
Council Meeting

of

NEW JERSEY ADVISORY COUNCIL ON ELDER CARE

“Testimony concerning health care and caregiving for the elderly”

LOCATION: Edison Municipal Complex
Edison, New Jersey

DATE: April 23, 1999
10:00 a.m.

MEMBERS OF COUNCIL PRESENT:

Assemblywoman Carol J. Murphy, Chair
Assemblyman Samuel D. Thompson
Assemblyman Louis A. Romano
John Michael Heath
Renee W. Michelsen
Roberto Muniz
Joanne P. Robinson



ALSO PRESENT:

Irene M. McCarthy
Office of Legislative Services
Council Aide

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ASSEMBLYWOMAN CAROL J. MURPHY (Chair): Ladies and gentleman, thank you very much for being here. We're about one and a half minute ahead before 9:30 -- 10:30, but we are late in beginning. To begin with, I thank you all for your patience and tolerance with this lateness. We are rather hoping some more members might appear, but they may along the way just come in, and we would be happy to see them whenever they do arrive.

Today, from 10:00 to 12:00, we wanted to talk about palliative care, hospice, and Dr. Louis Riscalla, who is our hostess here today -- she is not in the room at the moment, but she arranged these facilities for us here in Edison, and we thank her very much.

For the benefit of Gary Stein, who is our first presenter, and Pam Bonning who is here, would you introduce yourselves, and we'll start the meeting.

MR. MUNIZ: Sure. My name is Roberto Muniz, and I'm a member of the Commission on Aging for the State of New Jersey. I'm also the President of the Parker Homes in New Brunswick and Piscataway -- nursing homes. And I've been a member of the commission for a while -- the Council for a while, and I'm really thrilled to be here.

ASSEMBLYWOMAN MURPHY: Thank you.

MS. MICHELSEN: I'm Renee Michelsen. I'm the manager of Senior Services for Atlantic Health System, Morristown Memorial, Overlook Mountside, and the general hospital center at Passaic. I am a social worker, and I'm also the President-Chairperson of the Morris County Senior Services Provider Group.

ASSEMBLYMAN THOMPSON: I'm Assemblyman Sam Thompson, 13th District, which represents a portion of Middlesex and a portion of Monmouth County. I was with the State Department of Health for 22 years, so I have a little background in the area.

ASSEMBLYWOMAN MURPHY: And I'm Carol Murphy, Chairing this Council, and I am the Assemblywoman from the 26th District.

Gary, we will start with you because we have eaten into the time, and the quality time, we are going to have with you. Let's talk about palliative care.

GARY L. STEIN: Okay, please. Thank you.

Assemblywoman Murphy and Council members, I'm Gary Stein. I'm the Executive Director of New Jersey Health Decisions in Princeton. I'm very pleased to be before you to discuss and provide some overview of issues in providing palliative care as a modality for end-of-life care.

Let me just give you a moment in my background in the field. I'm a social worker and an attorney by training. Before coming as the Director of Health Decisions, I was the Director of Palliative Care Training at the New York Academy of Medicine. I'm also on the Board of Directors of the Center for Hospice Care in Glen Ridge, New Jersey, and I live in Montclair.

I will attempt to just provide an overview of the issues in palliative care to give you a flavor of what people who are in the field -- what are the issues they deal with and what are the issues that people at the end of life who are experiencing pain need to help relieve and provide more comfort for their situation. People with chronic and terminal illnesses frequently encounter unnecessary physical pain and psychological anguish that might have been

addressed by palliative care. For example Dr. Cathy Murphy (phonetic spelling), who -- Cathy Foaly (phonetic spelling), excuse me, who is a world-renown expert on cancer and pain, reports that one-third of cancer patients in active therapy and up to two-thirds of patients with advanced disease have significant pain requiring analgesic drugs. Dr. William Brightbard (phonetic spelling), another expert on pain at Memorial Sloan-Kettering, finds significant undertreatment of pain -- 85 percent in patients with AIDS and 40 percent in patients with cancer. Most recently there was a pivotal study that was published in the *Journal of the American Medical Association* and on the first page of the *New York Times* last year where a multistate research team, including a researcher from UMDNJ up at Hackensack Hospital, examined treatment of pain among elderly nursing home residents. And I have asked that the article from JAMA and the editorial accompanying that be attached to my transcripts as materials for your review.

ASSEMBLYWOMAN MURPHY: Thank you.

MR. STEIN: This research team found that daily pain was highly prevalent among nursing home patients who had cancer, pain often untreated particularly among the oldest patients, over 85 years and older, minority patients, and patients with low-cognitive functioning. Patients more than 85 years old were less likely than those a little younger, 65 to 74, to receive either weak opiates or morphine to treat their pain. More than a quarter of the patients who were in daily pain did not receive any pain medication.

To adequately address pain and related symptoms, there is an enormous need to increase expertise in pain assessment and treatment. Several excellent guidelines have already been developed to train clinicians. Guidelines

have been developed by the World Health Organization, and here they have been addressed by the Federal Agency for Health Care Policy and Research. There are a range of documents and modules available to train clinicians in treating pain.

However, training a physician and other health-care professionals has failed to effectively promote the attitudes, knowledge, and skills required to care well for the chronically ill and dying patients. The recent editorial in JAMA -- in there, cancer researcher Charles Cleeland observed that “clinical training and pain management other than for pain specialists is almost nonexistent.” Instead treatment often stresses aggressive curative therapy over comfort care.

What I'd like to do is to provide a definition for palliative care and what exactly we're talking about, and there are some variety of definitions, but the World Health Organization I think puts it very well. Palliative care is the active, total care of the patient whose disease is not responsive to curative treatment. Control of pain and other symptoms, psychological, social, and spiritual problems are paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Palliative care affirms life and regards dying as a normal process that tries to neither hasten nor postpone death, but instead to provide relief of pain and other distressing symptoms.

I'd like to contrast palliative care with hospice. Hospice is a very well-respected modality that provides comfort care for -- to a particular phase of end-of-life care, in the final six months, which is a requirement under Federal Medicare reimbursement regulations. Hospice is a part of palliative

care, but palliative care can be much broader. It should be provided to people who have chronic and terminal illnesses at all stages of their illness and need not be restricted to the final months of life. Hospice also differs from palliative care in another very important way. People who are obtaining palliative care can also be treated for the condition. People can also get treatment for their cancer or for HIV or what other condition they have while they are getting treatment for pain and other symptoms. In hospice, it's generally not acceptable to be aggressively providing treatment at the same time people are receiving comfort care. So just to be clear, hospice is a part of palliative care, but people who are in hospice care have some different needs than people who might get palliative care generally.

I'd like to provide just a framework of what the palliative care approach is about. Palliative care is very interdisciplinary. It involves an overlap of the field of medicine, nursing, social work, pastoral counseling, law and ethics, hospital and nursing home and other long-term care administration. There is a range of professionals that need to be involved to create an effective and well-run palliative care program. First, in terms of the principles and philosophy, as I mentioned, the principles and philosophy are that patients with chronic and terminal illnesses, including the elderly with these conditions, should not need to live in pain during the course of their illness. Whether or not they are in hospice and have decided -- that they are end of life and they have decided not to have other aggressive treatments further or whether the people have decided to continue treatment for their illness, they deserve the best that they can get in living comfortably and getting their pain managed.

This is very different from the philosophy of end-of-life care generally in the United States, which reflects traditional medicine, which has always viewed the goal of medicine as one of curing and where the goal is not necessarily one of comfort, but keeping -- but trying until the very end to maintain life as long as possible, so it goes to quantity of life and to treat people as best as possible. Instead palliative care emphasizes much more quality of life.

As I mentioned, the palliative care approach involves team practice. All parts of a team are critical to providing effective care to patients and their families, from the medical and nursing staff to the social work and other mental health staff who provide supportive services to the pastoral care team who provide spiritual help and to the administrators who make this possible.

It promotes communication. Medical practice and physicians generally have not been -- done a good job in terms of communicating with patients and the families about the course of illness, what to expect, and what the process of treatment and what the pain and discomforts involved will be. When palliative care approach is involved, communications between all professionals, as well as between the professional and the patient and the family, is stressed.

Two different clinical aspects are stressed, pain management and symptom management. Both of them involve and require extensive training for clinicians in both the assessment and treatment of pain. As I mentioned in my introduction, physicians are very poorly trained in both areas, and we at Health Decisions are very much working with other organizations around

the state to increase opportunities to train professionals, so they can provide this kind of care to their patients. Physicians need much more information about, while they're assessing pain, the various drug protocols that can be used to alleviate pain and how to titrate medications to be -- to treat pain most effectively. In terms of symptoms that need to be treated, there are a broad range of symptoms that people experience especially as they get close to the end of life. There's a range of gastrointestinal symptoms that can range from constipation, diarrhea, vomiting; neuropsychiatric symptoms that could include anxiety, depression, fatigue, delirium; and there are respiratory symptoms that face people. All of these symptoms need treatment, so people are comfortable.

Communication and spirituality are key aspects of palliative care, and this is usually addressed through the mental health and supportive services team, the pastoral care team, and also we are -- the programs that I have been working with in the past, we have been trying to train physicians and nurses to play a much greater role in communication. This requires that the health-care team in general have a greater awareness of personal death issues -- how death in their own personally and in their own family has an impact on the type of care they have and people's attitudes towards them. That providers need to play a greater role in listening to and communicating with patients and families, and this requires substantial training to help them break bad news to patients and families when needed.

Caretakers have particular needs. For a family member or other individual who is an unpaid caregiver to someone with a chronic or terminal illness this exacts an enormous toll on people who may be trying to maintain

careers and social life at the same time they are providing round-the-clock care for a loved one. This is a particular -- sometimes presents particular financial burdens on families and caregivers who are expected to provide care and, if they try to obtain various types of personal-care attendants or home nursing, can be very expensive and maybe very ill reimbursed by insurance plans.

And finally -- the final aspect of communication is spirituality, the need to-- Patients who are religious and people who regard themselves as maybe not religious, but as spiritual their needs need to be addressed to help them deal with getting over the final, very difficult last leg of their life.

Palliative care at the end of life has presented a range of legal and ethical issues that we have been really as a society struggling with especially over the last few years. Everyone is very well aware of the debates over physician-assisted suicide, the Supreme Court case that recently came down that both determined there was not a right -- a constitutional right to physician-assisted suicide, but did in fact tell us that individuals do have the right to obtain palliative care services and, second, that the Supreme Court did direct states to remove all barriers that prevented people from obtaining adequate pain control. So their legal framework is there to support the right of individuals to have their pain treated.

Other important ethical and legal issues that come up are advanced directives. New Jersey, in 1991, passed Advanced Directive for Health Care Act. Citizens have the right to assign health-care proxies to appoint others to care for them when they're unable to, to make decisions for them, and to enact living wills. Providers need to be aware of people's legal

rights to advance directives, and they need to respect the advanced directives when people have offered them.

Futility becomes a very important issue. Futile care is care that based on the standards of care that we know, will have no impact on improving or enhancing either the quality or quantity of a person's life. Providers are not obligated to provide futile care, and sometimes what is futile at the end of life is sometimes a difficult issue. There are guidelines in place -- State guidelines regarding withdrawal or withholding life supports in medically appropriate situations at the request of patients who have capacity, or their surrogates. These situations should be honored.

And finally, just in terms to verify the right of people to obtain pain control, there is a long-standing theological, philosophical, and clinical doctrine, known as the doctrine of double effect, which in its conclusion, without going into any length of explaining the philosophical basis, it's clear that since the motive of providing pain control is in alleviating and not in hastening an individual's death, this doctrine makes clear that it is morally ethical to prescribe high dosages of pain medications even if the medication may contribute at some point to a patient's death.

Finally, there are a range of institutional issues and barriers to creating palliative care services whether we're talking about hospital settings, nursing homes, or other long-term care settings. There is a need now for new models of providing palliative care in other settings. The United Hospital Fund in New York City has recently funded a range of models to be developed in hospitals there which provide some models for hospitals in New Jersey to follow; although, there is no special funding for New Jersey hospitals to do

that. The Ombudsman Office in New Jersey, in coordination with Cooper Health Center, has developed a long-term care palliative care training program that I'm a legal consultant to, and I will talk more about that, which is another model for providing palliative care.

Financing is a particularly critical issue in this area. Right now the Medicare benefit for palliative care is one just to -- essentially just studies the issue to get a sense of what kind of palliative care services are used. Palliative care services may be significantly underfunded. The only benefit is the hospice benefit under Medicare, and that is limited to providing palliative care services to people in the last six months of their lives. I can also report that being on the board of a hospice in New Jersey, the hospice benefit may be inadequate, some medications for pain can be expensive, and the daily benefit does not always well provide for costs of medications, and hospice care -- supportive care that is available to families after a patient passes away is not reimbursed at all.

There is a real need for advocating for palliative care approaches, and I'd really -- I applaud the Council for looking at palliative care. It's very important on the State level that there be councils, the Legislature, the Governor's Office, and other administrative bodies to take a role in advocating palliative care for patients. And I very much applaud the document that recently came out of the New Jersey Legislative Commission for the Study of Pain Management Policy. The recommendations issued by this report are quite sound.

And lastly, the other -- another barrier is one of team building. Medical team, from physicians, nurses, social workers, are not always well experienced in working well and coordinating their efforts well, and their

philosophies to care and cure somewhat conflict. There needs to be new interdisciplinary training efforts, so people learn to listen to and respect their colleagues in various care settings and that physicians come to learn that care is just as important as curing people of their illness.

I'd like to just give examples of programs that I've been involved in that I've tried to address the lack of palliative care services and to really develop new opportunities for training and for care. As I mentioned before, the State Ombudsman Office for the Institutionalized Elderly and the Cooper Health System has a new long-term care palliative -- it's called the Long-term Care Palliative Project, which has been funded by the Health Care Foundation of New Jersey. I have played a role to this Project as a curriculum consultant as well as the legal faculty for the nursing home. This Project has provided an effort to develop a model to train nursing home staff on palliative care, have them develop palliative care teams, and learn from the information that we're providing them to provide bedside care to patients. The philosophy is one that develops the structure for nursing home residents to what we're calling aging and dying in place. So as patients are in nursing home, gets sick, and then maybe needs care, where in the past if they are in a lot of pain they might be sent to acute care facilities, then back to the nursing home, then back and forth, we're trying to set a palliative care approach that unnecessary transfers between facilities can be avoided. We're trying to foster a shift in thinking and practice by demystifying pain management and providing care at the end of life.

