion, they have had devastating outcomes. And I as a professional social worker with my care manager teammate cannot look at what is the immediate step right here that we will take. This individual may have limited assets, and this individual's full care may have to be covered by those limited assets, so we've expanded our vision beyond. It is not just referral to rehab hospital. It is referral on to the next step. How far will the funds stretch? What other resources are out in the community? So we have expanded our vision in that fashion, have brought into our team approach other players from the community, and our team conferences. It is very often the case that we will have persons join us so that we can have a larger vision.

One of our biggest challenges, though, is the crisis of the moment in acute care because it is very tragic. It is very difficult. One of those challenges is the fact that we are raging against the storm in terms of trying to maintain a healthy lifestyle for older individuals, and they're fighting and holding onto everything but maybe not dealing with the realities of what we're presently faced with.

One of the other challenges that we see is the dilemma of trying to talk about those intimate details at that moment in time. So even as it was mentioned by representative Murphy that we have-- She had a personal experience where she tried to keep her ears open and tune in to all of the

information given. You're not in control. You're not feeling totally in control. You're in a foreign environment. You're trying to adapt and cope as effectively as possible. And even with written instructions and reinformation, it's very difficult to manage just the onslaught of stimulus that comes forth from such a circumstance.

I think that hospitals and the teaming that they've done with the extended agencies in the community and the various partners that they've come together with -- their efforts are very admirable. With all of the education that we have, the multiple pieces of information upon discharge, the support groups for referral, the insurance company brokerage and negotiating that we do -- all of that is quite wonderful. But when you come down to the basic issue when you're trying to work with individuals in crisis, it's a wonder point for them to change a behavior. But at that moment in time, it is what they're able to hear, accept, deal with, because it doesn't fit at all with their own future picture and vision of, of what their self was or what their loved one was going to be, and knowing that, I may say it 47 times while they're there, but the next challenge may really disrupt that learning and that information. Hence, the invaluable connection that we have as we pass our information along from the acute care to the elder-care resource center; to the home care agency, where I wish we had more social work hours available; to the nursing facility, which I wish was more accessible to get into because the pass and passer take too long and are sometimes are ridiculous for quick and short stays to return persons to their home community.

What I think we're most challenged with in this scenario is looking at how do we change the front end. We can't wait until the acute care

hospital. And there are a tremendous amount of initiatives that have helped that become more of our focus and foray, but we really have to level -- raise the bar and standard for what we do on that front end. At that point in time, we can begin to talk about the critical personal issues. We can begin to shape expectations to be realistic. For the fact that when you come into the hospital or have a really unfortunate circumstance, the length of stay is not four weeks for a stroke. It's about five days. And when patients come in and families come in with that expectation of four weeks, it is just so jarring. There is nothing that I can do to engender and build a positive relationship with that family when their first thing is you're pushing me out, and you are now my enemy.

Our focus really has to move to the front end about educating and doing some of those different initiatives. One of the aspects that Atlantic has done over a long period of time has been our elder-care resource center and the services there. We do have elder-care case management in the community. It is well promoted throughout our System as being available, and we also have a senior contact program, which does some of these critical issues, which it, embraces our elder population. And even in some of other programs or other populations of different diagnoses to say, "Come be with us, come hear about what we can offer you." And it's almost like a priming of the pump so that they have a trusting relationship with us, and there is an innate sense that we are here to be your partner. We are not here to do it to you. Let us begin to plan and think. Because typically, I don't know that you all might attend any kind of social gatherings in, as I affectionately call it, cocktail sessions where you sit around and talk about the really difficult and dastardliness of a recent

hospitalization or, “Theresa, have you done your life-care planning lately and have you considered Medicaid for your mother?” That’s not even in the realm of conversation, yet we really do talk about, “Are you doing echinacea for your cold so that you stay well for today?” So it’s really an education element that comes into being that we bring our arms around our community.

Atlantic has done very comprehensive, community-based, health-care assessments to identify some of the trends and issues that we might be responsive to. One of the unique things that we have done is we’ve put social work staff in physicians’ offices so that they might begin building relationships with patients prior to any event happening that’s called an acute care episode that requires hospitalization, subacute services, etc. We begin to plant the seeds there.

And because I know Renee, I can mention and say, “Renee, when you brought your mom today -- your mom’s visiting with the doctor -- can I talk with you about what your challenges have been? Has it been difficult? Are you taking care of yourself? If it’s a challenge because you’re caregiving down to your children as well as up, can I share this caregiver resource guide with you that talks about the stress that you’re experiencing and says that it’s okay? These are normal things to have happen.” In that venue, we’re offering an opportunity to educate and prepare persons for what they might experience at a later point in time. Not that it normalizes it or takes it totally away, but rather reshapes their expectations and helps them to mobilize and begin to identify some of the resources and issues that they may need to address.

Trying to be sensitive to your time, I did try to touch on the caregiver issue. There have been a lot of Federal grants recently that have been

awarded. There have been numerous documents written acknowledging the caregivers. In a recent study, it was considered that there's over \$27 billion worth of services provided by family members to patients out of health-care settings to bring them back home and support them. And the caregivers are by far one of the most unregarded, disregarded, and underrecognized and supported entities in terms of what their challenges are. Clearly, it's a venue where we could focus more information education. That might even be something that through New Jersey EASE we can build a specialty element of information and not just make it understood to be services that are available for persons who need the services directly that are health-care related, but even broaden it more and said, "Let us bring the caregivers in." We do often think when we think of health care as services just looking at the medical entity.

It's interesting. Did you see the advertisements for the TV programs tonight? I think it may be *20/20*. They recognize that a physician, a very prominent physician, is now diagnosed with cancer himself -- an incurable version with very, very low opportunity for any kind of recovery. He has clearly explored some alternative therapy ideas in terms of looking for a way that he can live, even if it is within a parameter of a limited lifetime. So we're looking at how we can open up and recognize different kinds of components to give patients and their families the opportunity to choose and to be more in control of their destiny and help them live with whatever time frame that they have.

We clearly have seen a difference in the acute care setting with the onslaught and the initiation of PPS. And most recently in-servicing all of our physicians, at least endeavoring to do so, on one of the aspects of the changes

in the Balanced Budget Act is the ambulance provision under Medicare, where now as I walk into the room the physicians are saying, “You’re the one making me sign that form that I have to do in order to get stretcher transport for my patient to a certain setting.” There clearly, out of the totality of the Balanced Budget Act, have been enormous changes.

We’ve begun to log, specifically, at my hospital, the scenarios where we’ve found that nursing facilities under the new PPS system and the scoring through the RUGs, the research utilization groups, are tremendously slowing down patients’ timely movement through the continuum because it is a resource issue. And I think that some of the coming of age for health care where we begin to talk about, “Yes, I understand, Joyce Hildenbrand, nursing facility, that the patient I last referred to you was expensive. However, here is another person who may be able to complement this.” It begins to be a complementing of -- these are the different types and myriads of persons out there. You will not be able to take all of the cream. If I’m able to share with you and refer to you based on patients’ choices the different levels of care needs, I will endeavor to work with you and be your teammate because I need you as a resource as much as you need me as a referrer. So it’s a very different approach in thinking about health-care allocations of resources. We’re forced into it because of some of the things that have come down the road from HCFA. So it’s a very challenging kind of time that way.

We have heard of staffing changes within the facilities because they’re very frightened about what kinds of survival rates they’ll have under the new PPS system. Health care has never been a business. It’s been a benevolent, God-given, you-should-take-care-of-me kind of genre even for the

patients when they come in. They have no sense of what their HMO benefits are. Many of the staff in the hospitals don't even understand their benefits, let alone the patients coming in, so they just expect it to be there. They expect their employer to have done the right thing for them. They trusted that. So it's a very difficult time for them because they're unprepared. They truly are unprepared. It's not night table reading to look through your HMO benefit book and think that that's really, like, maybe reading *Message in the Bottle*, as one of the nice light bed table readings.

So we find a very uninformed public. There are individuals who are surfing the Web and who are happy to come in and tell me exactly what the physicians need to be doing to treat their parent. And they have no qualms about telling the physicians their perspective on that. So it's a challenge for health care to understand that and not see that as being aggressive or difficult, but rather an empowered, an educated individual and consumer who is trying in a very difficult circumstance to resume some of those issues of control to make sure. They're looking for the value to their dollar. They're paying their premiums. They're looking for that value back. So it's a very interesting continuum even in the presence of the clients -- totally uneducated and unaware, very educated and very aware, and somewhere in between there. We're all thinking about customer satisfaction trying to make sure that we meet everybody's needs and that we as hospital systems have a tomorrow, too, so that we can provide integrated services that goes from soup to nuts and really keep our community's health served and satisfied.

I think when it was referenced a little bit earlier -- the dilemma between care and case management -- care and case management are terms

that are sometimes interchangeably used. At Morristown, we chose to use care management because we found that in an adversarial way, the physicians thought of case managers as external insurance case managers who sat at the end of the 1-800-just-say-no number. (laughter) So we just wanted to make sure that we didn't build just by labeling and language an adversarial relationship. So we have social work and care manager teams, and we do divide the functions amongst them. Because as far as we know, there is only one Superman, and there is not a clone available to do that, who would be one person who could do it all. And the intensity and the complexity of the patients' issues, as well as the short time in which we have to deal with them, requires the expertise of the two professionals coming together and looking at the larger whole, especially in the shorter time frame.

But we also find that we are just the beginning and the tip of the iceberg, if it's a critical and traumatic situation where patients come into acute care. We have to look at being sisterly to our next care partners in transitioning care and information and making sure that we follow through. I'm not sure that we'll ever be superhuman and be able to meet all of the needs of the patients so that every time everyone feels that they left with total information that they could reflect back to us accurately and in an on-target fashion that wouldn't require looking at crib notes or cheating a little bit to say, "I heard this. Did you hear this?" because of the situation that they're in. Therefore, I think our obligation and responsibility as health-care systems is to provide a variety of places where they can come back and touch base, get a reclarification, get a reiteration, get a resource that will say, "Oh, if you didn't hear that information, then it could be that they didn't hear it, not that they

were not given it. Let me offer these ideas to you at this point in time because timing in this business is everything.”

So in that venue, we need not to be pointing fingers, “You didn’t do this in acute care. You didn’t do this here,” but rather say, “What was done in acute care we found that they could have maybe improved with this and not done tips and exchanges,” and then move forward in terms of saying, “Now let us pick up,” because the patient and family maybe ready at that point to take the next step. And they might have not been ready for that in acute care. We have to read where our patients and families are, and we have to adapt to their ability to hear and to response and to move forward.

I hope I addressed your questions. If there’s anything--

Yes, Renee.

MS. MICHELSEN: Joyce, one of the missions of this Council is to make recommendations about the future. We have heard very eloquently from you today and from other presenters before that there does seem to be a lack of planning. That people don’t want to address those awful issues or ugly issues until they have to. If there were, like, three things that people should plan for, when they’re planning for their older years, what would you say those three things might be?