The funding allowed us -- has been allowing us to select 10 long-term care facilities in the northern part of the state. Our focus has been Essex

and Morris County to participate in a two-day training program. We have now completed about half of the trainings, and we'll be doing the second half over the next few months, and we'll be very carefully trying to research through focus groups the impact that this training has had on patient care and faculty knowledge and skills on end-of-life care.

Health Decisions, with the Ombudsman Office and Cooper, will be looking to expand what has been a really and primarily a two-county project to expand this program statewide to nursing homes in all the regions around the state.

A second effort that our agency is spearheading is the New Jersey Comfort Care Coalition. Our agency has convened many of the primary public and private agencies and organizations across the state to develop a consortium for a proposal that is being submitted to the Robert Wood Johnson Foundation in mid-May. The Robert Wood Johnson Foundation has a request for a proposal out called Community-State Partnerships to Improve End-of-Life Care. Our consortium includes -- on the State level, we have the State Department of Health and Senior Services, the Department of Human Services, the Ombudsman Office for the Institutionalized Elderly, New Jersey Hospital Association, the Medical Society, the Nurses Association, the Long-term Care Association. We are trying to create a very broad-based effort, and we are joining new members on over the next few weeks.

We've tried to identify what we saw as some of the key deficiencies in providing palliative care and end-of-life care, and what I found-- I've only over the last two weeks received a copy of this document. (indicating) I assumed that identifying the gaps in -- there's nothing magical about finding

the gaps in palliative care. The process that we went through took us to a very similar recommendation that this Council came to. And what we are proposing to the Foundation, and we are hoping that we can get this program off the road very shortly, are programs to do four -- address four separate areas.

We'd like to address the educational deficiencies. We want to create health professions programs; to develop consortiums amongst UMDNJ, the nursing schools at Rutgers, the social work programs, the pastoral counseling programs to provide new training that is largely nonexistent now, palliative care and end-of-life care; and we wish to develop continuing education programs for current practitioners, especially physicians and nurses.

We feel it's really vital that State regulatory bodies, such as the State Board of Medical Examiners, really look carefully at ways to make training mandatory for physicians -- that they should learn to assess and treat pain in patients with chronic illnesses and amongst people with terminal illnesses and the elderly.

Public education is really critical for the health-care system to really respond to the need for palliative care at the end of life. The public needs to demand this kind of care and needs to know that these kind of options are available to them. We will be looking to provide public education through a multimedia education campaign and to also develop forums -- community forums where providers, clinicians, payers, and the public can have dialog on the various clinical and policy issues involved in palliative care.

Very importantly, we need to look at the financial and reimbursement barriers to palliative care. There needs to be considerable advocacy at the Federal level to expand the Medicare benefits to include the

range of palliative care services needed for patients and their families. At the same time, the State does have some input. What we are trying-- What we hope to do, through our coalition, is examine opportunities to develop an end-of-life benefit package and a palliative care package where managed care plans, commercial -- other commercial payers, and Medicaid, which is controlled by the State, can begin looking at developing a package to reimburse these services where they're not under the control of the Federal authorities.

And finally, we will try to collect data better on end-of-life care. In working to develop this application for the Foundation, we really found that the State Department of Health needs quite a bit more of assistance in collecting data on how people die at the end of life and what kind of services are needed. We hope to develop a structure where better data could be collected, so we can better see where we're at.

In conclusion, I think that the final statement of the New Jersey Legislative Commission on Pain Management Policy really says it well, and I am aware that you do have a copy of this, but I think this states where we're at.

"In recognition of the pain and distress, which often characterizes the dying process, the public policy of this State should support a compassionate and humane approach to caring for patients who are terminally ill, which seeks to mitigate their physical pain and mental anguish and preserve much of their peace and dignity as possible. We are all stakeholders in the public interest to be served by the advancements of a kinder and gentler approach to the caring of patients as they approach the end of life because we all take that journey."

Thank you very much.

ASSEMBLYWOMAN MURPHY: Questions?

Roberto.

MR. MUNIZ: Mr. Stein, could you please elaborate a little bit more on the difference between hospice and palliative? I know you touched on them, but I'm still kind of confused.

MR. STEIN: Palliative care, essentially, is an approach to treat pain and manage the uncomfortable symptoms with people who have chronic and terminal illnesses. Palliative care could be in place from the time people are diagnosed with a chronic illness. It attempts to address the pain and discomfort throughout the course of their illness.

Hospice care-- And let me say at the same time that palliative care-- At the same time we're treating pain and symptoms, physicians and nurses can also aggressively treat the underlying condition that's -- such as cancer, that might be contributing to the pain people are experiencing.

Hospice, in contrast, and I know you have a presenter from a hospice, is one segment of palliative care. It's the segment of providing palliative care at the final months of life -- the final six months. People who are in hospice care have made a decision that they wish, during their final days, that their primary goals of treatment are to be comfortable and to be relieved of as much pain-- They have also decided, generally, not to receive treatment -- continued, ongoing treatment for their underlying condition. So someone who is in hospice care will not, for example, being treated for cancer, generally -- they will not be getting chemotherapy or radiation or other types of treatment for their care.

Someone who is not in hospice, but is getting palliative care services may be going for chemotherapy, may be actively treated, and at the same time, can be having their pain and symptoms addressed. There are complementary approaches to care, but they're somewhat different. Hospice is a part of palliative care, but palliative care is much more.

ASSEMBLYWOMAN MURPHY: Does that help, Roberto?

MR. MUNIZ: Sure.

Thank you.

ASSEMBLYMAN THOMPSON: Madam Chair.

ASSEMBLYWOMAN MURPHY: Yes, Sam.

ASSEMBLYMAN THOMPSON: New Jersey Health Decisions, your firm-- I'm interested in how it's funded. This is a nonprofit that is working basically on grants, and so on, or-- It is clear, from what you've said, that the firm works with hospitals and other facilities to attempt to develop palliative care plans. So again, if your scope is broader than that, let me know or again-- Is it a fee-for-service-type situation with the groups you're working with or-- How do you get funded, and exactly what scope do you cover?

MR. STEIN: Our organization is funded -- has been funded solely through foundation grants such as the Robert Wood Johnson Foundation, Prudential Foundation, Fund for New Jersey. We do not get, and have not received, up to the present time, any type of public funding. We work with organizations around the state through collaborative efforts. Our office works both with private associations as well as State agencies. We have a very close relationship with the Ombudsman Office for the Institutionalized Elderly.

We basically provide service-- Our mission is one of addressing -- of getting citizens more involved in issues of bioethics, which includes, at this point of our existence, a very strong focus on end-of-life care and palliative care. We do training. We try to convene policy forums. We do not-- We're not a fee-for-service organization in that we don't provide direct services of medical or social services that we would be billing as a fee-for-service.

ASSEMBLYMAN THOMPSON: (indiscernible)

MR. STEIN: Well, I mean, for example-- When you say fees-- We ran our seventh annual conference a few weeks ago, which was a two-day conference on excellence in end-of-life care. The fees that you're suggesting-- There had been a registration fee for people who attended the conference. And we also received a grant from the Health Care Foundation of New Jersey to support the training effort.

ASSEMBLYMAN THOMPSON: So it's strictly a public service organization that you have there.

MR. STEIN: That's right.

ASSEMBLYMAN THOMPSON: And you've said-- You cover bioethics, and palliative care falls in as a portion of that. What else would fall into areas of interest within the definition of bioethics?

MR. STEIN: That has been-- Right now, end-of-life care issues have been a major concern and focus of our organization. We have also been concerned about getting information out regarding managed care. We recently completed guidelines -- sort of a guide book for the public to explain to them their -- what the managed care processes are, help them navigate the system, and understand what choices they have.

A third area that we've been very interested in is health-care decision making and the area of advanced directives. We work very closely with other organizations to make sure that people who -- can get information about their rights to do advanced directives. We distribute advanced directives to the public upon request. And we have an effort coordinated with the Medical Society of New Jersey where we make available -- provide information and make available to people out of hospital "Do not resuscitate bracelets" for people who are in a chronic or terminal condition, and if they are found by emergency services and they do not wish to be resuscitated because of their condition, they can request that through a bracelet that was developed in coordination with the Medical Society.

ASSEMBLYMAN THOMPSON: I do commend your firm. Obviously, you're providing a very valuable service here.

In your presentation, you indicated that you would like to see the government advocate related to palliative care, and etc. Of course, at the present time, palliative care, being adequately trained and handled properly, is strictly on a voluntary basis. If some hospital wants to be involved and wants to know how to do it, and etc., they would, while if another hospital decides, "Well, you know, our time, expenses, etc., don't justify our having people for training"-- Is there anything beyond merely advocating what you feel the governmental agencies should be doing?

MR. STEIN: Well, in terms-- Regulatory agencies always play a very strong role in the type of care that is provided in licensed facilities. There could be, at a minimal level, guidance to health-care facilities on developing palliative care programs, both at hospital levels and at long-term care settings,

which are both licensed by the State Health Department. Guidance could be a minimal recommendation. At the other side, the government could take a much more aggressive stance and, as a part of licensing, require that hospitals and long-term care actually develop palliative care projects. The government-- The State can also help in that process by making some funding available for facilities to develop palliative care programs and to provide the training that is needed. I have no doubt that our health-care programs, whether UMDNJ, Rutgers Social Work or Nursing Schools, the other various nursing schools around the state-- I have no doubt that if funding were available to develop new programs in palliative care, schools would jump on board.

ASSEMBLYMAN THOMPSON: Thank you.

MS. MICHELSEN: If you were going to produce a one-page outline of the kind of consumer education that we need to do, what would you say those topics would be? What should we educate patients and their families in?

MR. STEIN: I think patients and families need to be aware that options -- that they have the right to be treated for pain and uncomfortable symptoms for their illnesses. It requires a bit of assertiveness on the part of patients. It's very difficult because people are most vulnerable in times of very serious illness, but there is no reason that patients should feel uncomfortable to discuss their discomfort with their physicians and to insist that their pain be adequately treated. There is no reason that-- The studies that we saw that came out of JAMA last year -- there is no reason that elderly patients, as we see there, should have their pain completely untreated or really inadequately untreated.

I think a second area that the public really needs education on is that there is a lot of fear in this society about the use of narcotics. And that fear stems from the public all the way up to the professionals that administer them.

MS. MICHELSEN: Fear that they'll become addicted, is that what you're referring to?

MR. STEIN: Right.

There is a real fear that these are-- Obviously, some of the pain medications are powerful narcotics, and there is a fear of addiction. There is a fear on the physician's side that their patients may become addicted, and there is also a fear on the physician's side that they may be prosecuted for using narcotics. There is also the fear on the part of the public. We've spent our whole lives getting very negative images of narcotics. However, for people who are in pain -- suffering from painful conditions, narcotics is medicine and is treatment. And the public needs to be reassured that these substances play an important role as medication for them, and they should not be fearful of using them if they're in pain.

ASSEMBLYWOMAN MURPHY: This is the California argument on the public use of marijuana for medical purposes. It's really generated a lot of discussion.

MR. MUNIZ: Madam Chair, I have another question.

ASSEMBLYWOMAN MURPHY: Yes, Roberto.

MR. MUNIZ: How were the two counties chosen for the State training? I know they're northern counties.

MR. STEIN: Basically, the way the catchment area for this program was selected was based on the mission of our funder. The Health Care Foundation of New Jersey has a mission of providing services to groups in the northern part of the state. That has been-- It's an offshoot of the Beth Israel Medical Center in Newark. When they were taken over by Saint Barnabas, I believe the assets were then transferred to a foundation, whose mission was to provide and fund for services in the catchment area that was formerly served by that hospital. So the guidelines for our program were -- and our funder was one of providing services to-- It was primarily Essex and Morris counties, as well as some of Bergen, Passaic, and Union counties, which is sort of in that northern New Jersey area.

We use this effort-- The resources were limited, and it really enabled us to create what was a pilot project. We had the ability from the resources to actually go on-site at the 10 nursing homes to provide training. What this has done is allowed us to use a training intervention on a very limited scope, research that, find out what worked and what did not work, and then try to develop a broader training program to expand statewide. And in our next integration of this Project, what we're going to be looking to do is create regional, long-term -- use the currently existing regional, long-term networks to provide training on a statewide basis, rather than going to individual nursing homes, because I believe there are about 410 nursing homes in this state, and it would be virtually impossible to go on-site of each facility. So we're going to try to do training on a regional basis.

ASSEMBLYWOMAN MURPHY: And how many nursing homes did you train in that first go-around -- doing Morris and Essex?

MR. STEIN: We have 10 facilities.

ASSEMBLYWOMAN MURPHY: Ten facilities.

MR. STEIN: They were selected through an application process.

ASSEMBLYWOMAN MURPHY: And how does a patient know that they can require or request or get medication for pain, particularly a nursing home--

MR. STEIN: Well, that is why the role of public education is so important. People need to hear about it, and there are a range of messages. For the project that we're proposing to Robert Wood Johnson currently, we're suggesting a multimedia campaign because people are going to need to hear about this through written form, the newspapers, and various press, radio, and television because we all get information in very different ways. So the hope is to get information out to the public very broadly.

For people who are in nursing homes, I think the way that people are going to find -- the best way for people to find out is that this information should be made available by the facility to patients and their families when they're admitted and if they're already there on an ongoing basis. It needs to be part of the culture. Medical culture is not one of comfort, it's one of curing. We need to really address the institutional culture of facilities that focuses, in addition to curing, also on providing comfort.

ASSEMBLYWOMAN MURPHY: Do you find that the State has fulfilled, as you see them, its obligations relative to any regulation concerning end-of-life issues in terms of-- What is the term I'm thinking of?

ASSEMBLYMAN THOMPSON: Palliative care?

ASSEMBLYWOMAN MURPHY: No, not palliative care -- the statements you sign about--

MR. STEIN: Advanced directives.

ASSEMBLYWOMAN MURPHY: I'm sorry?

MS. MICHELSEN: Health-care proxy.

ASSEMBLYWOMAN MURPHY: Thank you. Boy, I couldn't have thought of that for anything. Senior moments -- they're getting worse.

Do you feel that the State has made allowances well enough for those, that those are clear and that the ability of people to use them is clear enough? And do you feel that the hospitals are, indeed, respecting these?