MS. HILDENBRAND: Certainly, financial assets. Clearly, financial assets. There’s a lot of misconceptions and misnomers. I can’t tell you the number of clients I’ve sat with and patients who say, “Okay, I’ll transfer mom’s house to me today.” That’s not how it works. So it’s the element of understanding that there is a very large financial impact and commitment that’s necessary for providing continuing care.

The second part is just an awareness of their own insurance element as they purchase them or as they hope that their employers purchasing them. It's an element of being responsible to find that out ahead of time and be informed and advised. It's not a great time after having a stroke to find out that you have no rehab benefit in your insurance program from your company, and they cut that because of other cost-cutting elements -- to become an advocate for yourself. It doesn't necessarily mean that being in an advocate role you will be aggressive or unfriendly towards an employer, but rather will say, "These are the kinds of things that we value." There may be tradeoffs in negotiations for employment that could be acknowledged and recognized.

And probably the final thing is just a tremendous amount of education and constantly keeping issues out. Have you noticed lately the pharmaceutical companies doing commercials on a variety of drugs? That was never ever on TV. I think we need to look at the different kinds of modes and venues that we can reach out on, and we may need to break down some of those barriers in terms of how we can reach folks. And honestly and frankly, though unfortunately, TV is one of those things that does reach a great deal of people. Not everybody reads the newspaper. Certainly, our patients and families are not able to afford computers to do Internet, but it's amazing a lot of houses have more than four TVs in them. So in the venues of doing a lot of different modes and modalities talking about advocacy, talking about not just living in the moment, but looking at our health and our longer-term longevity, and being aware of how you can be an informed person, the translation could well be if you're informed, you will receive better services because you can advocate for yourself. I think there are ways that it could be

understood and, frankly, sold to patients and families so that they can understand the value and the importance of pursuing things like that.

DR. ROBINSON: Joyce, you referenced the elder care case management system that Atlantic has as really a model for taking the front end or the long view on case management. Could you tell us a little bit about how this works? Who pays for it?

MS. HILDENBRAND: Sure. I'm think Renee will be happy to chime in at one point.

MS. MICHELSEN: That's the service that I run now.

DR. ROBINSON: Oh, great.

MS. MICHELSEN: So we can talk about it together.

I guess the way that it works-- It has a very historical perspective that it began with the Robert Wood Johnson grant--

MS. HILDENBRAND: Right.

MS. MICHELSEN: --15 years ago and then was New Jersey-- That was where I met-- Ricky was right there. When I first met Ricky was when we did the State initiative, and we had the geriatric assessment centers, and then it evolved over time to be a county-funded program. Right now, it's a partnership between the county of Morris and the hospital. The hospital covers one-quarter and the county covers three-quarters of the cost, and it is peer grouping and Title 3 initiative. It's a subcontract with the County of Morris Office on Aging.

MS. HILDENBRAND: In many instances when we have patients who are discharged home, they may not have a skilled home care need, which would enable them to access nursing PTOT speech home health aide services

and the social worker. As much as we'd like to get that social worker in there, there has to be a skilled service to prompt it for financial viability of the agency. We will often refer or collaborate with our elder care program so that we can get case management services in there to help patients continue with the discussion that we had with them about continuing care, nursing home assisted living, those different options. We often start the process by planting the seeds, but we need to be able to hook families up at those critical points to say, "I understand you can't hear this now, or it's difficult to think about this now. Here is a resource that we'll follow up, specifically, on this with you."

There are limitations to pilot programs like this because it's county based. However, it has enabled us to get persons hooked up that are at very, very critical points to take a next step because we find in the follow-through, unless there's support, it often will break down, and then we've lost all of the investment on the front end. So that's where that continuum connection has to be critical.

MS. MICHELSEN: And then it just continues all around because, when the people are readmitted, then we have privilege to read the chart and to write on the chart and to call the social workers and care managers that are part of the hospital to let them know how the person was doing in the communities and to be able to write the person has PAAD, has a home health aide three times a week, goes to adult day care, so they don't try to do all those things--

MS. HILDENBRAND: Exactly.

MS. MICHELSEN: --that are already in place that the family has no idea.

MS. MICHELSEN: The efficiency gain is tremendous.

DR. ROBINSON: Are you linked to New Jersey EASE?

MS. MICHELSEN: Yes. We're the New Jersey EASE leader in Morris.

MS. HILDENBRAND: Right.

The other element that's really important to think about is that I understand and realize that the Council is looking at an elder-care perspective, but we've even begun to do that specifically in our cardiac surgeon's office. They have a master's-prepared social worker there who sees every patient prior to open-heart surgery. That's an elective case. There is counseling that happens there to bring up critical issues. We use a high-risk screening tool to look at high-risk scenarios and begin to say, "Well, if you think you may need convalescence and this is something that is not doable with the daughter, would you go and visit these facilities before they come in?" We have to do this work way, way ahead of time. It's too late, frankly, when it's in the hospital. It leads to dissatisfaction. It leads to people not being able to hear because they're in a crisis. There's other things that are prioritized tremendously higher.

ASSEMBLYWOMAN MURPHY: Joyce, can I ask a question? You're saying in the doctor's office. What doctor's office? And do they see every patient that comes into whoever that doctor may be or the specific offices and for specific patients?

MS. HILDENBRAND: They are specific at this point in time because it was a pilot that we began at the end of '97. We drafted it and said we would put a full-time social worker in the cardiac surgeon's office.

ASSEMBLYWOMAN MURPHY: Not the office in the hospital, but the private office.

MS. HILDENBRAND: Their private practicing office. So if I were to have open heart and I was booked for a consultation with the surgeon next week, I would see the social worker for half hour before I see the surgeon to do an overview and a basic interview of what my life is at that point in time and issues. We find family members there. We find daughters that come with moms and dads. We find that to be a very open time because they ask us questions that they may not feel comfortable asking the surgeon. That gives us an opportunity to say to the surgeon, "Touch on this, touch on that." It's very collaborative.

We're looking at that model to do it in pediatric scenarios with our ambulatory pediatric settings. We're looking at expanding it to the internists. In terms of cardiologists, though, we have, like, 120. It's difficult to pick exactly who, but then the other element is diabetes. And we're thinking about how can we work with patients and families around holistic issues. Because if you're diabetic, you probably have issues with your food. You may not have the right assistances in incomes. You may not have enough support. It is so enmeshed you can't separate medical from all of these other lifestyle and life-presenting issues.

Yes.

DEPUTY COMMISSIONER REINHARD: To follow up on that, you're saying that your hospital pays for this? The Atlantic Systems pays for these social workers to be in the doctor's offices?

MS. HILDENBRAND: It's a joint effort between us and the physicians.

DEPUTY COMMISSIONER REINHARD: So it's a 50/50 paying the salaries? Do you get any other dollars for that? Any Medicaid match, for example for some of these?

MS. HILDENBRAND: We don't get Medicaid match at this point in time, and we are looking at the opportunity for billing any kinds of private insurances. But at this point in time, it was felt to have such an impact on the inside part because the complete assessment that's done by the social worker in that office, she hands it off to her teammate in-house and says, "Smith, Jones, and Ryan coming in. You need to do, like, a SWAT intervention on immediately." We know exactly what's happening before they walk in the door. So in the most expensive environment, we've done legwork so that we can maximize and make efficient our interventions there. If there are others that are not needy, we frankly have done the psychosocial assessment on the front end and that way we can spend our resource time, which is scarce, in the acute care where it is going to make the most difference and keep the stays going. It helps us reduce our length of stay.

ASSEMBLYWOMAN MURPHY: And do you find in an overall look, if you began this the end of '97, I believe you said, do you find now cumulatively that it has cost you less money -- a deference? I mean, you're paying in one place or the other, but you found that theoretically it's really costing you less money in deferred.

MS. HILDENBRAND: We're looking at the whole year in terms of performance, and we are finding that patients are able to hit their timely

discharge based on their pathway because they've done legwork ahead of time. So we have saved days absolutely. We have also increased patient satisfaction and their whole experience and trust with the System and with the health-care services that they've received. So in that venue, they are happier. They are functionally doing better because they don't feel they're unprepared or it's as difficult. And we find that their surgical outcome stays on track.

We can't say that it's absolutely influenced by us, but it does stay on track in historical times, and we would have seen really dramatic changes and difficulties getting things accomplished.

DR. ROBINSON: Joyce, do you have one social worker who follows the patient through all of the settings, or do you just transfer records because your system is so tight?

MS. HILDENBRAND: We do transfer.

DR. ROBINSON: Okay.

MS. HILDENBRAND: We do transfer because we try to do it with one person following everybody even from the physician's side into the inpatient hospital, but volume and timing is what's really quite critical with what happens in the hospital. If you get tied up with a patient that you knew from the physician's office doing something because the patient's condition has changed, and say possibly it's a counseling session about nursing home placement, you could be tied up for three hours. You just lost four patients over in the physician's office because they're booked and they're coming. So while it's happening there, it's also happening in-house. So we built the System with our assessment information being exchanged using voice mail, using E-mail, using all of those technologies and shaping the expectation of the

patient and family. You will meet my partner, Maura, if they're on these specific issues, and we walk them through to the point of admission. And then they know that they're going to meet Maura, and that she's going to talk about these three points. And we find out that the transition is not really disruptive because they know what to expect and they've been informed and they have that advance notice.

DR. ROBINSON: And you communicate--

MS. HILDENBRAND: Yes.

DR. ROBINSON: --that's what's missing?

MS. HILDENBRAND: Yes.

DEPUTY COMMISSIONER REINHARD: Do you have any of this written up?

MS. HILDENBRAND: In terms of the comments today or the program that we've done?

DEPUTY COMMISSIONER REINHARD: The programs that you've done.

MS. HILDENBRAND: Yes. Yes. We do.

DEPUTY COMMISSIONER REINHARD: You could send it to us?

MS. HILDENBRAND: Sure. Be happy to share it with you.

ASSEMBLYMAN ROMANO: Much earlier in your presentation when it said about presubacute care, is this what you're talking about with this sort of program, when you said we must not wait until the subacute is taking place?

MS. HILDENBRAND: Absolutely.

ASSEMBLYMAN ROMANO: But that prior to?

MS. HILDENBRAND: Absolutely.

ASSEMBLYMAN ROMANO: This is the program that you're talking about?

MS. HILDENBRAND: Absolutely. Because a person's options or potential places where they may receive care are introduced at that point. They're told that they may be going home with home care, they may be going in a subacute setting for services on a short-term basis and that there are limits to that, and what expectations they may have for co-pays or deductibles. We talk about the financial impact of health care. That's something the joint commission has asked us to look much more intensely to. You don't go and buy a car and not know what your payment is going to be. This is an obligation that we have to families is to be able to prepare and plan. They have to feed their families; they have to meet other financial commitments. We can't just again do it to them and say, "Okay, here's a \$10,000 bill. Thank you very much. Hope it was good for you." We have to let them know, so they can prepare, and those prediscussions have been very valuable towards that end.