MR. STEIN: I'm not sure. I've not seen research coming out of New Jersey facilities. From research that has been coming down, there's mixed reviews coming in as to whether or not hospitals and doctors are actually honoring the directives that people are signing. What I-- And the State, too. The State-- In 1991, there was a former commission on legal and ethical issues in the delivery of health care. I might have the title just slightly off.

ASSEMBLYWOMAN MURPHY: I remember that.

MR. STEIN: And that commission developed a very admirable document that was available for the public, and we still distribute it to the public, that provided for health-care proxy documents and living wills. My own assessment of where we are now, almost a decade later, is that the State, perhaps, should reexamine this to make sure that all the standards that come out, for example, from the Board of Medical Examiners, continue to support the right of individuals to make advanced directives. And there's been some

really positive change on that level in terms of policy on advanced directives and very significant change over the last two years. I don't want to get--

MS. MICHELSEN: Advanced directives are a very big issue with the regulatory bodies like the Joint Commission. When they come in, they want to see that you've done it and you've reviewed it every three days with the person or their family to be sure that they still want that advanced directive.

I think the harder thing might be the health-care proxy and having the patients be really educated and active in saying before they go into their surgery, "I have a health-care proxy. Here it is. And if anything happens, be sure you ask that person what to do." It's again that patient advocacy, that patient being able to speak or a surrogate being able to speak for the person. I think that's the bigger problem. If you have a DNR or an advanced directive on a chart, there's a policy that hospitals really are -- it's imperative that they follow.

MR. STEIN: Exactly.

MS. MICHELSEN: But the health-care proxy is a lot blurrier.

ASSEMBLYWOMAN MURPHY: Now, I don't know anything about that.

MS. MICHELSEN: That says that if you're going in for gallbladder surgery and you don't know how it's going to turn out or that something might happen while you're under anesthesia, you write out a health-care proxy that says that you allow me, for example, to make a decision for you should you be unable to make it at any point in that illness. And that way, if

something happens and they need to also take out something else and you're under anesthesia, they would ask me.

ASSEMBLYWOMAN MURPHY: Now, does every patient going into a hospital receive a copy of that?

MS. MICHELSEN: They receive a copy of--

MR. MUNIZ: No.

MS. MICHELSEN: Well, they do. They receive a copy of an advanced directive. They're asked if they want one, and with that, also, is a health-care proxy form. But you have to push as well.

MR. STEIN: Could I just elaborate on that?

There was a (indiscernible) survey that was done two years ago amongst adults nationally, and only 20 percent of adults across this country signed some type of advanced directive, be it a health-care proxy or a living will, which suggests there's a lot of need for public education.

However, the Federal government-- There's a Federal law from 1990, Patient's Self-determination Act, which requires hospitals and other health-care facilities to inform patients of their rights to sign an advanced directive upon admittance. Whether or not all hospitals and health-care facilities have been following that and providing this information and education to patients, I don't have the answer to that. They are required to do that.

However, the time of your admittance to a hospital is not the best time to be thinking about health-care planning. That's a very stressful time. Patients need much more information -- consumers and citizens, rather than patients, need more information of the importance of doing health-care

planning. A health-care proxy is very easy to do. It simply requires one to fill in the name of another individual you want to make health-care decisions for you if you're unable to do that. People need to know more about it so that they're filled out to a greater extent. I always take the position, and this is my own personal professional bias, that health-care proxies are much more important than living wills.

ASSEMBLYWOMAN MURPHY: Yes, that's the person who is going to carry out the living will.

MR. STEIN: That's right. People need to empower people close to them to make decisions for them when they can't. And health-care providers, especially physicians and health-care administrators, need to be trained on the importance of respecting people's wishes that are contained in advanced directives. That's the flipside. If a doctor has it in the file but then doesn't respect it, that's where the second problem comes up.

ASSEMBLYWOMAN MURPHY: And I just want -- because someone we know went into a hospital, and it was a hospital whose religious bent, if you will, was not--

ASSEMBLYMAN THOMPSON: In agreement with the directions.

ASSEMBLYWOMAN MURPHY: Right. And as a consequence, they had a great deal of difficulty making sure -- the person didn't die, but there was a real concern about staying on top of this so that if something happened in the middle of the night, there wasn't a great effort taken when it wasn't needed or requested or whatever. It does, it becomes a real issue.

ASSEMBLYMAN THOMPSON: I have to say, relative to advanced directives, my own personal experience. I was in the hospital a year or a year and one-half ago or something like that. The hospital supplied me with one to complete. In fact, subsequently, my health-care company sent me one to complete. I started on it. There were two or three questions on there I felt extremely difficult to decide which way it was or exactly what they were asking. Consequently, I haven't finished it yet. I still wait for those two or three questions.

MR. STEIN: I think it would be a valuable step, as a policy matter, for the State to take. There was the former Commission on Ethical Issues in Health Care. It no longer exists. If there could be a comparable or a new commission or a current body that exists like this Council or the Commission on Pain to look at the advanced directives that were advocated 10 years ago, what is needed-- I mean, I've looked at them again. I read them very carefully just a few weeks ago, and I really felt they needed to be simplified. Someone who has a health-care proxy should not be asked a million difficult questions that Assemblyman Thompson has suggested. The question should simply be, "Who do you wish to make decisions for you if you can't do so yourself?" And for most people, they have someone in their life they can trust, a family member, a close friend, who would make those decisions for them. For people who don't have someone they would like to name, living wills are valuable, and those are much more complex documents to fill out. But I think the health-care proxy would probably do for most people.

ASSEMBLYWOMAN MURPHY: I think so, too.

Joanne, thank you. (speaking to just-arrived panel member)

DR. ROBINSON: Oh, you're welcome. I got directions from the Internet, so I've been driving around Edison for about an hour now.

ASSEMBLYWOMAN MURPHY: Oh, dear.

DR. ROBINSON: Sorry to be late.

ASSEMBLYWOMAN MURPHY: I'm sorry.

DR. ROBINSON: That's all right.

MS. MICHELSEN: I called the Edison Police from the road. They were very helpful.

ASSEMBLYWOMAN MURPHY: Are there other questions or comments for Mr. Stein?

MR. MUNIZ: One comment, if I may, and that's the fact that we do have an office on aging for each county. I think that it's very important that we start getting them involved in the process so they can start relaying that message to the elderly when they're calling the 800 number or whichever.

MS. MICHELSEN: Or to do consumer education when they're, well, like at senior centers when outreach presentations are done.

ASSEMBLYWOMAN MURPHY: Right.

MS. MICHELSEN: That kind of thing. Not waiting for the critical moment.

MR. STEIN: That's a very good idea.

ASSEMBLYWOMAN MURPHY: It is interesting, Mr. Stein, that one of the things that we have heard, almost from the first meeting of this, is that education is what's lacking: education for caregivers and the kinds of responsibilities that they will have, increasing education for the medical

profession in terms of dealing with the elderly as opposed to dealing with other people, education for the elderly as they move along, and education for those who are going to be their caregivers and who don't know it right now. A whole lot of these conversations, education, and communication-- It is the nature of us, in life, I guess, never to have time enough to communicate and talk about everything and explore it all.

We thank you very much for coming today. Palliative care is something that we're all concerned about.

I sat on a group that was put together by Bishop Spawn (phonetic spelling) to look at physician-assisted suicide and to bring that subject to a discussion. It was very emotional and extraordinary hearing because no matter who was speaking, you could see the logic and the emotional pull of their argument. And there were as many arguments as there were people at the table. It was very interesting.

But I thank you so much for being here today.

MR. STEIN: I thank the Council, and I'm pleased to address you this morning. If there's any way that I or my organization can be of any assistance to the continued work of the Council, I welcome that.

ASSEMBLYWOMAN MURPHY: Well, we would welcome and be most receptive to receiving any recommendations you or the members of your group may have relative to things that should be changed in this state and more clearly outlined in the state. You are the professionals, or experts, in this field, and if there are things that we should be looking at, either through Bonnie Kelly, Ombudsman, or directly yourself, we would appreciate hearing

that. You've given us a lot to think about today. We're grateful for your attendance.

MR. STEIN: Thank you.

ASSEMBLYWOMAN MURPHY: Thank you.

And you are sending us that material, correct? We're getting material--

MS. MICHELSEN: A copy of your testimony.

ASSEMBLYWOMAN MURPHY: A copy of your testimony.

MR. STEIN: I don't have any written comments.

ASSEMBLYWOMAN MURPHY: We will get it in the transcript.

MR. STEIN: I thought that there was a transcript.

ASSEMBLYWOMAN MURPHY: We will get it in the transcript, but if there is other material you would like us to see, we would be happy to receive it.

MR. STEIN: Okay, thank you.

ASSEMBLYWOMAN MURPHY: Pam Bonning, Assistant Director of Haven Hospice at the JFK Medical Center, is going to speak to us on hospice and hospice care. And I am delighted.

There is coffee in the back room, Joanne.

Good morning, Pam. How are you today?

PAMELA H. BONNING, R.N.: I'm well, and yourself?

ASSEMBLYWOMAN MURPHY: Terrific, thank you.

MS. BONNING: Good morning, everybody.

I'm going to talk a little bit about hospice this morning. It's going to sound somewhat familiar from Mr. Stein's discussion.

I'm glad you asked a question about palliation and hospice because it is a question and it's a confusing issue for a lot of folks -- so much so that the New Jersey Hospice Organization has become the New Jersey Hospice and Palliative Care Organization. So we're all trying to learn to live together and make sure that all of the needs are being addressed, whether it be early on in diagnosis or later on when it is a terminal type of condition.

I'm just going to really provide a lot of information -- a lot of education this morning. Certainly interrupt me if you have questions. I'm going to be speaking very much from what I do, which is a registered nurse at JFK Medical Center for Haven Hospice. I'm in charge of, basically, the intake -- the coordination of the patient care of the program. I will be speaking from my heart for the most part this morning.

Hospice care is very near and dear to me. It is never a very popular subject. When I'm invited to places to speak about it-- I do a lot of speaking to senior citizens. They are a very powerful, very vibrant, energetic group. And when I come in, there is a free-for-all going on in there when I go in there. They're just having a wonderful exchange of information. And as soon as I begin speaking, I put a pause on the rest of the activities because I've had to bring them back into some very serious subjects that they really may not want to discuss. But what you say is right, you need to talk about it when you're up and you're walking and you're talking and you're well versus in a stressful situation when you're trying to come to some decisions.

Hospice care has been around a long time, actually from the time of the Crusades. It is much more accepted now in the United States from the very late '60s to the mid '70s. It is end-of-life care. It is terminal care. If

someone had contracted or has a disease or an illness that the physician has deemed that if the disease runs its expected course, you're looking at a six-months-or-less prognosis, then you are, in all likelihood, appropriate for the option of hospice care.

Some of the biggest concerns we have, and we see it every day, even with folks within my fellow nursing field, is that they think that it is cancer only -- that it is a cancer-driven approach. It can be any end of life -- any terminal condition, and folks simply do not know this. Certainly, cancer is a tremendous amount of our population, but it is end-stage cardiac disease; it's emphysema; it's end-stage pulmonary disease; it's a 16-month-old baby with Tay-Sachs; it's, "I've been on renal dialysis for 12 years, and I'm tired of it. I know if I come off, I will indeed succumb to my illness." That is, indeed, hospice appropriate. It can be end-stage Alzheimer's, and people aren't aware of that. So there are so many more than just what you think of. That has been a real stumbling block, that folks are out in the community and they don't know that services are available to them.

We do not go into a home, we do not go anywhere to introduce hospice care to a patient without a physician's order. In other words, he has made that determination, as he well should. He makes the determination that the patient is, indeed, working under a six-months-or-less prognosis. That means-- I frankly cannot go into a hospital room. I work at JFK. I do not go into that room and speak to that patient without the physician inviting me in to do so.

However, what we're finding in the community, partly with managed Medicare -- managed care, managed Medicare, managed everything --

is that the consumer is becoming more savvy and more educated, and they're willing to find out more information. And every day I'm getting calls in the community asking me about hospice. Five years ago, that wasn't happening. They're starting to take hold, and they're starting to take active roles and say, "Tell me what this means." And so what I do have are a lot of calls, "My husband is very sick," or, "My next door neighbor looks like she really needs some help. Tell me if this is appropriate." We certainly spend the time to talk to them. We can send them information, but we always have to redirect them back to the physician to make sure he is in agreement. We really cannot proceed without him because he's running the show. I'm working under his guidelines. He's the one practicing medicine, and he's the one determining that. So I really need his support.

When we talk to folks about hospice and what it means, it's a very frightening thing for people. If you say, "Hospice is coming in to see me," it's always a very negative connotation. It's almost as bad as morphine -- is a bad word. And what we will do is ask a patient or family -- say, "Listen, you've had these aggressive therapies, and it appears that perhaps they're no longer working or perhaps they're making you feel worse." Or perhaps you, as an individual, say, "I don't care what it's going to do for me, I chose not to have that aggressive therapy." We ask them, "What would you like to see happen? Would you like to have your quality of life maximized? Would you like to have your comfort maximized. If we could and if we could help you, would you like to finish out your life at home?" "Well, yes." "Well, would you like hospice?" "Well, no." Well, that is what hospice is. And so we find that people have such a hard time with the word itself, that we have to tread so

respectfully and so gently when we talk to folks, whether it be in the hospital or whether it's in the community.

It is so much of a choice, but you have to tell the patient what it is you're doing there. We do not misrepresent ourselves. And we hear that time and time again from families, "Well, don't tell him. Don't tell him what this is. If he knows, he'll give up hope." Well, we cannot misrepresent who we are as professionals or as an interdisciplinary team. And we do tell them. "Let us go speak with your husband." "Let us go speak with your daughter." "Let us go speak with your wife." Whomever the patient is -- be present and see that we're going to be very respectful of who they are and respectful of their fears, that we don't have a precut agenda to go in and devastate them, that we're going to go a little bit on a journey with them and ask them what it is they want and whether we're compatible with each other.

As much as I believe in hospice, and I really do, it's an option. And if someone says, "You know what? What you say is very interesting, but I don't want it. That's not what I'm all about. I want everything done. I want every possible tube, every possible treatment, I want it all. And I like the hospital, I like to be there," that becomes self-determination, but it also becomes a patient right. But my biggest concern is that they're not given the option of this. It's okay if you don't want it, but as an individual, they should be given the option of the care. And we're finding that to be a real problem globally, not in Edison, New Jersey, but throughout the country.