ASSEMBLYMAN ROMANO: Now, who keeps you up to date beyond, let's say, New Jersey EASE with, let's say, auto insurance such as PIP? You had mentioned before there was a car crash. That enters the picture. Whose policy is this person going to be served under because PIP comes first, which brings me to another question.

You appear-- I shouldn't say you appear-- You are very well versed, but how about the other hospitals? How do the other hospitals keep

up with the developments ongoing with EASE and all the other things that go on?

MS. HILDENBRAND: Theresa wants to respond. (laughter)

ASSEMBLYMAN ROMANO: Theresa, you're going to respond?

MS. EDELSTEIN: That is what the Hospital Association is charged with doing -- keeping our hospital members informed about changes in PIP, changes in HMO regulations, changes in just about anything that touches the acute care and, frankly, now the postacute settings across the board.

MS. HILDENBRAND: And it's interesting, too, because as much as we provide health-care services and we are medical in that venue, we are teachers. I say that all the time to the social work staff. We have persons come in from systems and talk to us about the PPS and the RUGs, and we bring in every vendor in under the sun. We're not going to show partially to that because everybody is coping with it and is approaching it from a different perspective. But we're challenged with providing the care to the volumes of patients who pass through, as well as, if I could open my T-shirt and show superperson, we become Dick Tracys about PIP.

We find out that Georgia -- because we had a person in our hospital who was in a car crash on 80 lives in Georgia, and their PIP is \$50,000. We're calling all over the country. We're advocating we get together as a group to say, "Hey, I've run into this. What do I do? I call my colleagues on the outside. I talked to subacute. Can we cut this deal? Can we negotiate this?" Health care has taken on a very different venue that way.

And each hospital is responsible for their staff under their directors and their mandates for licensure to chase that education all the time. That as you build relationships with persons in your own system or if there are sister systems in other parts of the community, which I have to send people to South Jersey-- I call colleagues down there and say, "What can you tell me about this? What can you tell me about that?" We've become competitive, but when you get to the intrinsic element of who's inside the hospitals, they're charged with planning care. And in that venue, they will go and get and do a variety of things to be able to do that reasonably.

ASSEMBLYMAN ROMANO: But your program is involved with pre and while in the hospital?

MS. HILDENBRAND: Absolutely.

ASSEMBLYMAN ROMANO: Now, how about posthospital? Does your plan go in to discover -- has the planning been the best planning that could have been made and/or, perhaps, something unique or something different has changed? Whereupon, you with all your information could lead that person as a caregiver?

MS. HILDENBRAND: Right.

ASSEMBLYMAN ROMANO: As a caregiver now--

MS. HILDENBRAND: Right.

ASSEMBLYMAN ROMANO: --as to what's new.

MS. MICHELSEN: That's actually the role of the elder-care resource center, case management program -- is for Joyce to pass the baton to me--

MS. HILDENBRAND: Right.

MS. MICHELSEN: --and for me to now know that information and to disseminate it to my care management staff that goes out and sees all those people that you're talking about.

ASSEMBLYMAN ROMANO: Now, don't let me domineer this, but you're talking about a certain area.

MS. MICHELSEN: Right.

ASSEMBLYMAN ROMANO: You're not talking about throughout the State of New Jersey.

MS. MICHELSEN: We can only speak about the area that we're--

ASSEMBLYMAN ROMANO: That's the point, you're not talking about New Jersey.

MS. HILDENBRAND: And that well might be a recommendation of, if you take a model project that has demonstrated its excellence and demonstrated its linkage and communication. Then, how do we look at that in terms of a broader approach and in circumstances such as where we have the social workers in the physician's office? If that were a different type of physician, such as an internist or a cardiologist, who sees the patient when they develop CHF, congestive heart failure, puts them in the hospital, and then they return to them because they're the primary caregiver. If I've got a social worker in that office, they're closing the loop to say, "Did you do well? Did you not do well?" There are a variety of settings in which follow-up can happen and a variety of personnel that can do it. It can be Renee's program. It can be in the physician's office. Our challenge is to keep it open and realize that not every place needs the same system. Possibly, it might be very hard in a community in another part of New Jersey to do the elder-care part. Maybe

we would do it in the physician's office and use that, but components of it can be drilled down and say, "Okay, let's flex it a little bit and put it here because every community is different in its capacity to support those kinds of things."

ASSEMBLYMAN ROMANO: Well, where does the visiting nurse service fit into this after the hospital where a nurse, more often than not, comes in on a weekly basis? Is that person as well trained as you are to be the first line to see things or to know things that should be referred to other agencies or the doctor? Does that happen?

MS. MICHELSEN: They usually are. They usually are. The problem with that, Assemblyman Romano, is that not everyone gets a visiting nurse. Only people who qualify for Medicare skilled care, and that group of people is smaller and smaller. And only when they get that skilled care do they get the visiting nurse. They can also get a social work component from the Visiting Nurse Association or other Medicare-certified home care company. And then when they're done there, then they can pass them either to the New Jersey EASE care manager -- should be and will be, hopefully, throughout the state, New Jersey EASE care managers in every county. And that would be the next place to pass the baton, whether it be in my program in Morris or another program in Monmouth, but that's the whole-- That's what the concept of the continuum in a dream would be.

ASSEMBLYMAN ROMANO: Yes, but I dislike, as I say, keep going on with questions, but now that person who is home, how does someone from New Jersey EASE become aware of this person who is home and could utilize the care management techniques? Who puts this together? Who says to New Jersey EASE, "Go in and see that person"?

MS. HILDENBRAND: I think--  
I'm sorry.

MS. MICHELSEN: No. Go ahead.

MS. HILDENBRAND: I think at one point in time we have to realize that we can't always do it to people--

ASSEMBLYWOMAN MURPHY: That's right.

MS. HILDENBRAND: --and we must educate them and empower them to do it for themselves--

ASSEMBLYWOMAN MURPHY: That's right.

MS. HILDENBRAND: --so we don't look for a nurse to come out and find you in your home, but rather send out information, do education, reach out in venues, if it's through senior groups, if it's through churches, if it's through mall demonstrations, etc., to say, "You are ultimately responsible for your health care. Here are your options. Here are the things available to you. Which do you wish to use?" Because in the end, I can't tell you where you're going to go and what services you're going to receive. You have that ultimate control and that authority. I don't. So in that fashion, we have to teach folks that we're not here to do it to you. We will join you and be your partner, but you have to be sitting at the table with us. So the education has to be shifted from "We're going to deliver it all to you" to "Here's information. Step up to the plate and join in in taking care of yourself."

MS. MICHELSEN: But I think that that also brings us to the point of -- that we need to have people view education sometimes as marketing, but it truly is education--

MS. HILDENBRAND: That's right.

ASSEMBLYWOMAN MURPHY: Right.

MS. MICHELSEN: --and an amount of money that we put in to “advertising” or promoting New Jersey EASE to the seniors and to the frailest seniors, is that where we’re putting some dollars? Are we sure that we’re putting enough dollars to educating the public about what New Jersey EASE is so they know where the entry point is, so they know what the 800 number is?

MS. HILDENBRAND: And then--

MS. MICHELSEN: Are those posters good enough? Are there enough of them?

MS. HILDENBRAND: And then providing the reasonableness to that. If you’re going to ask everybody to come to the table and call 1-800, there needs to be a person there who can answer questions and deliver the service in a timely way. Because you’ve just said, “I can help you,” and then the phone rings and rings and rings.

ASSEMBLYMAN ROMANO: But my point -- and I really apologize for this, though -- I have found and recently in Hudson County and other areas, KIDCare and the program for adults, the seniors with the real estate taxes, where it became that the rush came upon in the hours just before the close. There’s a big program in Hudson County through the schools and through 800 numbers about the KIDCare Program of how many people do not know about the KIDCare Program. Now, in this particular area, I’m saying, information is the keystone--

MS. MICHELSEN: Absolutely.

ASSEMBLYMAN ROMANO: I serve on the budget committee, and we've had, when Law and Public Safety -- where the Attorney General's Office has taken over the insurance prosecutor. And they're going to be coming up with periodicals out to people explaining to them about why car insurance or auto insurance is so high. Most of it is done through fraud. To explain to them, what fraud is. To explain to them, it's against the law. I made the comment that I wish somebody would put in a little about basic morality or ethics in this same time. And I use those other examples.

Now here-- We come back to here. Not everybody gets the information. Not all senior citizens belong to a senior citizen center or go out for adult care. You have to rely upon a son or a daughter or somebody who's even a neighbor to be aware. I have a particular situation where I had a family call me where the wife is completely blind and the husband is legally blind. And they called regarding the real estate taxes -- the succor that they would be receiving from the State. And I proceeded in a conversation that asked, how are things? As soon as you hear that somebody was blind and somebody's legally blind, well, get to the bottom line.

I called the Division on Aging. I had them go in, explaining that they had several problems, and they checked them out, and the one big thing was weatherization for new windows in the winter. They were paying an exorbitant amount of money, and this is what I'm talking about. Now those two people called because of a certain fact that they found out and then-- This is a legislative office, you know what I'm talking about. Somebody calls and you respond. But that only came about because they heard of the freeze on

taxes. What would have prompted them to get information about all the other programs?

ASSEMBLYWOMAN MURPHY: Lou, you have to put the notices, and I think we as Assemblypeople have a good opportunity to do a lot of it. Every time you go out and talk to anybody, anybody, you hand them one of these. I just asked Susan to get me 1000 of them. I don't care if they're young people or old people or middle people or my church or anything else. I'm leaving them everywhere. It's like a trail behind me.

ASSEMBLYMAN ROMANO: Right.

ASSEMBLYWOMAN MURPHY: They'll find me in the forest.  
(laughter)

MS. HILDENBRAND: She's been here. (laughter)

ASSEMBLYWOMAN MURPHY: They'll find me in the forest.  
It's kind of everybody's responsibility because you can only do what you can do, and you can only get information to people that they will hear on the radio, hear on the television, read in the paper. And most of us don't hear it until we need it.

MS. HILDENBRAND: That's right.

ASSEMBLYWOMAN MURPHY: Long-term care insurance is something that I have only, since we began this, really gotten -- even looking at or beginning to read about. Probably wouldn't have known until I had to be put somewhere and didn't have the insurance to cover it.

So I think that your age-group, Joyce, is the group that we need to have-- I wish every person your age understood as much as you do, but it's your business, your career, as well as an avocation for you.

ASSEMBLYMAN THOMPSON: You're speaking of an universal problem here, Lou, regardless of the program you speak of. A significant portion of the population has an amazing ability to shut the world out, and no matter how loud you shout, or so on, they don't know what you're saying. They don't hear it. They don't want to hear it, etc., until you say, they need it. Suddenly, when they need it, then they start asking, "Where is it? Why isn't there something?"

ASSEMBLYWOMAN MURPHY: "Why didn't she tell me?"

ASSEMBLYMAN THOMPSON: And frequently, they find out, hey, it's there. You just haven't looked around.