When you talk to someone about hospice, it is end-of-life care, but it's not a negative approach. We meet the patient where they are. People are on hospice who are still going to the beach. People are on hospice who are still

going to Menlo Park Mall for lunch. And that's what they don't understand a lot of times. They think it means that "I go home, and you put me to bed. You pull the covers up, and then you wrap my hands on my chest." And that's, by no means, what it means. It means that we meet them where they are in their illness. And people come on to hospice in various stages of their illness. Some are very near death when they come on. Some of them may have a new diagnosis, but it is a bad diagnosis, and they know that there's no treatment, but they may have several months of really quality time. What you do is you individualize your care based on the condition and the disease progress.

When the team of hospice comes in, the physician is still the physician. You don't lose your physician. The patients have bonded with their physicians, and they don't want to think they're going to lose those physicians. They're not going to lose their physicians. They're still running the show, but realistically, they may not be going to their offices so much anymore. It may have become physically too much for them. And what the physician counts on is the interdisciplinary team of hospice to come in and provide the appropriate care.

The interdisciplinary team consists of the attending physician. There is also a medical director who is a physician on the hospice team, certainly, a registered nurse who is kind of your symptom manager and your liaison between the patient and the physician. That nurse is in between, where she is coming in assessing comfort needs and then calling the physician and getting the necessary and appropriate medications or changes or whatever needs to be addressed at the time. So you have the medical director, the

attending physician, the registered nurse, the counselor who typically is a medical social worker who is there to provide a multitude of services. Certainly, it is for support, and it is for guidance. It can be anything from, "Can you help me with Meals-on-Wheels," to "Can you help me plan my funeral," to "Can you help me pick out a dress because I love my family, but they don't have good taste." It could be any type of approach.

What we also provide are certified home health aides to help with the physical care. That's a real important part of it. I can tell you that. From all of the education and all of the professionals -- a certified home health aide may have had a 12-week course on patient care, but you can't underestimate how important he or she is. They are truly in there doing daily bathing or helping with linens or helping with bed changes. Those are tremendous stressors to families. Ninety-nine percent of our families have no medical background, and they're terrified, respectfully so.

What we also provide are chaplain services. Spirituality is a very big piece of this, and we certainly do provide those types of services. Chaplain meaning, of course, ecumenical or nondenominational, but it is no one's agenda to convert anybody -- to change them, to bring them back to do whatever. It's again to meet them where they are and whatever spiritual needs the patients have.

We have over 100 volunteers, as do all hospice programs, to augment care. Volunteers may do anything from relieving the wife, so she can watch a 30-minute program she hasn't seen for two months because she's been at her husband's bedside-- We have a recreation therapist. You don't think of hospice and recreation together. But you know, these folks are still with us,

and they're still alive. And if they have avenues to access joy, we need to be able to provide that avenue for them. If you needed speech therapy, if you needed occupational therapy, if you needed physical therapy, those are things that are provided under hospice care. And people, typically, don't know that.

If I have a gentleman going home from the hospital and I say, "Mr. Jones, tell me, what is it we can do for you when you get home?" and he says, "You know, Pam, the spring is coming, and I know things don't look good for me, but I really need to get my tomato plants in before I'm gone. My wife needs to have tomatoes by August"-- Well, that's certainly an appropriate goal for this gentleman. And what you do is you say, "Let me get my physical therapist in to help him because he's certainly deconditioned from being in the hospital. And let me get my recreational therapist in here with a trowel." And we're going to help him meet his goal. So what you're not hearing me say is that we discount a patient once they're terminal. They are so much a part of the plan of care. Your patient is part of your plan of care as is your family. You are asking them, "What is it we can provide for you?" We can't change what is before us. We are approaching end of life, and that is something that has been determined. But what can we do to help them on the journey. What you hear from people is not that they're so much afraid of dying, but they're afraid of that process in between.

That is where the interdisciplinary team comes in. We certainly do focus on pain management. We're really aggressive about pain management. We're not afraid of pain management, but that's all based on what the physician allows us to do. Morphine and addiction and those types of things certainly are major issues in the community. Again that's an

educational process. We're not afraid to increase pain medication. If people have increased pain, you need increased pain medication, but what you also do is you ask the patient. If he says, "You know, if you're going to give me a lot of this stuff, it's going to make me very sleepy, and I'd almost rather be awake and have a little bit more pain, so I can spend time with my grandchildren," we're going to let him make that determination. We're going to give him the downside of him choosing that, but we're certainly going to give the patient and the family the choice.

As far as the arenas of hospice care and where you may do hospice care, it is done primarily in the home. That's probably the bulk of what we do throughout Middlesex, Union, Somerset counties. That is where we focus our care. But the home is not always the best solution for folks. You can also do hospice care in a nursing home, and again the same services go in. You're treating the nursing home as the patient's home. You also have an option of inpatient hospice care. And that is not a six-months-or-less prognosis. That is truly for end of life -- very end-of-life care if systems have fallen apart at home or perhaps the patient is having a very difficult or traumatic death for the family to witness. We will certainly work with them on that.

ASSEMBLYWOMAN MURPHY: May I ask you, Pam, a question?

MS. BONNING: Yes, ma'am.

ASSEMBLYWOMAN MURPHY: You spoke about that in hospitals, it may be less than six months' care.

MS. BONNING: Inpatient care.

ASSEMBLYWOMAN MURPHY: Inpatient care. What about in nursing homes?

MS. BONNING: We absolutely service nursing homes. The six-months-or-less prognosis stands for the nursing home environment and for the home care arena, provided you can document a decline. In other words, if someone-- What we do here is-- The physician may be hesitant to put someone on hospice because they say, "I don't know if this is going to be six months. I'm not sure what the process is going to be with this illness." And they're right, sometimes they don't know. Sometimes they're very clear on what end of life is and what kind of time frame you have. Sometimes, with a cancer diagnosis, you have a very clear path. End-stage cardiac pulmonary disease is much trickier. They may have had a very difficult time, but they've really bounced back. What we do, then, is we reassess the patient. If they're truly not appropriate for hospice, we take steps to discharge them that protects everyone. It protects the integrity of our program, it protects the physician from saying someone is not as terminal as they were, but it also protects the patient's benefit so that they have it when they need it later.

ASSEMBLYWOMAN MURPHY: Now, when you say patient benefit, this is reimbursable through the Federal government?

MS. BONNING: Yes.

MS. MICHELSEN: It's a Medicare benefit.

MS. BONNING: It's a Medicare benefit.

ASSEMBLYWOMAN MURPHY: It's a Medicare benefit.

MS. MICHELSEN: So someone can go off hospice?

ASSEMBLYMAN THOMPSON: Don't most health-care plans cover it?

MS. BONNING: Sir, I'm sorry.

ASSEMBLYMAN THOMPSON: Do most health care plans cover it?

MS. BONNING: They're getting better. They're getting better. They're seeing that it is really a more appropriate-- And truly for a managed Medicare -- a managed company, a more economical way to go. They have someone at home versus paying for them to be in an acute setting.

MS. MICHELSEN: Can somebody bounce back and forth if they appear to be end stage and then they do, somehow, have a miracle remission -- they go back on traditional Medicare -- then they can flip back to hospice?

MS. BONNING: Right. They can. And that is also a big question for people because they feel like they're boxed in. "If I go into hospice, I've given up every option I might have." And we say, "Listen, if you hear they're injecting raisins in Jamaica, take a flight and go do it. If you need to go off program because they're doing something fascinating in Staten Island, you always have the power to do that. What you have to be careful of, though-- We have great services. It's that they're not just signing on to the program without agreeing to the philosophy. If you have someone bouncing back and forth and back and forth, we sit them down. We really have a family meeting and say, "You may not be ready for us yet, and that's okay. When the time comes, call us. But it sounds to me like you're really needing aggressive therapies, you're wanting them, and respectfully so. But then what you need to do is pursue those until you're really ready."

DR. ROBINSON: Pam, are there aspects of the Medicare benefit for hospice that really get in the way of providing what you think is appropriate? Are there limitations on the number of visits -- home care visits or--

MS. BONNING: No, the current way we are reimbursed is a per diem rate. That means they give you X amount of dollars a day, regardless of what you do, regardless of how many times you go in.

What we have always done-- And I have to say we are very well supported by our medical center. They really believe in what we do. You really base your visits not on your reimbursement, but on your patient need. And so you don't limit yourself to that.

DR. ROBINSON: And you get paid, you're not rejected.

MS. BONNING: They pay that money regardless.

DR. ROBINSON: So you're not dealing with rejections for services that you're providing.

MS. BONNING: No, because you have no means of rebilling or overbilling. They determine to you you're billing. And if my nurse goes in at 8:00 in the morning, goes back at noon that day, and goes back at 5:00 that night, and 10:00 that night, reimbursement is still the same. But you really do it based on your patient need, and they know that. The staff knows that this is what we're here for.

MS. MICHELSEN: It's rather advanced. It's like a capitated rate.

MS. BONNING: Yes it is, absolutely.

MR. MUNIZ: Pam, the patient has the right to stop treatment at any time if they wish to?

ASSEMBLYWOMAN MURPHY: You mean to leave the hospice program?

MR. MUNIZ: They can just say, "I don't want to be on hospice any longer."

MS. BONNING: Yes.

MR. MUNIZ: And he or she can stop at any time.

MS. BONNING: Yes they can.

MR. MUNIZ: Is there a limit -- a maximum number of days that a person can be on hospice?

MS. MICHELSEN: Yes, what if you get to month seven?

MS. BONNING: If I can still document that patient is in a state of decline and it's appropriate for hospice services, I can continue there.

ASSEMBLYWOMAN MURPHY: And that's with a physician's--

MS. BONNING: You bet.

ASSEMBLYWOMAN MURPHY: --support.

MS. BONNING: Right. He has to actually guide us. We're forever in contact with him. And what we may even do is say, "We're unclear, may we bring this patient to you, and let's work this patient up? Let's do some labs, let's do some things to see if we're appropriate." But it's really based on if there's a decline. There are some very terrible degenerative, very slow diseases. We've had patients on hospice for over a year. We've had patients on hospice for six hours, depending.

But as far as people coming off, the patient knows that. And we basically say, "You know, if this is something, when you get home and rethink, you have the power." And it's really important for the patient to know that they have that power because they're fearful. This is a tough, tough decision to make. And we say to them, "If this doesn't taste good to you when you get home and you need to reassess or you need to reevaluate whether this is appropriate, you tell us."

ASSEMBLYWOMAN MURPHY: And do-- No matter where I am-- You are one hospice, and you work in a certain catchment area or a limited area. But no matter where I am, can I pick up the phone and request hospice if I'm in a nursing home or anything? Can patients in your nursing home just reach any hospice they want, or do you work with one? How does this work?

MR. MUNIZ: Usually, you have a contract with that hospice office.

MS. BONNING: You need to have a contractual agreement.

MR. MUNIZ: Either with the hospital or a local agency.

ASSEMBLYWOMAN MURPHY: Now, what if you're a person not in a nursing home or not in the hospital who wants hospice?

MS. MICHELSEN: Talk to your doctor.

MS. BONNING: You've got to call them.

ASSEMBLYWOMAN MURPHY: But if the doctor doesn't have-- Do doctors sign contracts with them?

MS. MICHELSEN: No, there are regional hospices, and the doctors know the hospices.

ASSEMBLYWOMAN MURPHY: All right. So through my doctor, I can reach a hospice whether I am in a facility or not in a facility.

MS. MICHELSEN: It's often the doctor that initiates it. The doctor realizes he or she is sort of at the end of that aggressive and says, "You know, it's really time I look at something else. There's this thing called hospice." I would guess that it's almost most frequently directed by the physician that this is where to go--

ASSEMBLYWOMAN MURPHY: I'm thinking--

MS. MICHELSEN: --especially if you're dealing with oncologist and radiation oncologist. They know how to get you there.

MS. BONNING: Those specialties get it.

ASSEMBLYWOMAN MURPHY: I guess I'm thinking mostly of caregivers or children of elderly patients who may need to know.

MS. MICHELSEN: Caregiver support groups have a lot of education on hospice.

MS. BONNING: And we have a tremendous amount of support groups in education.

DR. ROBINSON: And I think there are also provisions where a caregiver or a patient can call a hospice and express interest. And then the hospice can contact the physician.

ASSEMBLYMAN THOMPSON: In fact, you indicated that you have a number of cases where people call you. Then you tell them to contact the doctor or something?

MS. BONNING: All the time throughout the community.

ASSEMBLYWOMAN MURPHY: Now, what if a nursing home doesn't have a contract with a hospice, but a patient there wants hospice services? How can they get them?

MS. BONNING: They will, typically, have a contract with a hospice. Typically, the nursing facilities throughout the state do have contracted hospices.

MR. MUNIZ: And it is a simple process to get a contract with any hospice.

MS. BONNING: That's right.

MR. MUNIZ: We don't pay at all. Basically, they bill Medicare or Medicaid or whichever facility they have. They pay them directly or something like that.

I think if there is family involved, most likely the communication comes between the doctor and the family. They say, "Well, we have other options. The option is hospice." And that's when the family can pick up the phone and call the hospice center or call the administration and say, "I'd like my mom or my daughter to be in hospice care." And that's when we, the nursing home, contacts the agency and say, "Would you come in and do an assessment on this person? We do have doctor's order to go for hospice, and the family has agreed."

MS. MICHELSEN: Ms. Bonning, can you be a little more clear about inpatient type of hospice? I know in the '70s, there were the Coublera (phonetic spelling) Center where people went to die. Does that kind of thing still exist?

MS. BONNING: What we are doing, and I can speak from my own frame of reference from where I work-- Like I say, we found that sometimes end of life at home is not really the best idea. It could be anything from a cultural thing to, "I don't think I can live in this house if my father dies in this house," to where he is going to have a very difficult death with seizures or whatever it could be that basically what we have done is made an arrangement with the hospital where you were doing end-of-life hospice care within a facility. And that means that your arena of care has changed. You're not in the home anymore, but the philosophy is exactly the same. You're maximizing comfort. You're addressing your spiritual, physical, emotional, social needs for that matter in this--

MS. MICHELSEN: So does your staff go and do that in the--

MS. BONNING: Absolutely.

MS. MICHELSEN: --hospital?

MS. BONNING: How it works is, the hospice team provides the care, so you're getting 24-hour care then. You have a nursing staff like you normally would. Philosophically, you're exactly the same. That is just a short-term solution, though. It's not long-term care facilities. It is truly for someone who may have a week or a little longer.