MS. HILDENBRAND: I'll even flip it and turn it another way. This person called because of another presenting issue. Because your office was informed, they were able to lead them to something else. Oh, look at the glass half full and say, "Let us be sure that we educate people who receive calls and can utilize the opportunity to take the next step," because you can't do it all. And if we looked at it a little more businesslike, you would say you have to have at least 12 exposures to one thing in order to learn. Do we send 12 exposures on one specific topic to any audience in our state?

ASSEMBLYWOMAN MURPHY: No.

MS. HILDENBRAND: So we have to look at who are the strategic teachers, as well as do other reasonable kinds of things, and trust that when it is needed the point will come together. It's never going to be perfect.

ASSEMBLYMAN ROMANO: Well, I found it interesting. I received some mail from DMV, and in there was a voter registration blank. Okay. Now, that's fine because that's part of the law and to the motor voter

where it was demanded they make them available at DMV centers. Now, for that for a want of a case, how much more important is it for people to be notified? There are so many public things that go out that these items should be enclosed within that envelope.

In my particular case with the blind person, and the husband was visually, physically blind -- or rather legally blind, I don't know if that would have made a difference, but that's atypical. But your driver's license -- they wouldn't be getting it, I don't think.

ASSEMBLYMAN THOMPSON: Frequently, you enclose these things, and they go in the trash before they read them. In fact, I think--

ASSEMBLYWOMAN MURPHY: Let me tell you, I empty the envelope out, and it all goes in the garbage. Right.

ASSEMBLYMAN THOMPSON: --KIDCare was being enclosed with income tax returns, but the number of people that, well, hated income tax return, everything else goes out too.

ASSEMBLYWOMAN MURPHY: That's right.

ASSEMBLYMAN THOMPSON: As an Assemblyman, I think you know, when you do the mailings out there on your pieces, you get an evidence of how much is read and how much isn't.

DEPUTY COMMISSIONER REINHARD: I think, Assemblywoman Murphy, it might be helpful to have this Advisory Council make a specific recommendation, though--

ASSEMBLYWOMAN MURPHY: Absolutely.

DEPUTY COMMISSIONER REINHARD: --that the State should be putting more resources into informing.

I do agree with you, Joyce. It takes-- I thought it was seven times. I guess the new research is twelve times--

MS. HILDENBRAND: Too much stimulus.

DEPUTY COMMISSIONER REINHARD: --to have people receive a message. We do have some resources set aside within my Department to get the word out on the statewide, toll-free number. I don't know that that's adequate what we have put aside, and it certainly would be helpful to have other people's ideas.

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN THOMPSON: Again, it's been evident in past testimony, again people coming in and saying, "These programs were there. We had no idea they were there, etc. Just by accident almost we discovered it."

DEPUTY COMMISSIONER REINHARD: Right.

MS. HILDENBRAND: So many things are changing in terms of what we deliver and have. We have to think differently about how we can educate because everybody's lifestyle has changed, and the challenges are difficult. It's a different vision, but I think it's a reasonable one that could be recommended. I think that's a great idea.

MS. EDELSTEIN: Joyce, you mentioned some of the challenges that PPS has brought up in the skilled nursing environment, and there are equal challenges in home care for a lot of the same reasons. I wonder if your system has found ways of partnering with both home care and skilled nursing facilities to make transfer of information that leads to the decision about admission more efficient, less time consuming, more on target. And if you have, what strategies have you found that have worked? Because I hear from

both sides of the equation and I hear from the discharge planners that “I used to be able to get this group of patients placed relatively easily. Now it’s like pulling teeth for me to find a placement.” And on the skilled nursing or home care side I hear, “We just don’t have the right information. We’re not getting it timely, and when we do get it, they are too many gaps.” There has to be a way of bringing those needs together, and I’m just wondering if you’ve found any so far that are working for you?

MS. HILDENBRAND: I don’t think we’ve found the absolute solution. The communication is most critical, and truly what we found to be most valuable is to have persons come from the facilities on-site so that they can -- with their perspective of needing to look at what is that individual skill base under the new system with PPS, they can look back on services that we’ve provided patients over the course of two weeks or more and get them a higher reimbursement rate under Medicare. It’s unreasonable I think to ask the acute care staff to know all of those nuances, but to have a partner on the next setting level come in with their glasses on-- Educate us certainly, so we can make appropriate referrals, but bring that expertise in because it becomes unwieldy to be expert on everything and say, “This is what will work.” That again becomes educative. They can take things that are going to be appropriate for their information needs right there on the spot. It doesn’t get faxed. We don’t worry about violating sending information across the wires, confidentiality. We have immediate communication, and we go forward with a committed plan.

It also allow us, if that person is found to be ineligible for whatever the reason, to know immediately we have to shift and go with Plan 2 or Plan

3 or Plan 4. That's especially critical when families are saying, "I'm going to go to Facility A on the sun and the moon and the stars, and I'm going nowhere else." If we can quickly address that expectation and reshape it, it allows them to move through the system. Many times folks say, "Well, what's your big rush to push me out? You're going to get paid. Or, if you're not getting paid, it's not my problem." In the end, they shouldn't be there. They are going to get sick again. There are germs and bugs in acute care. It is not the place to be. You need to move to the next level psychologically. You need to move to the next level for health reasons, etc. So it really is a process that needs to stay timely because the interruption in being in an institution is so foreign and disorienting that we find that it backtracks us greatly in coping skills. And folks become so dependent that taking next steps are very hard.

But having persons come in-- My staff love-- The care managers love when somebody is there. They can trust that they'll see what they need to see, communicate that, and action will be taken then. Long range? It's going to be interconnected computer systems. It will be ID accessed for systems in North Jersey and South Jersey and Barnabas and Atlantic, that I will be able to walk into Overlook and pull a patient up and see their record of care throughout the entire system. That's a huge endeavor to do, and I think it's down the road. That it's something that's reasonable to work toward, so it can exchange.

ASSEMBLYWOMAN MURPHY: Joyce, thank you so much.

MS. HILDENBRAND: Thank you very much.

ASSEMBLYWOMAN MURPHY: If you are not pressed for time and you stay for a few more minutes, if we all come to other questions, we can ask you, but I think we've got to move along.

MS. HILDENBRAND: Absolutely. Be happy to.

ASSEMBLYWOMAN MURPHY: But thank you so much.

MS. HILDENBRAND: Thank you.

ASSEMBLYMAN ROMANO: Excellent presentation.

MS. HILDENBRAND: Thank you.

ASSEMBLYWOMAN MURPHY: Mike Dennis, Vice President, Senior Services, Kennedy Health System.

Mike, thank you for your patience, and we're delighted you're here today.

**MIKE DENNIS:** Thank you very much for letting me come and speak. The nice thing is by following Joyce, she's got all the facts and details out on the table, so I only have to touch the light things at this point. I'm in an interesting situation, and you're going to hear a lot of parallel situations between what Joyce just explained and what I'm going to talk about, but there are actually-- You're going to hear from a different side. I'm an administrator. I am just a poor cabbage farmer. I don't have the social skills the social worker has and that sort of thing. I'm a 15-year hospital administrator that about two and a half years ago became Vice President of Senior Services, and that's part of what makes my testimony probably different.

Kennedy Health System, where I work, decided it wanted to be an integrated delivery system. And I would tell you that the difference, if you polled the state right now, on all deference to my peers across the state-- If you

polled the state right now, we'd probably find out there are 25 integrated delivery systems. I will tell you that the difference between an integrated delivery system and a hospital is normally about \$40,000 worth of sign on the front lawn. Because they put a new sign on the front lawn and they go back in and work just like a regular hospital. The system in all deference to the other hospitals and to the Department isn't an integrated system. The reality is hospitals do acute care business, nursing homes do long-term care, adult day care, and the system doesn't function as a system. It isn't an integrated system.

Now, I'm not going to pick on that. I'm going to try and tell you what we did to try and fix that. And I'll start with a story. About three years ago, a nursing home was for sale down the street from the hospital I was running. The hospital system that I worked for came to me and said, "Do you think we ought to buy it?" And I said, "Do you think we need it?" I said, "I don't know." Well, we already owned one. Another one is for sale. We always have trouble with placements. We always have trouble getting people into things. I said, "How many do you need? What's the right number?" It became the prunes question: Is two enough? Is three too many? (laughter) And so in reality, unfortunately, I made the mistake of asking the corporate vice-president for planning, "What was the right number?" And, therefore, got the assignment from the president to go figure out what was the right number is. (laughter)

But more important than that, knowing what's the right number in nursing homes, but what's the right-- How many assisted-living beds should you have? Should you be in adult day care? How many home health visits

should you do? What does a population really need? What is an integrated system? We actually went out and figured it out. We actually went across this country and studied what utilization models were used in California and in Minneapolis, St. Paul, and places like that. We actually went out and built a demand model and came back and said-- We're in Camden, Burlington, and Gloucester counties, basically, is where we service. And if you look at that area, that's about a million people. It's about 1000 square miles.

We were running at that time about 25 percent market share in the acute care business, and our target was to be 30 percent. It's real simple. It's 132,000 people over the age of 65. My 30 percent of it becomes 42,000. How many nursing home beds do you need for 42,000? And more important than that is, as we're getting into more managed care, as we're getting into more integrated systems, as we're changing our utilization patterns, how many nursing home beds does Southern California use for nursing home beds? The answer is for 42,000, it's 1976 beds. And we set out to build a network of 1900 nursing home beds.

We found out that it was about 750 assisted-living beds. We found out that it was almost a quarter million home health visits. I mean, literally, we sat down and said, "This is what we think an integrated system ought to look like." And what we did was we went out to try and build that. Two years ago, I presented the plan. They gave it back to me and said, "Congratulations, you're now the Vice President of Senior Services. Go build the postacute continuum." So the reality is I'm the guy, I'm the highest ranking person in this multihospital system that has nothing to do with the hospitals.

I've got all the other stuff on the other side of the wall. I've got nursing homes. We own one nursing home. We have a management contract for another nursing home, and we have 11 strategic alliances. Gets me to about 1750 beds right now that we have in the network. Average time of a nursing home placement in my facilities right now is about three hours. Okay. You've heard lots of stories of people that have trouble placing them. I can take, if you'll excuse the vernacular, I can take a train wreck. I can take a person who nobody wants and place them in three hours. Okay.

We've built some of those systems in. We've built in those things, but to do it, we had to create what amounts to an integrated delivery system. I don't own it all. I don't manage it all. It doesn't report to me. My job is very little in terms of line responsibility. It's not like I have 5000 people reporting to me. Most of my job is managing the relationships. If you think that easy, that's an interesting story in and of itself.

But our health-care system, as you talk about care management and case management, especially at the acute care level is focused on an episode. It's focused on an event. It's focused on a problem. My father-- And I'll give you an example of how if, in fact, you really look at an integrated system, how you can change the way you work. My father died of congestive heart failure. He died about 10 years ago. For the 3 years before that, he went into the hospital about every three weeks because he'd go into congestive heart failure. They'd stabilize him. They'd discharge him. He'd go home. He'd be fine for a few days. He'd eat a pickle on his hamburger. It would throw it electrolyte balance off, and all of a sudden he'd go into congestive heart failure, and he'd learn not to eat pickles. But he would regularly crash and end up

back in the acute care setting, end up stabilized, and end up going through the cycle over and over again.

A couple of years ago, even two or three years ago, a person would go into congestive heart failure, come to the emergency room, be admitted to ICU, spend a day or so in ICU, be pumped full of Lasix, spend maybe two other days in the hospital and be out. My hospital today and several other hospitals around the state don't routinely admit for CHF. Okay. The person presents at the emergency room. If we identify them as being in congestive heart failure but basically stable and healthy otherwise, fill them full of Lasix in the emergency room. They pass their fluids, and in a couple of hours they go home. We've carried it so far that today the patients in my nursing home who routinely have a problem with congestive heart failure get weighed every eight hours. They get checked to see if there holding fluids. If, in fact, they're retaining fluids, we can give them a little diuretic at that point. They don't even know that they had a problem. They go to the bathroom. They don't ever go into congestive heart failure, and the entire cycle stops at that point. But for us to do that, we have to look at that full continuum. For us to do that, I have to be able to handle people, hopefully, all the way down to their houses.

We went so far-- I will tell you last year we created something that we called senior health centers, and we've put them in senior high-rise apartment buildings. And we put our senior health centers in senior high-rise apartment buildings, and we put a nurse in the building full-time, rotated medical staff in as need be, ran what we would call in our vernacular a clinic there kind of thing. But I wanted the nurse in the dining room every day at

lunch because I wanted the nurse to see that Mrs. McGillicuddy wasn't eating. I wanted the nurse to see that Mrs. Goldstein didn't feel good enough to come down for lunch today. I wanted them to know those people in that building and understand what was going on, and we've effectively changed the way some people live because of that.

You talk about the suburban hospitals, and I'm one of those not being interested in the plight of the inner city. We operate a senior health center at a residential health-care facility called Dayton Manor in downtown Camden. And I'm proud to say today we've been operating there about a year, and we have about one-third the hospital admissions that we had when we first went in there. I will tell you that it's a place that none of us would want to retire to. It's a place where none of us would want to grow old, and it is exactly the kind of place that I am proudest of for what we've done in the last couple of years.

Part of the problem is that lack of integration of the health system. Part of the problem is in the hospital today because of payments and insurance and utilization review and managed care and all of those lovely things, the job is to throw them over the wall, get them out of the hospital, get them placed someplace else as quickly as possible, and there really is no incentive to get them out there properly. And I don't mean that to be mean, but the incentive is to get them out. All right. We see managed care companies denying days at the rate of about a third of all their patient days being denied now. None of us can tolerate that from a financial standpoint. You just can't survive and do that. So what we're looking at is trying to build an integrated system to where it works for me to pass that person off to the nursing home, and it works

for the nursing home to take them. And the nursing home doesn't have to worry about taking that one problem patient because the nursing home knows that they're going to get their fair share of the good patients that follow.

Now, I'll give you one other interesting policy issue, and it's not at the local level or at the State level. It's actually at the Federal level. We've run into a lot of problems. If I built this network, if I create the network, and I try and move people into the network where I've got the systems in place and I've got the mechanisms in place, do I run into Medicare fraud and abuse compliance problems? And myself, referring people to a place where I have a financial interest and am I at risk at that? Okay. So there is a serious, as far as we're-- The more I built the integrated system, the more I'm at risk of Medicaid and Medicare coming in and flagging me on it.

I will tell you that right now we're at the process where we literally, when a patient is ready to be discharged or moved to a nursing home, etc. -- we have a piece of paper we hand them. The piece of paper lists and discloses the nursing homes that we're involved in, the assisted living we're involved in, the home health agencies we work with, the hospice that we use, etc., and it discloses that we have financial arrangements in some of these. We trust the care. We trust the way people are handled in these facilities. And if you don't like them, there are every other facility in the area listed on the other side of the paper. And I'll say to them point blank, "Here's the names and the phone numbers of every other facility in the area. If you want to use any of them, you're perfectly okay. These are the ones that I work with, and these are the ones that I'm comfortable with, and these are the ones that I can control the quality of care that goes back and forth." It probably only took nine months

of debate between corporate council and outside council and everybody else to figure out whether that was even legal. We think it is.

I think the problem is financially the hospitals have been separate from the nursing homes, have been separate from the adult day cares, have been separate from the home health agencies, have been separate from X and Y and Z. I think that if you want to fix the care problem you need to integrate those systems.

I'll give you one last analogy. We literally think of our little network as a biosystem, as a ecosystem, that we have the right number of nursing homes to feed the hospital beds that we need. We have the right number of home health visits to handle the visits coming out of the hospitals and the nursing homes. We have the right number of assisted-living slots at different pricing points for what we're going to need. We literally think it's a balanced, relatively integrated system that will make sense by itself. It keeps me from attritioning off beds. It keeps me from-- I went up 10.2 percent. The other guy, my peer at the hospital, went up 10.2 percent in inpatient admissions last year. Why? Because of the business from the assisted living and the adult care and the hospice. So I think that it is possible, as Theresa kind of prefaced things here, "We wanted to hear of things that worked, of systems that made sense." The truth is we think ours does.

While I have a public ear here, I have to put in one little bit of a commercial. We went last year and built senior health centers in high-rise apartment buildings. We thought they made-- And it's one of those things that we were really happy with. We did it. We thought they made sense. We talked with the Department before we built them. We asked the Department

how to-- What standards do we have to build them to, that sort of thing. And then the Department came out with a new ruling that says for a center to be considered hospital based, it has to be 0.5 miles from the hospital and in the same town. Well, guess what? I can't do much community outreach staying within a half a mile of a hospital and in the same town.

So that's a regulation that truthfully has caused me to shut down four of the nine facilities I opened last year. We went out-- We thought we did it right. For a perfectly good reason -- and I don't know what that was, but I assume it was a perfectly good reason we promulgated a regulation. That regulation changed the reimbursement, and that reimbursement said that these facilities will be paid exactly the same as a doctor's office. Sometimes our good intentions get in the way of other people's good intentions. So that's my commercial plug here.

I want to thank the Committee for hearing me today. I'd be happy to answer any questions you've got about anything.

ASSEMBLYMAN ROMANO: Is the Kennedy System an HMO system?

MR. DENNIS: No.

ASSEMBLYMAN ROMANO: What is this system per se? Is it such as several hospitals working together in conjunction with a program and tied into other facilities for nursing homes? I mean, when you say Kennedy Health System, you own -- the Kennedy Health System owns the hospital?

MR. DENNIS: The Kennedy Health System is a multihospital system of three hospitals.

ASSEMBLYMAN ROMANO: Three hospitals.

MR. DENNIS: Three hospitals, Cherry Hill, Stratford, Washington Township, all down -- basically, Philadelphia bedroom communities. They're on this side of the river from Philadelphia.

ASSEMBLYMAN ROMANO: Do you do anything in the primary care aside from the health centers that you've opened up? Where does the primary care come in? I mean, you carry it from primary all the way through?

MR. DENNIS: We carry from primary all the-- We do not at the moment -- we do not own any physician offices. We owned a few. We divested of them, very candidly, but we are in South Jersey. We are the core teaching affiliate of UMDNJ. So I have the University down there with us. We have 900 primary care docs in our network if you include internal medicine, pediatrics, OB -- all the primaries. We have about 900. When we looked at primary care and were looking at networking, we literally put together a network of 156 just family practice and internal medicine docs to cover that area. So we do through our independent physicians, as well as the University, do have primary all the way through to the nursing home and hospice. So it literally takes it from cradle to grave.

ASSEMBLYMAN ROMANO: Is there a fiduciary arrangement between you and the doctors?

MR. DENNIS: There is not.

ASSEMBLYMAN ROMANO: It's just -- be part of our System.

MR. DENNIS: They are our medical staff.

There's one other thing that came out of the questioning before. Twelve years ago, we created what we called The Gerontology Center, which is very much like what Renee described. Our Gerontology Center, and let me

take a second to talk about that, has a Seniors Membership Program where right now I have 42,000 active members in my Seniors Membership Program. I have 8000 members a month participating in some sort of activity. We run -- between our educational programs and our seniors-oriented support groups and our health and wellness activities aimed at seniors, we will run over 100 activities a month and have 8000 people participate at some sort or other.

I'm at the point where I've got so many members in that group now I have about 800 to 1000 every month that actually use Kennedy for some acute or outpatient service or something. So I'm getting about 800 Elder Med members a month who come in and use the hospital or one of our services.

ASSEMBLYMAN ROMANO: Who financially supports that?

MR. DENNIS: We do. We receive no reimbursement -- no direct reimbursement for those services. We do try and do as many things as we can to raise-- If you sign up for the tai chi class, you may get to pay \$25 for the tai chi class, that sort of thing. And so, we try and make it as breakeven as we can. May 4, we're running senior health and fitness day. The last time we ran it, we had 11,000 people show up for senior health and fitness day. It's a fairly large enterprise. It will cost us about 20 grand to run senior health and fitness day. We actually went out and got pledges of \$12,000 from other businesses to help us offset senior health and fitness day.

We also run in conjunction with-- The Elder Med is the membership education wellness side of it. The other side is what we call Elder Care, and our Elder Care Program is basically community-based case management. We have for 12 years now in that program-- If you were an

Elder Med member, you could call up and say, “I don’t think I can live alone anymore. Can you help me with that?” And we would literally go out to the person’s home and do an assessment of the home.

About a year ago we created a specific product that we call Senior Class Solutions which we sell, and that’s all private money and that’s all-- And what we find is we now sell most of that to families who want us to go in and talk to mom. And Senior Class Solutions will do everything-- The whole purpose of Senior Class Solutions is to figure out how to keep mom as independent as possible as long as possible. So if that means putting together a list of things that have to be fixed around mom’s house so that it’s safe for mom, we’ll do that.

We’ve actually struck a joint venture with the local Triple A -- Triple A meaning the auto club -- which has a list of approved vendors that they deal with now in doing home repairs. We use their home repairers. And so literally, we’ve gone and built strategic alliances with accounting firms in our area that do elder care advice on financial planning so that they refer to us when it is time for -- mom needs an assessment.

ASSEMBLYMAN ROMANO: There is no fee or anything when someone joins the Kennedy Health System?

MR. DENNIS: Nope.

ASSEMBLYMAN ROMANO: This is just derived from as they pass through using the services.

MR. DENNIS: Correct. Correct.

DR. ROBINSON: For Elder Med, is there a fee to join Elder Med?

MR. DENNIS: Nope.

DR. ROBINSON: And case management or care management is part of that or--

MR. DENNIS: What actually happens is you get the-- Part of the trick is, we make everybody join Elder Med, just because that's where the database is and that's where all the names get controlled and that's the infrastructure we put in place. So you can't get case management unless you join Elder Med.