MS. MICHELSEN: What does someone on hospice, at the last minutes of life or the last day or whatever -- the wife calls 911 and says, "Get the guy out of here. This is too much." I know that happens all the time.

MS. BONNING: I know you do.

MS. MICHELSEN: Then what happens when the person arrives in the E.R. at JFK Medical Center or wherever?

MS. BONNING: It really depends. So much of this is so individual and so personal that you look at each case separately. And if the wife has a moment, and they bring them in, invariably what happens is that they go, "Oh, my gosh. I panicked. I don't know why I did this." We will call down to the emergency room and say, "This is a hospice patient, please treat with comfort, and let's make plans. Do we want to admit them in inpatient for these final moments? Do they want to go back home? Do they want to change their mind and go for everything and is the patient aware enough to agree to that?" So you basically treat it individually. And you're right, those calls are never easy, and respectfully so. Having someone die in your home couldn't be a more frightening experience. No matter how much education is provided, folks are going to do what they're going to do. And that's the truth.

DR. ROBINSON: Pam, I'm interested-- Must patients necessarily forego the aggressive treatment in order to receive hospice care? I'm a hospice nurse back from the early '80s, and I recall a lot of patients continued chemotherapy and radiation therapy; although, their prognosis was very poor. They kind of needed to hang on to that. Is that still allowable?

MS. BONNING: Yes, that is still going on -- that if they're finishing a course of radiation or they've got another course of chemotherapy, more from a philosophical standpoint, we say, "You know, you're kind of hanging on to that, and you can, but you need to really complete that before we bring you on to the program. We're going to refocus you a little bit from more of a curative flavor to a comfort flavor." We would never negate the hope mechanism. We're just going to help with something a little bit different.

You initially hope for that cure. Now we need to hope for something else, perhaps a more comfortable life, perhaps a comfortable death.

DR. ROBINSON: Would that preclude getting Medicare hospice benefits? In other words if they said, "We want to play both ends of the field here."

MS. BONNING: Then we have a basic-- It's not even about Medicare. It's about a basic lack of philosophical agreement about what our roles are because we don't change who we are. In other words, if I go into the home and they say, "Pam, we want CPR and everything," I'm not going to change my role. I'm going to say, "Call 911," so they know very clearly who we are. If we do a consult and they say, "We really have a lot more treatment to go," we go, "Please go do it. That is what you need to do for yourself right now. But please do that first, and then let's refocus and go for comfort care after the fact."

MR. MUNIZ: I guess that's one of the differences between hospice and palliative.

MS. BONNING: That's right. It's certainly much needed.

MS. MICHELSEN: So it's like a progressive--

MS. BONNING: Yes.

MS. MICHELSEN: If someone was an AIDS patient, they would definitely want palliative along with aggressive and even experimental treatment. But as their situation declined, they would sort of merge gently into hospice and focus totally on palliative.

ASSEMBLYWOMAN MURPHY: And how broad-based do you feel the knowledge is -- the accurate knowledge of the hospice program? And how do you feel it could be helped?

MS. BONNING: I certainly know it's a big hill that we've been climbing for a long time. It is better than it's ever been, but there is a tremendous need whether it be-- It's certainly through community. We do a tremendous amount of speaking to again senior citizens, to community groups, to churches, to synagogues, but it is also from the medical community. I can't tell you how many referrals that I finally do get, and the patient or the family says, "Why didn't my doctor tell me this four months ago?"

MS. MICHELSEN: So the doctors have to be able to accept the not curative aspect, as well as the family, because as long as the doctor is holding on to hopes of curative, it's unlikely that even the most educated family is going to say, "Okay, forget it. Let's go with just palliative."

MS. BONNING: Yes. He's saying, "I've got this, this, and this I can do," and realistically, that's what people do.

And it also depends, I think, on the physician's speciality. We know the oncologist, which are of course our cancer physicians, really have a better sense of it. Maybe some of the other specialties who don't deal with it as much have a harder time letting it go, and they also have misconceptions.

ASSEMBLYMAN THOMPSON: Advice you gave earlier referred to some pediatric situations. Do you feel they are (indiscernible) to--

MS. BONNING: My personal opinion, and that's what I can give you on this, is that with an infant or with a child, if there is a possibility of any cure anywhere, a parent, in all likelihood, will take that.

ASSEMBLYMAN THOMPSON: Well, I was referring to the pediatricians, and so on.

MS. BONNING: Same thing. They are of the same mind-set, and respectfully so. We do not get a tremendous amount of children because, if they can save that child, they will. And I couldn't respect that more.

MR. MUNIZ: What percentage of patients do you get in nursing homes? I guess it's very low, as well.

MS. BONNING: Not a tremendous amount. That is a big point for education as well. "You're in a facility, you have nursing care, why do you need hospice to come in and add to that?" There is a lot of question about that -- a lot of resistance from the physicians. And of course, our thing is, why not? If you can offer that additional care and expertise, please provide it. Please give your patient and family the option. I would say, out of our (indiscernible), we probably have a 5 percent to 10 percent nursing home population.

MS. MICHELSEN: Do you think people talk to their doctor and say, "My mother's in ABC nursing home. Just let her go, let her be peaceful, let her -- take away her pain," and they don't really engage in the services of hospice, but they just work privately with the physician to carry that out.

MS. BONNING: Right, the physician says okay.

MS. MICHELSEN: I think that happens a lot.

MS. BONNING: The next step typically doesn't happen. What does happen is that once you have created a really good relationship with a nursing home or a nursing facility, because that is certainly-- We're a guest there as well. We're very respectful of being in that facility, and once we've

established a trusting relationship, then, of course, your staff is keyed that they go, "Hey, Dr. So-and-so, what about having hospice come in and help us out with this end-of-life care?" But it really is a trust issue.

MR. MUNIZ: Which is also a benefit for the nursing home because you're providing many hours more than the nursing home probably can provide to that individual.

MS. BONNING: And you really, unofficially, see the nursing home staff as family. They're there 24 hours a day providing the care. And they're invited to our memorial services just like the family is. Some of these facilities have been caring for some of these patients for years, and it really is a sense of loss when these folks pass away.

ASSEMBLYWOMAN MURPHY: Pam, thank you so very much.

MS. BONNING: Yes, ma'am.

ASSEMBLYWOMAN MURPHY: We appreciate your coming and talking to us about it. And I'm gathering that you have some material that we can--

MS. BONNING: I do. This is just general information that I will leave for you.

ASSEMBLYWOMAN MURPHY: That's wonderful, thank you.

MS. BONNING: If anybody needs to get in touch with me -- if you ever need me to come speak, I will. Public speaking certainly is not my forte, but--

ASSEMBLYWOMAN MURPHY: I think you did very, very well.

MS. MICHELSEN: I was going to say, "I think it is."

ASSEMBLYWOMAN MURPHY: We're real impressed now. And we have been hearing a fair amount of public speaking over this time.

Thank you, Pam. We do appreciate it.

And Gary Stein as well.

Hearing the differences in the two programs and the compatibility of the two programs at the same time has been very, very helpful, very good for us.

MS. MICHELSEN: And the importance of palliative care and elder care and in thinking of the future of planning--

ASSEMBLYWOMAN MURPHY: I will tell you that I think that you're quite right in saying one of the things people fear the most -- and I think it's why we all say, "I'd like to die in my sleep in the middle of the night, please, and don't tell me." But I do think it is the fear of pain that we cannot control and have no options about that is really bothersome as you move along and you watch people you love very much with diseases or things that are very painful for them. It's something we all wish we can take away, the pain. It's very difficult to deal with.

Thank you very much.

Dr. Riscalla, who has provided us with the opportunity to be in this wonderful facility and enjoying ourselves, thank you very much. You wanted to testify to us this morning, and we appreciate that.

LOUISE B. RISCALLA, Ph.D.: Assemblywoman Murphy, it's good to see you again. I've been following your career for a number of years. And I'd like to welcome you all to Edison. I hope you're comfortable.

ASSEMBLYWOMAN MURPHY: We are very comfortable.

DR. RISCALLA: And if there is anything further that I can do to help you, I'd be more than happy to.

What I'm about to say is quite a bit different from what you've heard this morning. I'm a senior citizen myself; although, I don't like the word. I'm retired from State service and county service. I'm currently, among my other activities, the President of the Highland Park-area chapter of the National Council of Senior Citizens. I have worked for over 30 years mainly as a psychologist in various State and county facilities. My experience includes, but is not limited to, working with the elderly. I have an academic background in and have done research-- I am here both as a concerned professional and as a taxpayer. I'm also-- I think this is relevant. I'm a member of the County Commission for Disabled Persons. I'm also a member of the Edison Township ADA Committee.

People with disabilities, as they get older, may not be troubled by it, but when they get older, the disability becomes worse. So I think this is a factor to be considered. We also have a population of what we call MICA patients, mentally ill chemical abusers, your substance abuse patients -- alcoholism. These are conditions that you're going to find now are among your chronic illnesses. As they get older, they are senior citizens, this is a very neglected area, but I think it needs to be considered along with your other population of senior citizens. I don't even like the term elderly.

There is evidence to indicate that services for the elderly are, in the final analysis, determined by dollars and cents, largely due to the privatization of Federal, State, and county facilities, and there may be no accountability to government officials. The result of privatization is a business philosophy and

model of care. The individual is known as a consumer, which means that a person is a user of the product line in a marketplace of an industry which includes, but is not limited to, insurance, health-care, and pharmaceutical companies -- have hospice companies, also, which is a part of the industry.

The industry has its own trade organizations and lobbyists who spend large sums of money on political campaigns designed to elect government officials who will serve their objectives. The primary goal of industry is to get money for the stockholders resulting in cutting costs to direct providers such as physicians, nurses, home health aides, etc.

I'm going to go back to 1996, three years ago, where the CEO of the Oxford Health Plans had a salary of \$29,061,599. And that did not include the unexercised stock options. Sigma Corporation Chairman -- CEO -- \$11,568,410, and it goes on-- And this is from the premium pay corporate compensation and America's HMOs.

More recently, it was reported that the -- in the Sunday *Star-Ledger* of April 18, it was reported that in 1998, Charles Heimbold, the CEO of Bristol Myers Squibb received a base salary of \$1.25 million plus a bonus of stock with a total of \$38.1 million. Melvin Gooden of Warner Lambert made a base salary of \$1.18 million with a bonus and awards yielding a total \$12.3 million. Richard Kogan, CEO of Shering Plough, received a base salary of \$1.1 million plus a bonus and awards with a total of \$16.52 million.

According to documents filed with the Security Exchange Commission and reported in the *Home News Tribune* on January 7, 1999, Jack Mazur, the CEO of PHP Healthcare Corporation, received a salary of \$675,000 a year, plus perks which consisted of the use of a chauffeured

limousine and a company airplane, free country club membership, and \$25,000 a year in tax assistance preparation. William Lubin, Executive Vice President of PHP, received a salary of \$300,000 a year. I have reason to believe that these salaries are not atypical. Now, this not only applies to senior citizens, but it applies to the population as a whole who receive health care.

Another issue is the fact that elderly individuals often require large amounts of medication. It is usually assumed that if a drug works for adults, it will work for the elderly. However, it may not be observed that not all of the medications prescribed for the elderly have undergone clinical trials with an elderly population. If you-- When you get medication, if you check, there is an enclosure there which tells you about clinical trials, effects and side effects of medications. You might see where the clinical trials were run and on what population they were done. That is public information that is right out there. Drug research is often sponsored and paid for by pharmaceutical companies.

ASSEMBLYMAN ROMANO: (indiscernible)

DR. RISCALLA: I beg your pardon.

ASSEMBLYWOMAN MURPHY: Assemblyman Lou Romano just arrived, and he was speaking to his aide, Dr. Riscalla.

DR. RISCALLA: Shall I resume? (no response)

Drug research is often sponsored and paid for by pharmaceutical companies. Drug companies supply the medications and protocols to be followed. Results of research are determined by the protocol including research design so that the results could be misleading. Drug companies might use these seemingly misleading results to advertise their product. Truth in research legislation is needed to protect health-care providers and the public. I presume

that the doctor who is going to be speaking this afternoon might elaborate on what I've just said there.

There is a belief that it is better and cheaper to keep the elderly in their own homes rather than in a nursing home, intermediate care, or assisted-living facility. The purpose is to provide home health care. However, the need for interior and exterior home maintenance, property tax relief, transportation, along with snow removal and leaf removal is also needed because you have to obey the town ordinances. Phone service, including a cellular phone for emergency purposes if phone lines or electricity are out of service, gas and electric are not usually considered in planning for the care of the elderly in their own homes. We found this out in a recent storm, when a tree branch took out our phone services. Fortunately, I had a cellular phone. I only got that when I found out the hard way that if an emergency occurred, what would happen to us. We would have no way of getting out or getting attention.

A sliding scale fee from those elderly who can afford it could be used to help offset the cost of care provided by State and county agencies. I'm a great believer in a sliding scale fee.

ASSEMBLYWOMAN MURPHY: I have an aide who is equally passionate about sliding scale fees to make things--

DR. RISCALLA: Well, I think that-- I believe in being practical about it. Some people can't afford it, others may. I think a lot seniors would be willing to help contribute towards their care. I can only speak for myself, I'm not--

There are various stages of illnesses such as Alzheimer's disease and Parkinson's disease. This is a very, very difficult population. In the early

to middle stage, there are facilities for individuals who did not require 24-hour care, yet need assistance with their activities of daily living. These facilities can be located in buildings no longer needed by the community or built on a property of existing structures of local organizations that no longer need the space. For example, in Edison, the sale of a portion of the Elks Lodge property to a for-profit company was approved for building a facility for the care of early and middle stage Alzheimer's patients. The for-profit company will be a tax ratable for Edison. The towns need tax ratable, so you have a dual service here.

There are elderly individuals who require specialized nursing home care because their condition constitutes a danger to themselves and/or others to the extent that they require a closed, structured setting. I elaborated a bit earlier on those patients that required the setting. There are empty buildings on the grounds of psychiatric hospitals and institutions for the developmentally disabled because of the deinstitutionalization which could provide a safe, humane, and relatively economical way of providing care, specifically at Greystone. I had worked at the (indiscernible) Building, which was originally a geriatric unit (indiscernible). The Central Avenue Complex at Greystone had originally been the general hospital -- complete. I think that could be used. Woodbridge Developmental Center is being deinstitutionalized. There are-- And that's fairly modern. We have the geriatric facility up in-- I forget the name of it.