ASSEMBLYWOMAN MURPHY: And what are the requirements of joining Elder Med?

MR. DENNIS: Fill out a card.

ASSEMBLYWOMAN MURPHY: And that's it?

MR. DENNIS: Yes. Fill out the card, give me name, address, telephone number.

ASSEMBLYWOMAN MURPHY: You really just want to get your arms around them more than anything else not--

MR. DENNIS: That's right.

ASSEMBLYWOMAN MURPHY: You were saying that they do accounting services. Do you do financial planning consulting sort of?

MR. DENNIS: Here again we don't. We refer off to an accounting firm.

ASSEMBLYWOMAN MURPHY: Okay.

MR. DENNIS: Okay.

ASSEMBLYWOMAN MURPHY: And would you do that, as Joyce had described, for instance, if someone were going into the hospital for major surgery, would you be looking at--

MR. DENNIS: If we found that that was what they needed, we would do it. But again, as Joyce very eloquently explained, the reality is, when the person needs to go in for major surgery, they don't want to talk about financial counseling at that point.

ASSEMBLYWOMAN MURPHY: Well, I guess I meant sort of, how do get into the insurance policy the same kinds of things because I think it's key.

MS. HILDENBRAND: (speaking from audience; indiscernible)

ASSEMBLYWOMAN MURPHY: Okay.

MR. DENNIS: You mentioned long-term care insurance.

ASSEMBLYWOMAN MURPHY: Right.

MR. DENNIS: We've even worked -- I get to put two plugs in -- with New Jersey Hospital Association which has a long-term care product, and we're working with the same company to be able to sell that long-term care product at a discount to our Elder Med members should they choose to.

ASSEMBLYWOMAN MURPHY: Or their families?

MR. DENNIS: Or their families.

ASSEMBLYWOMAN MURPHY: Because that's what we got to get them.

MR. DENNIS: That's right, for their families, and that's exactly what's set up. We literally tried to take an almost unlimited view of what it is that we can do.

ASSEMBLYWOMAN MURPHY: What we're hearing is that there are many ways to skin the same cat -- poor cat.

MS. MICHELSEN: I think what we're hearing is there are many avenues to reach the same individual, consumer, patient, whatever we want to call that person, when they're well and they're at the senior membership club, when they're going for surgery, when they're post-op, when they're in acute. We have a lot of opportunities to educate them.

ASSEMBLYWOMAN MURPHY: And in theory, you are educating their families, the next generation at the same time--

MS. MICHELSEN: Right.

ASSEMBLYWOMAN MURPHY: --because they have to hear some of it.

MR. DENNIS: I was at a presentation last night that one of our people was giving as part of Elder Care, and it was a presentation on the sandwich generation. There was nobody over the age of 65 in the room. It was mostly the 50- to 60-year-old people who were worrying about what to do with mom, what to do with dad, what to do with so-and-so. We held it at a Barnes and Noble Bookstore in Moorestown, New Jersey, and had 74 people at the thing last night.

ASSEMBLYMAN THOMPSON: First a comment regarding one remark you made. You mentioned the problem caused by the Department's new regulation stating that your satellite facilities have to be within a half mile of a facility within the same municipality. I heard from another hospital system a similar problem, that they have satellites that were established under

the regs as they had existed and now they are going to have a problem. So I'll look forward to hearing more from the Department about this regulation.

DEPUTY COMMISSIONER REINHARD: Yes. Actually, I thank you. I was going to raise that. I am unfamiliar with this. I'll be happy to look into it and talk to you about this. I assume it really wasn't so much senior programs as some other issue that they were trying to manage.

ASSEMBLYMAN THOMPSON: I'll forward all of my correspondence to you, too, that I receive.

DEPUTY COMMISSIONER REINHARD: Thanks, I appreciate that because I think that is--

MR. DENNIS: And I didn't say it to--

DEPUTY COMMISSIONER REINHARD: No. That's fine. I think it's unfortunate to have prevented you from moving forward with that concept. I used to be a nurse working in senior housing--

MR. DENNIS: Okay.

DEPUTY COMMISSIONER REINHARD: --and, obviously, this is near and dear to my heart. I think it's exactly what you should be doing.

MR. DENNIS: Well, we literally took -- and just to take 10 seconds on the seniors -- and put geriatric nurse-practitioners or very close to that in senior high-rise buildings with 250 people and said, "You care for these 250 people." And we found, in a building of 250 people, we probably rotated in -- two half days a week there were primary care docs. We made sure that we had more than one doc, so people had choices of who they liked in there. We'd rotate podiatrists in a couple days a week because of the population that was there. We're in a building called Dubin House (phonetic spelling) in

Cherry Hill which is owned by Jewish Federation Housing, and for some reason, we found as we got in and evaluated the population an extremely high incidence of diabetes. So we rotated an endocrinologist in every two weeks for an afternoon.

So literally, it took care of access, it took care of transportation, it took care of a lot of problems. We were considering them hospital-based clinics, so in fact, that nurse became part of the clinic staff, and they counted as clinic visits.

MS. MICHELSEN: Mr. Dennis, though, what you said before about one good intention sort of counteracting another, I believe that that legislation was passed because hospitals complained that one system was opening their clinic in the other hospital's immediate catchment area. Like your competitors coming into your primary town -- and I don't know what that is, Cherry Hill -- and a different health system is plunking theirs down, and it was you that -- not you, personally, but that original one that complained. So that was what the Department was reacting to frankly.

DEPUTY COMMISSIONER REINHARD: That's true.

MS. EDELSTEIN: Yes. But, Renee, the other piece of it is the reimbursement side.

MS. MICHELSEN: Right.

DR. HEATH: What's the diagnostic and treatment reimbursement, and what's an outpatient? It's a 100 percent difference.

MS. MICHELSEN: Right. So it's like there needs to be different carve-outs of these speciality pieces.

DEPUTY COMMISSIONER REINHARD: I agree.

ASSEMBLYMAN THOMPSON: And this impacted existing program. It wasn't a grandfathering. It was like they got them out here now. They're going to have to cut them lose or something or other.

DEPUTY COMMISSIONER REINHARD: Well, we should certainly look at that.

ASSEMBLYMAN THOMPSON: That was just my statement. I had a couple of questions.

The study that you indicated that you did initially there, going out and checking on what's the right number of the various types of facilities for a given population, etc. -- and you came to the conclusion that you have a population of about a million in your service area which had about -- how many?

MR. DENNIS: One hundred and thirty-two thousand seniors.

ASSEMBLYMAN THOMPSON: Which required about 1900 beds in order to take care of 30 percent of population. Within this study, what was your definition of senior?

MR. DENNIS: We used 65 and above for the definition of seniors.

ASSEMBLYMAN THOMPSON: Because, of course, the elder they get, the more beds would be needed, or whatever, or the younger there are less.

MR. DENNIS: And the truth is we just applied that across. We actually went out and looked at the actuarial usage in nine different markets around the country and ended up actually using San Diego, California, as our model because it most represents-- If you go to Sacramento, California, it's the

home of Kaiser Permanente. It's a different view of the world than what we've got out here. You go to Minneapolis-St. Paul, you're dealing with -- 400 docs in a group practice is considered small. We don't have that in our area. So when we looked, and we were really looking at a five-year time frame, we found that San Diego, California, appeared to be the most like what we would look like five years out, and so we built our system based on that.

ASSEMBLYMAN THOMPSON: My other question was that you indicated that in three hours you could place a train wreck. With that being so, what kind of occupancy do the homes that you have-- You said you don't own them or so, so the ones that you avail yourself of, what kind of occupancy rates do they run?

MR. DENNIS: Truthfully, if I average them all out, it's probably 90 percent.

DEPUTY COMMISSIONER REINHARD: That's not good.

MR. DENNIS: No. Some higher, some lower.

ASSEMBLYWOMAN MURPHY: What is the length of stay in your nursing home usually?

MR. DENNIS: Well, length of stay in the long-term care pieces, two and a half years, something like that. In the subacute parts of our-- And we have about 140 beds of subacute at one, which are meant to be short term, rehabilitative, etc. Just opened a 19-bed unit yesterday at the one we own. We see those places running about 15 days, and that's with fairly high read numbers.

DEPUTY COMMISSIONER REINHARD: I have to talk to you later about that.

MR. DENNIS: Go ahead.

DEPUTY COMMISSIONER REINHARD: No, we won't put that on the record.

MR. DENNIS: Okay.

DEPUTY COMMISSIONER REINHARD: Can I follow up with a question?

ASSEMBLYWOMAN MURPHY: Certainly.

DEPUTY COMMISSIONER REINHARD: I'm also curious in what Assemblyman Thompson starting talking about here about the model and this three hours to place somebody. One of our concerns from Senior Services which has this idea of trying to promote independence and choice, as you indicate you do, is how difficult it is to discharge someone to assisted living or to alternate family care or even to home care, as opposed to a nursing home, which especially with a 90 percent occupancy rate would be fairly easy to find a bed and do all of those kinds of things. How do you fight against that incentive which is so easy to put somebody in an institution versus more home- and community-based services? And do you go back for those that have been placed in a nursing home and, if they get better, help them to move back out into the community.

MR. DENNIS: Absolutely. To answer do we, yes. There's a quote from Mark Twain hanging on my wall in my office that says, "If you give a man a hammer, all the world looks like a nail."

DEPUTY COMMISSIONER REINHARD: Exactly.

MR. DENNIS: If the only thing the hospital has-- If the hospital owns one nursing home, guess where everybody gets placed? Okay. Well,

that's part of why we went out and opened assisted livings and nursing homes and established relationships with adult day cares, and etc., etc., because we wanted to be able to-- Now my people don't have an incentive to just use one tool.

DEPUTY COMMISSIONER REINHARD: But it's still easier-- It's much easier even if you have all the places there. It's much easier to send someone to a nursing home than to get it all organized to have someone go home.

MR. DENNIS: We've already established the criteria for when does someone go to assisted living. Let's use the total hip as an example. Someone comes into my hospital now and gets a total hip done. They're in for 1.4 days.

DEPUTY COMMISSIONER REINHARD: Amazing.

MR. DENNIS: Thank you.

Total hip, they're in the hospital 1.4 days. They're probably in the subacute level of the nursing home 12 to 15 at that point. Showing what great progress we've made, if you look back five years ago, they were in the hospital for 15 days. So we've really just changed the site they're in. It really takes the body about the same amount of time to heal, but we've got them in a less-intense setting. We've got them where they've got as much rehab as they need. We've got them in the place where they can be well taken care of, that sort of thing. But the trick is to try and identify day one, or even before day one, if it's an elective hip or something like that -- to try and identify, is this person ever going to make it home? Are they going to get functional when they're done 15 days down the road? And the answer is we try to identify

those people up front so that if they leave our hospital and go to the nursing home, it's already identified as to what they'll probably need when they go home health after they leave. We've already begun to identify and had the assisted-living people call in the nursing homes so that we're working on the transfer of that person from the nursing home to the assisted living if that's the correct step. The trick is to try and get them to the right level.