I believe you know which one I'm talking about. It's (indiscernible)--

MS. MICHELSEN: Glen Gardner?

DR. RISCALLA: Yes, it used to be Glen Gardner, but it's now--
I forget what the name of it is officially.

ASSEMBLYWOMAN MURPHY: Hagedorn?

DR. RISCALLA: Pardon?

ASSEMBLYWOMAN MURPHY: Hagedorn?

DR. RISCALLA: Yes, I think that's it.

That could be used, too.

In Edison, we have a job corp on the grounds of Camp Kilmore (phonetic spelling), which was a former Army base. That job corps is there. They have a place there for battered wives and their children. Some of these places could be rehabilitated and used. I don't believe in throwing the baby out with a bath, so to speak, but to take what's already there and use it. I think that this would provide a safe, humane, and economical way of providing care for people.

Individuals who have to be in nursing homes need more care because of people who might ordinarily be in nursing homes are now receiving their care at home. Staffing patterns are often based on State regulations that do not conform to the changing population of nursing homes. Nursing home operators, as a way to cut costs, can use these seemingly outdated minimal staffing regulations. This can be done especially by not having to hire additional personnel while still following State regulations. The consequences of outdated regulations can result in improper care, including death. I don't need to elaborate, I think.

A review and updating of State regulations for nursing homes, intermediate care facilities, and assisted-living facilities are essential, and I

would strongly, strongly urge this. We need to keep up with the times, and I think here is where legislation and regulation is needed.

Although competition in both private and government sectors is encouraged as a way to lower costs, competition can actually increase costs because it takes large sums of money to compete. There is a risk that awarding contracts to the lowest bidder could compromise services for the elderly and their quality of care.

Awarding contracts to the lowest bidder is most likely consistent with the policy of local, State, and Federal government. Professions and agencies compete with each other for jobs and funding. Block grants are a very good example of how people compete. They can get cutthroat. I don't like to say this, but I believe that the evidence will speak for itself. They may not work together -- agencies. People may not work together due to the competition with the result that care could, for example, be fragmented and/or inadequate. That's the reality, and I don't like it frankly. I don't want to be a part of it. I'm not a competitor. I believe if you know what you're doing and if you know your work and you care about people, you don't need to compete. Think of the money that's being spent on competition -- on getting contracts. It's astronomical. I think that should be kind of looked in to.

Policies: I think that the policies regarding contracts need to be reviewed, reevaluated, and revised for purposes of cost-effectiveness and quality of care.

Some form of government regulations, I think, are necessary to contain the rising cost of caring for the increasing number of elderly people.

I've spoken earlier of different populations, which are becoming now part of the population -- the elderly population, which had not been there before.

This may be unpleasant to some people, but I really believe that a return to the medical model or variations thereof, where physicians, not corporate executives, are responsible for the care of the elderly, should be considered. The medical model of care could be more economical than the business model of care.

When I'm sick, I want to be under the consistent care of a doctor I have selected for my care. I do not want to have a nurse, other health-care providers or employees working for a corporation determine who and when I should be seeing when I'm sick or determine what services I will receive. I do not want to be a consumer, a user of a product line, but a unique individual who is entitled to care when I need it. I'm afraid that the spiraling costs of care can result in the form of socialized genocide or can be socially acceptable genocide because, if you can't afford it, you may not get it. Another factor here is that when you're in nursing homes, you do not have -- in the privatization -- you do not have a consistent doctor or relationship and say, "This is my doctor."

If you have health-care insurance, I don't believe that you're free to use it. The nursing home-- I think that that could be a question to be raised.

ASSEMBLYWOMAN MURPHY: I'm going to let Roberto speak to this because he manages a nursing home. So I'm going to let him speak to that issue.

DR. RISCALLA: I think that there's-- I mean, I'm just raising a few questions here if you don't mind.

ASSEMBLYWOMAN MURPHY: Right. Well, let's let him address that issue of care in the nursing home.

MR. MUNIZ: In the nursing home, you have the right to choose your own physician. That is one of the patient's right that everyone enjoys, which is great.

DR. RISCALLA: Is it done? You may have the right, but is that right--

MR. MUNIZ: Well, it's up to the patient or the patient's family -- the resident's family to choose the physician they'd like to have as their attending physician. If the person-- If the physician does not cover that territory or nursing home, we go through the same process the hospitals go through to choose -- to admit or provide privileges to this doctor to come in and do the services in our facilities. We are required to do that.

DR. RISCALLA: Supposing someone has no family -- they have no children, they're all alone in the world--

MR. MUNIZ: If the person cannot make the decision as to what physician to use, we do have a medical director that could easily assign a physician to take care of this individual. But if he can make the decision, we will allow that person to make the decision, or the family or the power of attorney or the health-care proxy, and so on. We do give them choices. In my nursing home, for example, we have 20 physicians that come in to our facilities. And if the person wants to bring their physicians with them, they

can do that, as long as he or she meets the qualifications that we have set in our facility to have privilege to provide nursing home care services.

DR. RISCALLA: The question is that not all physicians are on all panels. Not all physicians have hospital privileges.

ASSEMBLYWOMAN MURPHY: But he is saying that if you are a patient -- if you are a resident of his facility and your doctor is Dr. A, you tell him, "This is the doctor I want here." And Dr. A, if he wants to come to that facility, can come to treat you there. But if Dr. A doesn't want to come to that facility, there is no way you can get him.

DR. RISCALLA: But you can't stop them. But the thing is--

MR. MUNIZ: Which is the biggest problem. Most likely the doctor doesn't want to follow that patient in the nursing home. And that has to do with the simple fact that the doctors don't -- not every doctor would like to have patients in nursing homes. They just don't follow them. They'd rather follow them in hospitals or at home but not necessarily in a nursing home.

DR. RISCALLA: That's true. It works both ways here. I realize that. But I'm looking at the risk--

ASSEMBLYWOMAN MURPHY: A patient's rights, in the State of New Jersey, demands that a nursing facility that receives any money from the State of New Jersey must allow every patient within that facility the right to choose their own doctor. Period.

DR. RISCALLA: That's unfortunate, but what a patient's right is -- what my rights are -- and when a person wants to apply them, they may be a mile apart sometimes. There is that risk. I would like to see that. I would

like to see what is on paper. See, many things look good on paper, but when you get down to the nitty-gritty, it doesn't exist.

ASSEMBLYWOMAN MURPHY: Except that it's in regulation.

DR. RISCALLA: I'm not being accusatory here, I'm just being practical.

ASSEMBLYWOMAN MURPHY: No, but I'm saying that's it's in regulation. We can't do any more than that. We cannot walk with every patient.

DR. RISCALLA: You can't, it's impossible.

DR. ROBINSON: I can just speak to the fact it is in regulation, but it also is practiced. I'm currently involved in a grant where I visit 30 nursing homes all over the state. I've done consulting work in nursing homes in New Jersey and in other states for the past five or six years. And patient's rights are emphasized, choice is emphasized, particularly with regard to who provides the medical care. And the nursing home bends over backwards, in most cases, to hook up the patient -- the resident with a physician of choice, with the kind of health care that the resident would like. If they don't abide by regulations, they're in jeopardy.

And the other thing is that there are-- You know, nursing homes have -- I think it's getting better, but for years have had such a bad public image. Every time that there is a story on the news or *20/20* or something about a particular resident getting abused, every nursing home in the country is suspect. And just from being in nursing homes, I would say that 99 percent of them -- 99 percent of the people who are there are trying their hardest to do a good job to serve the residents to make sure people have choices. It's just

unfortunate that the fear and the negative public image that exists-- I think we -- I don't know if I'm in the nursing home industry, I'm the helper of the nursing home industry -- we're trying to kind of change that image.

DR. RISCALLA: Well, my father was in a nursing home up in North Jersey, and he wanted to go. I had no problem. I was very much impressed with the caring of the staff, the activities that they had. It was unfortunate that one time my father was hit. A patient walked into his room and beat him up. That is why I feel that there may be some patients that need -- one of the reasons why I think some people need to be separated for their own protection and that of the nursing homes.

You have good and bad no matter where you are. I'm not painting a nasty picture of nursing homes or care. I'm just saying to be aware and be alert. Watch what we're doing. Look at the consequences of our reasoning and see where it leads to and what can happen. I think there are many good programs around, but what we need and what we can afford may not be the same.

ASSEMBLYWOMAN MURPHY: And I think, also, Dr. Riscalla, that a lot of what you speak to is an education piece for the younger members of the family.

DR. RISCALLA: Oh, yes.

ASSEMBLYWOMAN MURPHY: If you have a parent who goes into a nursing home-- My mother was in a nursing home for some time. Periodically, she thought that things had occurred to her that didn't occur. And sometimes she would make accusations about people that when I checked into them pretty thoroughly, I found out that sometimes she -- it hadn't

occurred. It was something she kind of dreamt up, if you will forgive me. But there were other people there who did that, too. There was one woman who swore her underwear were stolen all the time by the people who clean the room, and it wasn't. She put it in different places and could never find it. And they would always find it. And she swore that they produced it. After they'd stolen it, they just produced it and did this to confuse her. Well, they didn't, but it's hard to tell someone -- hard to convince someone of that.

DR. RISCALLA: Sure.

ASSEMBLYWOMAN MURPHY: And so sometimes I think the stories that come out from facilities are often slanted by the conditions of people who are in them.

DR. RISCALLA: Well, see this whole issue of privatization and control of the county and State is something which is currently being debated. I don't-- On one hand, I don't think the county or the State could afford, especially in my area, a nursing home because the -- a lot of these building are outmoded -- would need to be overhauled, etc. Yet, on the other hand, there is an accountability. I think the industry has its own organization, and there are controls. But I'm saying update them, make sure that things are current with the population. We have to (indiscernible) place things in the overall context.

Competition-- I don't like it because it just-- Someone's going to win, and someone's going to lose. And when you start competing, over in Human Services, with people-- You just can run people like you do a business.

ASSEMBLYWOMAN MURPHY: Dr. Riscalla, that's one of the reasons that the Department of Health and Senior Services started the New Jersey EASE Program--

DR. RISCALLA: Right.

ASSEMBLYWOMAN MURPHY: --was so that they could do more case management--

DR. RISCALLA: Right.

ASSEMBLYWOMAN MURPHY: --because I think you and I are cut from the same cloth in the area of the competition and the turf within human service agencies.

DR. RISCALLA: Sure.

ASSEMBLYWOMAN MURPHY: It's the dollar every time.

But case management, or care management -- giving grants to agencies that are cooperating in dealing with the person as a whole, holding the umbrella and allowing the services to be blended is the better way to go. And as part of the New Jersey EASE Program-- I have a brochure.

DR. RISCALLA: I have-- I've handed out the EASE cards, too. I've been-- Two of the members of the National Council -- Chapter -- I did that a long time ago. I also happen to be acquainted with a number of people in the State Office of Senior Affairs. Ruth Reader I've known for many years.

ASSEMBLYWOMAN MURPHY: And Bonnie.

DR. RISCALLA: Dr. Reinhard-- You have very competent, skilled people. I've had them-- I'm also a member of the Senior Rights Coalition, which meets down here in Edison. They've come to speak to us, and we hope to have others. We've had people-- It's a coalition of professionals and

members of senior groups. We all get together. I think these are excellent opportunities to dialogue. To me (indiscernible) where people work together--

MS. MICHELSEN: Dr. Riscalla, let me-- I'm sorry to interrupt you. Let me ask you a question directly related to that.

Part of what I heard you talk about was your concern about corporations and addressing -- making people consumers of products instead of humanistic services. And one concern that we have as a Council, and that I have personally, is about Medicare HMOs and the way they're promoted to seniors.

DR. RISCALLA: Oh, that's another story, yes.

MS. MICHELSEN: Do you find that that issue is clear with the senior groups that you chair or are a part of? I see you in a leadership role with them. Are the seniors educated that how they're being brought into these HMOs--

DR. RISCALLA: I don't know if you're aware of it, but I received a phone call. I don't wish to mention names. I think it's something to look into. I went through this HIP thing myself. I was a member of HIP, and I was a member of the HIP HMO -- the Medicare HMO.

ASSEMBLYWOMAN MURPHY: Right.

DR. RISCALLA: HIP provided me with the best of care. I have no -- absolutely no complaints in the type of care that I received. Medicare-- I think a lot of companies have found, and for whatever reason I don't know-- But New York HIP -- I just got a call this week that they canceled their Medicare HMO people. And one of my friends had to scurry around trying to -- who was under the HIP program had to find a new health insurer. I think

this is something to look into because I think-- Another company went under, too--

MS. MICHELSEN: Oxford.

DR. RISCALLA: They couldn't afford to keep up with--

ASSEMBLYWOMAN MURPHY: Right.

DR. RISCALLA: You'd think the consequences of this could be disastrous.

MS. MICHELSEN: But how do you feel about the education -- about people joining -- people joining or being asked to join HMOs or the way that the HMOs are presented to the seniors? Do you think that the people understand what they're getting into when they sign?

DR. RISCALLA: No, I don't think they do.

MS. MICHELSEN: Do you feel there is more consumer education needed from a nonpartisan point of view, so to speak?

DR. RISCALLA: I think on a one-on-one because as you go around and speak-- Now, next week they're having a senior day down at the Law Center. That can be useful. I've been announcing that for seniors to go there. I announce these different programs for consumers. A lot of people think -- they're too proud to admit they don't know. If you talk to them in a group -- "Do you understand?" -- but then, when you get to talk to them about it, they really don't know.

MS. MICHELSEN: Then they sign on, and they don't know why they can't go to their podiatrist anymore under this.

DR. RISCALLA: Or they sign on-- I was walking people through the HIP situation because you had people who didn't understand the English

language. You have a lot of immigrants. Edison, here, is a melting pot. A lot of other communities are melting pots. Try to get them to understand our system-- They have enough trouble understanding the language, how can they understand all of this?

ASSEMBLYWOMAN MURPHY: So there needs to be better education in all of these arenas.

DR. RISCALLA: Yes. For example, I was walking people through the HIP situation on a line down to Trenton trying to help them fill out the application for it. I wanted them to get straight -- directly. We had (indiscernible) at our group. I invited the director to come and talk to us.

ASSEMBLYWOMAN MURPHY: Right.

DR. RISCALLA: They had health fairs in the area. But again the language-- I found a lot of my colleagues who were from India could not understand the language. They couldn't understand what was going on. I think this-- I don't know how you're going to reach this melting pot of seniors.

ASSEMBLYWOMAN MURPHY: I don't know either. This is clearly something we need to do.

DR. RISCALLA: You need to do this. I mean, I tried to go one-on-one with people with my own background. I happen to have a southern mentality. I'm just neighborly, so I'll help out. But again, how much is it going to cost?

ASSEMBLYWOMAN MURPHY: And that's part of the issue to, Dr. Riscalla.

DR. RISCALLA: And I think this is part of the issue.

Dr. Reinhard -- I'm very much impressed with her. She has done a great deal trying to-- She came to one of our meetings. Now, in all fairness to Dr. Reinhard -- to Susan, I couldn't understand some of the stuff that people are talking about. And I don't profess to be scholarly or anything, but I had a lot of questions. I had to go for counseling to talk to a CHIME person myself, especially when you have several different kinds of insurance, which takes priority, how to select a company.

I asked people. I did a straw poll thing. "How did you select your insurance company?"

ASSEMBLYWOMAN MURPHY: This part of the issue--

DR. RISCALLA: "Did you select this because of your need or because of so-in-so? What are your needs?"

ASSEMBLYWOMAN MURPHY: It's part of the issue we're looking at with automobile insurance and will come up in the deregulation of the energy industry.

DR. RISCALLA: Yes, but this is all insurance.

ASSEMBLYWOMAN MURPHY: We have taken a lot of these things for granted. We just signed there, and now we have to read them and make phone calls and become educated in what we're selecting. And choice is a lot of work for everybody. When someone else made the decision for you, it was very simple. But when you have to make your own decision--

MS. MICHELSEN: When it was just Con-Edison, huh?

ASSEMBLYWOMAN MURPHY: That's right, when it was just Con-Edison it was really easy. Now there is a lot of people, and we do have to

make more decisions. And it is a lot of work, in particularly for the elderly and particularly for the elderly who don't have English as a first language.

MS. MICHELSEN: Or an impaired -- frail or impaired in some other way.

ASSEMBLYWOMAN MURPHY: It's really--

DR. RISCALLA: Another thing is transportation in this state. It's very, very poor. Pardon the expression. Public transportation-- You practically have to have a car to get around. That's another thing to be considered for the elderly. We have--

ASSEMBLYWOMAN MURPHY: Yes, but there just will never be enough. There will never be a chauffeur for everyone.

DR. RISCALLA: How high is up, and how much is enough? I mean, people are getting older.

ASSEMBLYWOMAN MURPHY: That's right. And it's part of the reason why we're looking -- keeping people in the community. I almost think -- a doctor in their own homes, if you will. I almost think, to some degree, when you look at the issue of a widow living in a big house in a community-- You're right, the keeping of the house, maintaining the house, and all these things -- the public clearly is not going to support that for every individual. They can't. So when we say keeping you in your own home, I think we're beginning to mean, "Sell your home and move into one you can deal with in some sort of senior residence or something like that, and we'll help you there. But we're not going to help you maintain the house so that you can leave it to your family and the State pays for it all along the way." There are a lot of things that all roll into one another in all of these issues.

DR. RISCALLA: What we did--

ASSEMBLYWOMAN MURPHY: And it becomes difficult.

DR. RISCALLA: What we did was-- We prepared for our retirement. We decided we're going to stay here. So I think, again educating-- Before we retired, we prepared our home, ramped it. We looked around at what services-- Again we wanted people-- There was a grant that the VNA had gotten. And again it's finding competent people who are not going to rip you off as seniors either. That's another problem.

ASSEMBLYWOMAN MURPHY: Yes.

DR. RISCALLA: So we prepared for our senior days while we were both working. And I think this-- Here's an area for counseling to put out some publications. They say to start planning for retirement-- What age it was-- Whenever you get married, start thinking about retirement.

ASSEMBLYWOMAN MURPHY: That's right, when you get your first job, start thinking about retirement.

DR. RISCALLA: But as you get older, people need to begin to not live the now, but look at the consequences. Look down the road. I'm not -- fright tactics or anything like that. This is practical reality. We are living to be much older. We hope we can live until we are 90 years old or so but comfortably. So we have-- Seniors have a responsibility, too, to fix up their home and maintain their properties. I think this is a dual way. And a lot of seniors, I find, all sit back and say, "You do it for me." They become very dependent. We need to empower them.

ASSEMBLYWOMAN MURPHY: Yes.

DR. RISCALLA: To get them to take responsibility for their lives and take control of it.

ASSEMBLYWOMAN MURPHY: A lot of balancing in all of this isn't there?

DR. RISCALLA: Pardon?

ASSEMBLYWOMAN MURPHY: There's a lot of balancing in all of this, Dr. Riscalla.

DR. RISCALLA: Yes, it's a balancing thing.

ASSEMBLYWOMAN MURPHY: We're going to balance our day now and have lunch. So I would ask you all to join us.

Peggy has arranged the lunch repast. It is in the back of the room.

Dr. Heath and Assemblyman Romano, we're delighted to see you both. Have some lunch.

Then we're going to hear from Dr. John Heath about education.

We have been hearing about the lack thereof this morning a great deal, Dr. Heath.

ASSEMBLYMAN ROMANO: A lack thereof of what?

ASSEMBLYWOMAN MURPHY: Education.

(RECESS)

AFTER RECESS:

ASSEMBLYWOMAN MURPHY: John, I think we will begin. Sam will join us. He may be on the phone.

DR. HEATH: I appreciate the opportunity to be on the other side of the table so to speak.

ASSEMBLYWOMAN MURPHY: Yes.

DR. HEATH: One of my children woke me up at about 4:00 this morning. I went downstairs and put on C-Span and actually saw some testimonies there. And it was taken from the individual sitting on this side of the table. And then they would, periodically-- I forgot the difference. I'm used to participating on that side versus this side.

I appreciate the opportunity to present some information about education from a professional standpoint. I have an outline to share with all Council members. I thought what I would do is kind of cut to the quick and talk about some of my initial bottom-line suggestions and recommendations for us to think about and then maybe go backwards and give some of the rationale, and we can have an open discussion about it.

I think of the recommendations that I think would be important, two of them, I would argue, would be more of a philosophical and prioritization. One would be that, at least as I've said on the Council and have heard from time and time again from both caregivers, as well as professionals, the need to have the human aspect of services for the aging, both current services as well as proposed services -- the personal contact, the respectful interaction, someone to be able to listen. That really points out to me that any professional service has to have an educational component to it. So one of the points that I would make is that as the State of New Jersey looks at elder care services, both current and future, they would really ensure that the education of those people providing the services is recognized as an important and, in

fact, the paramount issue along with how the services are provided -- how someone answers a 800 number, what the training a home health aide gets, how an individual respectfully interacts with a stressed out caregiver probably is as important as what the actual service delivers. The education of those individuals have to be critical, I think.

A couple other suggestions that -- bottom-line recommendations, one of which would be that we try to become as professional as we can when we talk about education of caregivers, education of health professionals. That is professionalism when it comes to the format of education. We've heard some interesting, innovative aspects of throwing things into license registrations, renewals over the mail. We've heard some interesting ideas of how to respond to a telephone solicitation and cold calls, so to speak. To the extent that the State has great resources looking into a professional education, let's utilize those resources and make sure that we have a good center -- infrastructure if you want to call it that, to do geriatric health-care education, both for professionals, as well as for caregivers, so that each individual initiative -- each individual program doesn't have to reinvent the wheel. We have to think about how to do educational initiatives.

Let me take a step back and describe some of the barriers, at least as I see it, from an educational standpoint, at least as it relates to health professionals. I'll talk about physicians first since that's my core discipline. And then maybe I'll broaden a little bit to health-care professionals in general. I guess, first and foremost, let's say that geriatrics ain't sexy.

In health care today, we've got lots of excitement going on. We're transplanting organs, we're researching, we're imaging, we're doing

phenomenally exciting stuff. Talking to 90-year-olds and talking to the stressed out caregivers of 90-year-olds isn't sexy. It doesn't make front page news. And when it does, it usually is bad front page news, rationing diapers in the case of an institution, dealing with elder abuse situations that hit the front page.

On the other hand, it's something that is intimately personal. Everyone has a story to tell about either their own aging, a neighbor's aging, their family member's aging. So if we make it more personal and we make it more relevant, I think education will accomplish a lot more. Early in the Council's work, I had suggested some language in one of the statements to say that it would be wrong to make our interactions us versus them. We're not talking about the elderly as a special interest group. We're not talking about caregivers as them as opposed to us. We're talking about ourselves and how we wish ourselves to be cared for and how we wish those that love us as we get older to care for us. This is a very inclusive process. That's one of the ways to make it a little more sexy.

Clearly, as it relates to physician training, there's an awful lot of competing demands. Every five to seven years, the medical knowledge base literally doubles. And when I teach my medical students, at Robert Wood Johnson, where I'm an associate professor nowadays, one of the standard lines is that when a first-year medical student starts, by the time that first-year medical student graduates, about 50 percent of what they learn will be obsolete. So what you really need to have to emphasize isn't so much learning the content, but learning the process. How do you learn? How do you do ongoing continuing education? That's probably where the greatest emphasis

needs to be. It's not so much what we learn in school. It's what we learn on a day-to-day basis. Our schools are practical experiences.

Think about that in terms of our own activities. I've heard the dedicated legislators on this Council talk about their experiences with their constituents. And obviously, they're serving their constituents and there have been episodes that have really touched their hearts and lead to passion, but I also hear the representatives describe it as an ongoing learning experience. A constituent can describe a situation. It's explored and it's an ongoing continuing education experience. It's not like you can learn it today and apply it tomorrow. You learn it tomorrow. You learn it the next day. You learn it on an ongoing basis. So the idea of continuing education, I think, is critical. It would be wrong to say that if we just had a single good "course" in how to take care of caregivers or how to train individuals who are taking care of caregivers -- a one-shot deal is never going to do it. It has to be on an ongoing basis.

A final point that I would make, and I think it's personally one of the things that has bothered me a lot from a health professional and training standpoint, especially when it relates to physicians-- Dr. Robinson can comment on this, too. Health professionals are trained in isolation. I went through four years of medical school. I've been faculty at medical school for 14 years now, and I can count, literally, on one or two hands, the times that there has been a formal educational -- formal educational experience that involved anything other than physicians.

When I talk to my colleagues in nursing school, there is very, very precious little interaction about how doctors and nurses interact. Social

workers learn their own dialog, they have their own lingo. When they have to call a physician, the interaction there is Mars talking to Venus, to borrow a pun -- or borrow an analogy that is out there from a relationship standpoint, but it is very true. The people from Venus speak in a very different language than the people from Mars speak.

As a geriatrician, when I'm out in the community serving individual patients and clients that I end up seeing-- I pick up the phone and I'll talk to a social worker, and after I develop a little bit of a relationship, it's not at all uncommon to hear social workers, very (indiscernible), discuss how they've interacted with primary care physicians in the past. There is not a respectful interaction in either direction. Doctors, oftentimes, are the main culprit in those situations. But it's a language. If we don't train individuals to work in-- If we don't train individuals to work with each other, how can we expect them to practice on a day-to-day basis?

Now that's probably not -- especially if you're doing brain transplant surgery. But it's critically relevant if you're dealing with a lot of the elders in the community because, clearly, a social worker can't prescribe medicine for Alzheimer's. And a physician can't know everything there is about adult day programs. And the nurse can't, in and of itself, understand what the best meals delivery service would be, and the best meal delivery service won't get the person out there.

The opportunities at New Jersey EASE, as an infrastructure, as a mechanism provides and tries to bridge-- That is very exciting. Dr. Reinhard and her colleagues are to be tremendously commended for that. But that still doesn't get to the issue of the cross discipline interactions. For instance, one

of the strongest recommendations that I have for the State is to really play its large Big Brother, if you will, role in really facilitating cross discipline interaction.

Let me give you an example of that. Last Friday, I attended an elder abuse conference that was held at the UMDNJ Scotch Plains conference. Dr. Reinhard was one of the featured introductory speakers. She did a wonderful job. The conference was sponsored by UMD Violence Institute. And it involved a lot of Allied Health professionals. That's why it was held in the Scotch Plains campus because that's the Allied Health-- There were maybe a dozen or so physicians like myself there. There were lots and lots of social workers from adult protective services. There were three cops that attended. And the cops, very appropriately, separated themselves into different working groups. And the working group that I was in discussed a situation of elder abuse where an individual was found to be battered and bruised. And the caregiver who was probably stressed out and really needed some adult day programming services but couldn't bring herself to acknowledge that and didn't really know about it, essentially, picked up the phone and dialed 911 when she couldn't take it anymore. And our working group was to try to decide what would happen next.

As a physician, as a health-care professional, we immediately went into a medical model. And the cop who was sitting next to me said, "We walk in. We see battering. That's domestic violence. That person's incarcerated." And the room fell completely silent because none of us had any idea that domestic violence legislation would be applicable for elder abuse.

ASSEMBLYWOMAN MURPHY: Oh, yes.

DR. HEATH: I've been doing elder abuse for a little while now. I was surrounded by very professional master-level social workers. They had no idea. That opportunity to interact-- There was a lawyer in the group that talked about what the guardianship and servitor procedures would be. It was an eye-opening experience for us. That opportunity, which was sponsored by the Department of Health and Senior Services, was an excellent example of really cross discipline interaction. It was a wonderful learning experience that taught me a whole lot -- in that one isolated example of how law enforcement might deal with elder views versus how a medical model would be. That's one of the examples that I would argue how a state can really advocate for cross discipline interactions when it comes to elder abuse issues, not just elder abuse, but also elder care in general.

Let me talk about some characteristics that I think would be most effective in planning some education, especially as it relates to health professions but in general. I've already touched on one point, it needs to be continuing. You don't just put on one course and think, "Well, we've addressed X issue, and then we'll move on to Y." Any type of educational intervention needs to be done on a continuing basis.

Another important point that I think is -- should be presented in a multiple of different formats-- Again let me give you a personal example. As a physician, I have privileges at a couple different hospitals. And one of the criteria to be on the hospital staff is that I have to undergo what is called universal precaution training, in other words, put on gloves when you come across bodily fluid contacts. And most hospitals that we've been affiliated with have a requirement that all physicians, all nurses, all technicians every year or

two years have to take this training. Most hospitals, when they've done that, essentially set up a training schedule, 7:00 in the morning on this day and 6:00 at night-- And doctors grumble and bitch because they don't like to attend these sessions.