DEPUTY COMMISSIONER REINHARD: My last question is really a follow-up to Assemblyman Romano also in this vein. Would you prefer to be capitated? Propose Medicare and Medicaid? Would you benefit in a capitated system?

MR. DENNIS: We built the system based on the fact that we thought it was going to go capitated.

DEPUTY COMMISSIONER REINHARD: Okay.

MR. DENNIS: And so we wanted to be ready for it. Now, I'm in a little bit of limbo.

DEPUTY COMMISSIONER REINHARD: Because of the perspective payment system or--

MR. DENNIS: Because the world's not going to flip capitated. We don't see anything--

DEPUTY COMMISSIONER REINHARD: You don't see it happening?

MR. DENNIS: --flipping capitated in the foreseeable future.

ASSEMBLYWOMAN MURPHY: Mike, I'm going to say thank you, and I'm going to ask John Gribbin to come forward. I'm going to say, if

you-all have a little more time, I'd like to hear John and give him a chance to be heard.

Time is moving on, but if we can stay, Theresa--

MS. EDELSTEIN: Absolutely.

ASSEMBLYWOMAN MURPHY: --we will.

MS. EDELSTEIN: The room is yours till 5:00 if you need it.

ASSEMBLYWOMAN MURPHY: At the rate we're going, we--

**JOHN T. GRIBBIN:** Well, thank you.

ASSEMBLYWOMAN MURPHY: Thank you, John.

MR. GRIBBIN: In batting cleanup, it's -- you're going to hear some very common themes here, and the reason for that is you've heard some very good advice and some very good explanations of what's happening in this arena. But let me give you a little quick background of who we are because it would help explain to you how we've changed over the last couple of years in response to these sort of things.

Meridian was formed about two years ago when we put together three hospitals, the Medical Center of Ocean County, Jersey Shore, and Riverview. Now it also includes today two skilled nursing facilities, home care and hospice, acute rehabilitation. We have extensive ambulatory programming. There's several assisted-living facilities projects that are underway, as we speak, and a transportation company.

Now, we serve the greater Monmouth and Ocean County region. Now Monmouth County mirrors pretty much the age profile of the state, but Ocean County is about 24 percent senior age. So when you think

demographically, Ocean County is and has been a microcosm of the world that we're going to be living in for the next generation.

In essence, our role and our view has changed particularly as to where we deliver services, and you're going to hear some of the common themes again throughout my comments. The needs of seniors and the ability of health systems to meet those needs is closely tied to our evolving view of health systems as mechanisms to integrate and deliver care across a continuum. Now in geriatrics, we view that continuum as spanning preventive care, primary care, emergent and acute care, rehabilitative and restorative care, and then most importantly chronic and supportive care. That's the continuum of care that we use when we talk about geriatrics.

Let me touch on a couple of specific programs because I think it will illustrate for you the ways in which we're trying to link these programs together. Even in a population that's victimized by chronic afflictions, prevention still plays a key role. Fitness programs and senior membership programs have proven really to be very effective means of sustaining and even improving health status.

Now in 1986, we began our own Elder Med Program as a typical senior bonding program. Its goal at that time was to deliver some basic services, and in return we'd like you to use our hospital when you're sick. I mean, the relationship was very evident: use us when you're sick. Today, though, it's very, very different. Today Elder Med has over 80,000 members in the two counties, but our relationship has evolved into something entirely different. We've created programming that has intrinsic value in and of itself.

So today our relationship is defined by what we do when you're not in the hospital.

The admission to the hospital is viewed by our Elder Med staff as really a temporary interruption in that relationship and not the reason for that relationship. And that's been a major reorientation in our thinking. That's one of the things that changed and driven our thinking. Preventative services, like senior fitness, we have several hundred seniors that participate actively in our fitness center. Education programs for health but also for a multitude of other topics. You've heard reference to that before. It's not just health education that's important to this group. Screenings -- these things remain very popular program offerings, but socialization such as our Morning Out Program, and I'll get to that in a moment, the trips that are sponsored, the volunteering efforts, the social gatherings -- these are the things that are really driving the popularity and the ongoing popularity of Elder Med.

Support groups, both targeted to specific situations, but also in the form of things like our telephone reassurance volunteers -- they provide members with a means to come to terms not only with major life changes, but also reinforces their sense of self-worth. And the reason for that is because Elder Med members both receive services, but they also deliver services as volunteers. All of these efforts have an ulterior motive candidly, and that's to deal with one of the most debilitating factors that we see a senior face, and that's isolation. Seniors who live isolated lives are seniors at risk. And the typical Elder Med profile is a 76-year-old widow. This understanding defines the way we relate to the seniors today keeping seniors active, engaged, and in

the community. Ten years ago that was not a driving force behind programming, but it is today.

Now our view of primary care for seniors has also changed. We sponsor a program called Med Wise, which is a primary care physician practice with an important difference. Physicians have great difficulty dealing with the intricate and many times the overwhelming psychosocial needs of seniors. Managed care has made this task that much more difficult. But we all know nonmedical factors are frequently as problematic as their acute care needs and oftentimes major contributors to their medical problems. And yet, with the pressure to see more patients and the pressure to see them more quickly, these factors just aren't adequately dealt with in a typical physician's office.

For seniors with particular chronic problems, traditional fee for service medicine is a revolving door. It just doesn't get to the underlying issues. Physicians need a lot of help in dealing with this. Recognizing this, our system over the last couple of years has been searching for new models of care, and Med Wise is one of those models.

Med Wise combines a geriatrician, a geriatric social worker, and a nurse-practitioner in a single model working collaboratively in really an inexpensively designed physician's office setting. Now we situated this in a shopping center because it was frequented by seniors, and it really helped to improve the access to this program. But hospitalization rates, average lengths of stay, consumption of resources, functional status measures, patient satisfaction importantly -- all of these things are measured in this program,

and all of them have turned out to be exceptional because of that model of bringing this all together into one continuum.

Now we're devoting resources to skilled nursing and assisted-living projects which are important to us in rounding out our vision of a continuum of care. Interestingly enough, this allocation of money is sometimes controversial within a hospital setting particularly with the medical staffs and the boards. With the medical staffs, their concern is that we're diverting needed scarce resources away from traditional acute care needs. Board members have slightly different concerns. They're concerned about the dollars that are required to accomplish this, and also, they're concerned about not having the right expertise to succeed because the expertise in putting together this continuum is very different than that of running a hospital, and that has to be recognized.

Although we're putting a lot of money into rounding out this continuum, you need to keep in mind that equity ownership is not the only way to create this network, and in fact, our model really relies on identifying key partners who will bring capital and expertise to the table. So we're doing a lot of that partnering. But on the other hand, these capital-intensive projects often overshadow the important programming that designed to meet those chronic and supportive needs I talked about because it's programming in this area that really creates the safety net for seniors that we need, and it allows us to achieve our principal vision of maintaining the individual in the least-restrictive setting that honors their right to choose.

Now, this is where Elder Med again enters the picture. Among the many programs in Elder Med are our Morning Out Programs and our adult

day care programs and an initiative that we call Home Connection. You'll recognize this from one of the previous speakers because it's proven to be a very effective and innovative way of dealing with case management in the community. The Morning Out and Day Break Program, which is our adult day care program, were created expressly to round out this vision. And we know over time that we've been very successful in maintaining particularly elderly parents at home longer than they otherwise would have. It's very successful in doing that. The reason is we have constant reassessment of our clients in these settings with the goal of bringing to these people the services throughout Meridian rather than bringing these people to our services. This helps them maintain their independence. Low-level case management is what's occurring in these settings, and the risk assessment tools that we've been developing provide a means for this to take place.

We all know that the care of elderly is a complex integration of often chronic disease processes. In fact, when you have an acute episode, an acute care admission, it's often not acute in the common sense of the word. It's really an exacerbation of something that's been going on for so long. And this points to the fundamental, we think, problem faced by providers and patients, and that's the poor continuity that exists in this system. It's a fragmented system. We happen to call it a system. It really isn't. What we have today is designed to deal with basically healthy individuals who have fairly well-defined illnesses. Funding is followed form, and that's what's happened and vice versa. And that's why this system is so well entrenched in our country.

What we need, though, is the safety net that's represented by programs like in our case Elder Med and Med Wise, but they need to be bound together, in our opinion, with three things: innovative use of case management, responsive risk assessment tools, and the information systems that are able to connect these providers. Finding ways to fund development of these initiatives should be a priority for all of us.

Now, part of Elder Med is something called Home Connection. Now, Home Connection is a community-based quasiclinical case management system that's closely linked into our home care company. At-risk patients are visited by the Home Connection nurse and evaluated using a rather simple functional risk assessment tool that's been developed. The assessment is generally nonmedical in scope, and it really tends to focus more on levels of function in the environment. The results create a database, but more importantly, it's the basis for segmenting our patients into different risk categories. The subsequent intervention could be as simple as placing this person on our telephone reassurance list that we talked about, but higher-risk patients that are identified through this are referred back to their physicians early and even into our home care program.

The problem with hospital-based case management, as far as seniors are concerned and as far as seniors with chronic diseases are concerned, is the fact that it is hospital based. That is the problem. It's necessarily focused on reducing consumption of a very expensive commodity, a hospital bed. For case management of seniors to be effective, a relationship has to be developed, and that relationship is not a seven-day average length of stay. We need in managing this care to consider factors which a hospital-based manager

simply can't see, doesn't see, and can't deal with. We need to find ways to manage care from the outside in, and that's a lot of what's occurring in the programs that I'm discussing and a lot of the problem we have because it doesn't occur with enough people. We still manage care from the inside out, meaning the hospital, and that is not terribly effective when it comes to managing chronic diseases.

Unfortunately, there's a fundamental considerable weakness that's inherent in what I've just described to you. And it really is that it's largely out of sync with the reimbursement mechanisms of fee for service. They just don't fit together. Med Wise which offers we think outstanding and well-planned primary care and, globally, is far less expensive than a fee for service model-- That depends on cost-based reimbursement, and that's going away.

Elder Med relies on grants and a patchwork of service agreements, and it is not self-sufficient. It's a net cost. Despite their intrinsic value, these kinds of senior services are in that cost to the entire system. And in a prepaid system -- that's what I want to close some of remarks in. In a prepaid system, though, they become the lubrication that makes the continuum work. Risk contracting has become kind of a dirty word lately for a lot of the high-profile failures that have occurred across the country. But those headlines kind of obscure a pretty important fact, Medicare risk enrollment in the country still increased about 20 percent last year despite what we've been reading in the papers. I believe this is a bump in the road. I do believe that when you look at the long-range picture of Medicare funding and couple that with the demographic profile, we are going to be pushed toward risk contracting in the future. We're going to see continued privatization of Medicare. It really is as

simple as that when you look at the large picture. That means we need to be prepared.

I share the view that I don't think capitation is going to be a short-term issue, but I do think risk management, risk contracting, is an element in everybody's future we need to prepare for. These type of programs are the essential underlying programs that are going to make it work to the seniors' advantage. And if we don't find ways to create these programs, fund them, and see their proliferation, we're going to be in trouble when we're required -- when providers are required to take on more risk for the care than they are today.

That's the message I would hope to leave with you. We only touch a small percentage of our seniors through these programs. The reason is the funding mechanisms don't support that. We've been caught in the same dilemma that was just mentioned about having outreach programs that are now -- we're having to pull back on because of changes in regulation elsewhere. These things occur, but we have to recognize that if we were going to succeed that continuum of care needs to be developed, needs to be funded, and it needs to be taken out of the hospital. That's where care is going to be rendered. Care gets rendered in the physician's office and from the outside in. That's really how it needs to be done.

ASSEMBLYWOMAN MURPHY: John, in listening to you and in listening to our previous speakers, it seems to me somewhere along the way there are arrangements or contracting arrangements with the human service providers in your community to pick up some of those services. Are those

reimbursed from the county in any way when they are community services or funded through United Way dollars as programs?

MR. GRIBBIN: Well, like I said, there is a patchwork of funding, but the case management, the care management effort, the things that really move patients through properly and take care of them, there's not a lot of funding for that, and that's the difficulty. Our Home Connection Program is basically a cost to the system simply.

ASSEMBLYWOMAN MURPHY: We tried in Morris when I was on the Freeholder Board to make case management, as it was called then, part of the agreement that you worked with an agency for county dollars through grant and aid or in human service contracting. When we purchase service, we tried to make case management a thing to put the agencies together. And while they would all talk about it, nobody was going to give up the umbrella they held or the fact that they have that client's name on their paper. They weren't going to share that client with anyone, even if they couldn't do the job, so I just wondered if it had gotten any easier -- the tension.

MR. GRIBBIN: Overall, no, but there's a problem with building and sustaining programs if the basis are grants -- if the basis for that is grantsmanship. Organizations are very reluctant to commit long term to these kind of programs not -- knowing that the funding could go away next year.

ASSEMBLYWOMAN MURPHY: That's right. It may not be an attractive public thing next year.

MR. GRIBBIN: No. No. And that's a problem.

ASSEMBLYWOMAN MURPHY: Yes.

Thank you very much.

ASSEMBLYMAN ROMANO: Madam Chair, one word I haven't heard anytime this afternoon -- Alzheimer's. Not anybody mentioned Alzheimer's here today, and for myself, and I've said this, I think one of my new missions, the unfinished work, is to work in the area of Alzheimer's. Now, I think this is the third scourge. Cancer being first, HIV being second, and as you get to our age where we have old people, people who still have mothers and fathers, I think the third scourge is dementia/Alzheimer's. That it's touching almost every family.

ASSEMBLYWOMAN MURPHY: But I think what we were discussing was whatever the illness, how it is treated in terms of the facilities that are our hospitals because anything can bring you in. It is how you are put into a management system instead of isolatedly treated. I think that was probably why you didn't hear any one particular disease.

DR. HEATH: I think perhaps another-- Actually, I agree with your point, but perhaps one of the other reasons we didn't hear that word is because a lot of hospital-based systems are triggered by DRG and used by either DRG cost-savings finances ultimate mechanisms outside the systems, and Alzheimer's is a hard DRG for hospitals. It's not a major cost as opposed to hip replacements so that these very innovative, very worthwhile programs are still driven by the major cost centers in hospitals and how to optimize that aspect.

ASSEMBLYWOMAN MURPHY: Okay.

DR. HEATH: For instance, if there was a diagnostic-related grouping of stressed out caregiver, I would feel that that's probably incredibly expensive, but that's not a diagnosis. So it's not easily tracked. So it's hard for

me to show how I would achieve cost savings when I've dealt with the stressed out caregiver. One of the challenges might be to look for proxies of that. Is it the frequent flyers, is it health-care utilization patterns? Now, reimbursement doesn't go that way. Maybe risk contracting through Medicare agencies -- if I disenroll frequently, maybe that's a proxy for it that could look for it, but that's kind of like the second generation of studies that need to be looked at.

MR. GRIBBIN: That's correct. Yes. Very much so.

Prepaid mechanisms really turn this around in many ways. They have their own set of problems and their own set of concerns, but they do enable you to think more of things like that.

DR. HEATH: And one of the things that prepaid agreement would do might be to completely rip me out of that loyalty that I've built to Acme Health Care Systems. I've developed this wonderful relationship with Becky who answers the 1-800 number when I call and I am known. And all of a sudden because I switch from X Insurance Company to a Medicare-managed contract and they deal with Hospital System Y, if all my loyalty is based to this one wonderful senior system that just doesn't happen to have the contract for the managed care, I'm ripped out of there, and I start from anew. Physicians see that all the time. You have this wonderful relationship built up with, and all of a sudden, "Hi." In my office, we're calling them HIP refugees. Next month it will be another type of system that kind of comes along.

Now, I realize that insurance plans are different than hospitals, and since hospitals are such a large capital system, that may not be as relevant, but in a system, maybe a tight urban system, where there's two large systems

competing, any one of them is going to get X contract. One of my fears is, if we rely only on hospital systems to develop these wonderful things and perspective payment changes hospital loyalties from one to the other, people get ripped out.

MS. HILDENBRAND: Madam Chairperson, may I make a--

ASSEMBLYWOMAN MURPHY: Joyce, yes, please.

MS. HILDENBRAND: I'd very much like to support what John was talking about in terms of the innovative programming. Timing is everything, and we clearly have wonderful creative ideas like we were talking about earlier about how to educate, etc. But the timing is absolutely at the opposite end of the continuum in terms of what it supports. I'm not sure what our -- how we would address the challenge of trying to rethink how we deliver care. If not in the hospital, it's outside the walls. There have been systems who have very creatively done that, yet every good intention that they've had hasn't been rewarded, hasn't been reimbursed, etc., so that might be one of the challenges of this group to say, "You have free and innovative thinkers out there, yet you're punishing them for taking a leadership role." How do we change that in the reimbursement structure?

A second point is, when you were talking about case management, I bring to your attention that since I as a licensed social worker in New Jersey can be a Medicare provider for services, I cannot file for any kind of payment or reimbursement for case management as a service to any Medicare client. They totally do not reimburse or recognize that service provided by me to a patient in the community who needs that. So here we have a huge population

who requires it, yet they don't validate their own clients or patients or subscribers needs for that by not reimbursing it.

ASSEMBLYWOMAN MURPHY: I think was part, Joyce, of why I asked you if it is a dollar benefit because it doesn't spend dollars. It's a deferral of expenditure really.

MS. HILDENBRAND: Absolutely. If you call anything that you do as a service case management, they will not pay that claim. Not that they have much to pay on it anyway.

DEPUTY COMMISSIONER REINHARD: Joyce, can I just-- Is it because you're a social worker or they don't pay case management?

MS. HILDENBRAND: No. They do not cover case management. Much like they don't cover wheelchair transportation, they don't cover case management. Yet that is the glue that we have consistently -- I'll share it from different perspectives -- as being very, very necessary to cut and reduce the institutional costs, etc.

The other quick comment I wanted to make, Ms. Reinhard, was to your comment of maybe a perception that you find in the hospitals. We find it very easy to place persons in nursing facilities. One of the reasons that that maybe a perception is that nursing facilities have two sources of reimbursement, Medicare and Medicaid. Trying to place persons in other settings in the community is literally impossible, if not extremely difficult, without private-pay dollars. The amount of facilities that will take Medicaid or Medicare as an assisted-living facility are so few most social workers/case manager persons in a community can count them on less than one hand. The

financial mechanism are all not out there. The waiver programs have no slots to send people home.

ASSEMBLYWOMAN MURPHY: Right.

MS. MICHELSEN: How can you send them on CCPED when there's no openings for years and years?

MS. HILDENBRAND: There are no slots. I can't send them home when somebody needs 24-hour care when there's nothing to provide 24-hour care.

DEPUTY COMMISSIONER REINHARD: So you'll like the senior initiatives since we're starting in Morris County.

MS. HILDENBRAND: Absolutely, because what then I have to do is sit down with the family and say, "Please come up with hundreds and thousands of dollars in a month to keep your mother or your father in their community home," and they don't have that. And then it reverts to Medicaid, and then it appears that we're just aggressively pushing persons into institutions when we really -- our hands are tied about what our funding options are that are supported out there.

We just had some folks present to us that they have two assisted-living facilities that would accept Medicaid. And we, like, filled them up immediately because it was such a rare commodity.

ASSEMBLYWOMAN MURPHY: Yes.

MS. HILDENBRAND: So the financial element of it and what facilities can take what kind of funding clearly drives that bus.

DEPUTY COMMISSIONER REINHARD: You're absolutely right. Every year the State approves over 40,000 people to go into nursing homes for Medicaid.

ASSEMBLYWOMAN MURPHY: Right.

DEPUTY COMMISSIONER REINHARD: But we will not do it for home care.

MS. HILDENBRAND: Give us 20,000 slots.

DEPUTY COMMISSIONER REINHARD: That's what we're trying to change.

ASSEMBLYWOMAN MURPHY: Yes.

DEPUTY COMMISSIONER REINHARD: It's ridiculous.

MS. HILDENBRAND: Give us something else that will help us meet the mission and mandate that you've given us, and then we get frustrated when there are persons who do need skilled nursing for a period of days and could use a Medicare benefit, etc., that were waiting for nurses to come to provide a preadmission screen, and we've just lost seven acute care days waiting because of staffing by that office to provide that service. So it appears to be a vicious cycle that way.

ASSEMBLYWOMAN MURPHY: And the nursing facilities are feeling the fact that there are fewer and fewer private-paid people who will go into the nursing facilities--

MS. HILDENBRAND: Absolutely.

ASSEMBLYWOMAN MURPHY: --and they take the beating for that. So there's a dollar issue all the way around. The whole thing is just a large circle.

ASSEMBLYMAN ROMANO: Madam Chair, you know what I think I'm hearing, when a person goes into the hospital, we talk about subacute care and then ending up in a long-term nursing home, that seems to be taken care of. What we are talking about, though, is that precare, as everybody talks about, a wellness program. So now how does somebody pay for a wellness program and then after the hospital when you're home? You recall my comment about a super care manager, who based upon for the want of five hours or something, this person will not have to go into a nursing home and can be cared at home. If that source of money, and as I said, we're hoping that the person will be very professional, or give them a polygraph once a year, one of those sort of deals. And by the way, the good news is-- You recall that case I kept referring to about the reduction in hours. Won the appeal. They're back at 40 hours. (applause)

ASSEMBLYWOMAN MURPHY: I can't thank you enough. I really appreciate your having taken the time. I have learned an awful lot. It's amazing how much you don't know and when you think you do know something. But I thank you for the education and for your time and your patience for this.

MR. GRIBBIN: Thank you.

ASSEMBLYWOMAN MURPHY: To the members--

And the meeting is formally adjourned now, so the machine can be turned off, if you please. (referring to recording machine)

**(MEETING CONCLUDED)**