This past year, the notice that I got said, "Hi, this is the Web site." The (indiscernible) Environmental Safety and Health School within UMDNJ set up a Web site for what's called bloodborne pathogen training. Ten o'clock at night I signed on to my computer, wearing my pj's, having a glass of wine-- I was much more interested, and I spent an hour and one-half; whereas, if I was sitting in a conference room at 7:00 in the morning, I would have been terribly disconnected with it. I learned more from doing it on the Web than I would have learned anywhere else. Not only that, but my wife was able to do it 6:00 the next morning. In other words, it was very user friendly.

At the end of the Web interaction, we were able to take a test. We documented our competence, and two weeks later we got the certificate in the mail. And I'm covered for two years for that.

In other words, the format of education really needs to be thought out. I'm sure it took a lot of time to develop, for instance, the Web-based training module. But that's a lot different than thinking that "well, we'll just put on a conference at X institution, and whoever can make it can make it." Videoconferencing, video linkage technology is out there. And especially, when we talk about people who are coming from vastly different disciplines, it, I think, would be important to think about the different formats of how educational settings would be put on.

Finally, I think one of the other key aspects of educational interventions is the idea of showing some type of acknowledgement that people went through it. It was very important to me, after I took that training, that I got the certificate in the mail. I mean, I've gotten tons of certificates. It's a piece of paper. It has a little bit of gold on it. But it was important to me.

In my role in the medical school one of the-- We had a meeting with a consulting pharmacy service. This pharmacy consultant tries to contract with the different nursing homes to do the review of medication for nursing homes. And one of their marketing ploys that they use with nursing homes is they will come in and do special training programs for the nurse assistants in those nursing homes. And, not surprisingly, the training programs focus on the role of medications and the elderly.

A lot of the nursing homes will think this is a valuable training experience for the health assistance, and they will ask the consulting pharmacists to come in and do it. Part of their general training that they told us about was that the end of their one- or two-hour lecture, they'll give all the nurse assistants a little pin to say that they attended the training experience.

One of the things that they found out is that after they did this time and time again, at the different nursing homes, was that the professional-level nurses, the people who have bachelor's and master's degrees in nursing, got very jealous because here are the health assistants walking around with their little gold pin to show that they had attended the service. And the professional nurses want to be able to have something like that, too.

I felt important when I got the gold embossed letter to say I was part of this Council. To educate without acknowledging it probably doesn't accomplish nearly as much as showing there is recognition at the end of that.

It sounds like an obvious thing to do, but many, many insitutional settings like home health care, nursing homes, hospital bases we put on a course, because we think you need to know about this, without making sure that you get acknowledged for learning about and showing how it is important for you -- acknowledging the education is very important. It doesn't cost a thing, but it makes it so much more valuable. At least it did to me. And I think if we all think about our own experiences, whether it be merit badges or perhaps taking a CPR course and getting that little card, acknowledging educational experiences is important.

ASSEMBLYWOMAN MURPHY: I'm going to interrupt you just to say that I did not graduate from college, but when I ran for office the first time and I got a certificate saying I had won the election, that became my graduation diploma. It had proved that I had put my name somewhere to compete in an arena with other people who were equally qualified. And I got my diploma in a sense. The Wizard of Oz has been true for all of us.

DR. HEATH: Let me go now in more detail to the four specific suggestions that I would have from an educational standpoint.

The first, as I outlined on my handout here-- Explicitly, link the State regulation and oversight of senior health-care services with the commitment to having some type of educational support for the people providing the services.

Again a personal story if I might. In another state, I happen to be a nursing home medical director. As part of that, my nursing home was very appropriately nervous and apprehensive when the State survey team would come in. It just so happened that I was able to help that nursing home get a grant from that state to do a lot of nursing aide training as it related to Alzheimer's, and we were very proud of that grant. The grant actually allowed us to pay the health assistance a poultry amount, but we paid them, to sit through a series of various courses. They were able to design a curriculum "What particular behaviors of the people you take care of are most problematic, and how can we help you with it?" And by the way, they got a pin and an acknowledgment at the end of it.

We wanted to tell the state surveyors how proud we were of that. And I distinctly remember this. As medical director, I was part of the administrative team. We sat on one side of the table and the state surveyor sat on the other. And I was charged with presenting this educational intervention that we did. And the head of the survey team interrupted me and said, "But, Doctor, you don't understand. Our survey specifies that we have to stand outside of the kitchen and monitor the temperature of the trays coming out, and your trays in your facility were five degrees below the threshold. Therefore, we are citing you for quality of life because the meal trays were five degrees what the minimum threshold was." That's not a criticism of the temperature of the meals because that is an important factor. But it just struck me that measuring the temperature of meals without necessarily thinking about the people that have to feed the residents was missing the forest for the trees. We were given great credit because the administrator of the nursing

home bought new tables that we're curricular. And the purpose was that you could have one health assistant sit inside the circle, and she or he, typically a she, would be able to feed eight different people more efficiently than a straight table where you could only slide three or four people up.

The health assistant said, "This is a wonderful table, but how do I do that? How do I get the people to open their mouths? How do I actually feed them? Teach me how to do that." And the administrator, who was well intentioned, said, "Well, we bought the table, but I don't know how to get you to do that. I don't know what the best technique for you is to use this table more efficiently." That was an educational opportunity that was missed.

I would argue that the same thing should apply when the State looks at how home health-care agencies run. I'm sure that there are reams of paperwork to document the functional status -- the so-called temperature of the meal trays -- those types of details. But it would be nice to show us your commitment to train your staff. Show us your in-service training schedule. Do the people that work for you have any say in what their educational needs are? Is there an on-going two-way communication back and forth? What's your educational commitment to these people?

At that elder abuse conference that I mentioned that I was at last Friday, the State ombudsman, Bonnie Kelly -- Ms. Kelly -- was her last name -- Bonnie Kelly was there. One of the things she spoke of that really silenced the room was that she had just come back from an ombudsman conference that had been held in the Midwest. It was not in New Jersey. She had heard at that conference that one of the speakers had done an informal survey and had found out that zookeepers in that state were paid, on average, I think \$15 an

hour, and nursing home health aides were paid \$7 an hour. And the room fell completely silent. And Bonnie Kelly's response was that "if we can't pay them as much as we can pay a zookeeper, at least we can tell them we value them more than we value zookeepers." And one of the ways to do that, that's not very expensive I would argue, is to make sure that there is ongoing education (indiscernible).

So again a specific recommendation -- more of a philosophy is that if the State regulates someone, regulate how well the employees, the people who are delivering services, are trained, that training could include many of the topics that we've heard in the Council, things like cultural diversity, "Hi, home health care agency. How do you deal with individuals that may have different cultural values, different languages, that look different than you? You're going into someone else's home. How do you approach that?" Those aren't easy subjects to educate about. But, at least, if it's talked about, and if the institution, whether it be a structural institution, a home health-care agency, an assisted-living facility -- if they acknowledge that and have evidence that their staff is being allowed to learn about those issues, I think that would go a long way -- a real long way to improve how caregivers interact with it.

As it specifically relates to physician education-- In this month's *New Jersey Medicine*, the publication from the Medical Society of the State of New Jersey, there is a list of what's called the *New Jersey Commission for Physician Workforce Recommendations*. I'm happy to submit this as part of the testimony. One of the things they mention in there, God forbid, attacks, that health insurers in this state -- would be asked to pay for what they call a Medical Education Improvement Fund. The logic behind this, very briefly, is that most

medical education -- physician, but also, to some degree, nursing as well as allied professionals -- is linked to a hospital. And if a hospital gets the money, hospitals want to train inside institutional walls.

ASSEMBLYWOMAN MURPHY: Right.

DR. HEATH: If you had an insurance fund that would help have some type of medical intervention fund, then maybe you might be able to support cross discipline training -- not a large amount, but some type of intervention for training. Geriatrics, I think, would be a large part of that.

The No. 2 recommendation, the interaction between New Jersey EASE and primary care providers-- I think New Jersey EASE sounds really exciting, and obviously it's a major investment that the State is making. It, obviously, is also designed to be the point of contact between elderly clients and their caregivers in the state. But, to date, I've not heard the interaction between New Jersey EASE and health-care providers.

Clearly, if an individual, take for example an Alzheimer's patient, comes in with their caregiver to the primary care physician's office and they're presenting issues that are beyond the scope of the primary care provider, which I would argue many times it's about 80 percent of what the issues of Alzheimer's is, that doctor's office should be able to have some way to respond to that caregiver. That response may very well be, "Well, here's an 800 number." That's kind of like an initial response. It would be nice if there was actually a greater degree in involvement. Maybe that can come from the case managers that New Jersey EASE is going to have.

I came from New York a couple of years ago. New York has something called Alzheimer's disease assistance centers. The state of New York

funded a relatively low amount of funding -- a series of initiatives across the state by which health-care providers would get state-supported, essentially social work, intervention. Sometimes it took the form of a psychologist to help do some of the mental status testing that physicians aren't good at. Sometimes, when it was a nursing intervention, they would actually provide easy access to physicians. In other words, it was allowed to be customized.

The distinction, perhaps, with New York compared to what I've seen here, it's a lot of-- The Alzheimer's-specific services in New Jersey that I've been able to see are really linked to the mental health system. I'm the physician that works a lot very closely with COPSA (phonetic spelling) in Piscataway as well as within the University of Behavioral Health (indiscernible). It's a wonderful intervention. It's cross discipline. It's helped many people. But it is really within the rubric of the mental health system. It's based within a community mental health system. It's run really within a mental health frame of reference.

That's great as far as it goes, but it doesn't necessarily help the primary care providers provide services in their own offices. If you give me a choice of should Alzheimer's services be within mental health or should they be within medical, I'll say both. And I don't think the medical services are there yet to help support how well Alzheimer's is taking care of in the community. So the idea of linking, perhaps, the New Jersey EASE case management with primary care providers-- That's very general, and I don't know how to go beyond that initial generalization, but I think it should be explored.

I also put a plug in there, from what I've understood a little bit, of the New Jersey EASE database. It sounds like a phenomenal resource. And to the extent the State would be really, really ill-served if it doesn't really explore this database in terms of what Alzheimer's, as well as general elderly, care really need and the caregiver support. So much of it we heard from the last presentation-- So much of the health-care system is very fragmented. Hospitals do their thing, home health care does their thing, institutional nursing homes do their thing. I would argue, oftentimes physicians do their thing. It really would take a State approach to cross a lot of those boundaries. Sometimes, insurances will cross boundaries, but to the extent that a referral service that's not linked to one insurance system or one hospital system or one nursing home network, but perhaps can cross an individual from a case management standpoint, that's very exciting. That would be a wonderful thing to explore.

Point No. 3, support, in partner with UMDNJ Geriatric Education Center-- Early on in the process, we heard testimony from Dr. Thomas Cavalieri. He serves as the Chairman of Medicine, but more relevantly for this committee's work -- Advisory Council's work rather, he's the Geriatric Education Center Director, which is based down in the Stratford Osteopathic School Campus.

Geriatric Educational Centers are a Federal initiative. I think there are about 22. I would have to check on that, but there is a number of them across the nation. For a number of years now-- I believe they're in their 10th year now. New Jersey, within the UMDNJ system, has been privileged to have one of those Centers.

In his testimony -- it's in our official transcripts. They can document over 7500 various health professional's interactions as it relates to geriatric training. Their training really, to date, has been the conference center. And one of the things I know they would like to do is branch out to use things like Web training, perhaps, interactive videoconferences -- to use the different formats for it. They have an existing infrastructure that's wonderful. One of the things that they don't have is any direct interaction, financial mostly, with the State of New Jersey to help support a lot of their initiatives. They run entirely on Federal support. I think one of the things that they would like to be able to do is show some State support when they go back to try to renew their initiatives.

I am not on the staff of the GEC; although, I'm part of UMDNJ system. I do not have direct links to it, so I speak as a fairly detached individual when I say that I've been very impressed with what they've done from a physician standpoint.

One of the other things that I would argue in favor of using a model like the Geriatric Education Center is that there are precious few other opportunities for cross disciplines to interact. Again schools of public health do public health, schools of nursing do schools of nursing. You need something to kind of cross the boundaries and yet has a high enough profile that you can get physicians to attend, that you can bring the social workers out of their offices so that the State partnership with an institution like that, I think, would go a long way.

Finally, and this is a reiteration of my last point, to the extent that the State, very much, is a large profile and sets a tone, really facilitate what I

call divergent constituencies interacting among elder care issues. I'm sure-- As an example, the New Jersey Bar has a number of practitioners that really do a lot of elder care law issues, but how often do they really interact with the physicians that may be seeing individuals that desperately need services? And how often, if those services aren't put in place now, then we look later on at the guardianship, the conservators that force legal interactions? And yet, there's no intrinsic mechanism by which physicians and lawyers interact. And when they do, both of us grind our teeth.

Likewise, there are lots and lots of advance practice nursing experience when it comes to geriatric training out there. Nursing, oftentimes, desperately makes wonderful outreaches to social workers and physicians, but in and of themselves, a lot of times the nursing disciplines -- health-care administrators also don't necessarily have the venue -- they don't necessarily have the format to interact very well. So to the extent that -- and I think I would have applied, from what I've seen so far. Health and Senior Services Department really seems to be doing a lot more of this, being a joint sponsor of conferences, really trying to get different people to talk together. That, I think, is a real important issue.

So just to wrap up my comments, I think the idea of a philosophical link between -- "If you want to provide services, show how you train and how you educate on an ongoing basis to people who provide the services. Don't just show us how hot your meat is, but show us how you take care of the people who serve the meat."

2. Think about New Jersey EASE to health-care providers, not just for the caregivers.

3. Think about the infrastructure to support education. It's not just the content. It's easy for us to think that we need to have more training about X, Y, or Z, but how is that training to be delivered, what type of format, who's the best person to do it?

And then, finally, to the extent that we can, let's encourage cross discipline interaction because that's very relevant. I would argue that is probably the most critical aspect. I can do a lot for my elderly patients in terms of prescribing medicines, but I'm nothing unless I'm able to deal with the caregiver stress. I'm much-- What I tell my fellows -- I'm the Director of a fellowship training program at Robert Wood Medical School. One of the things I tell my fellows is that "to do your job right, you will make the social worker look great. And she will make you look like \$100. And together, the two of you will make the caregiver feel so much more better than either one of you, individually, will be able to work with."

I'll stop my testimony there and see if there's other comments or discussions.

ASSEMBLYWOMAN MURPHY: I just have one question that is more-- UMDNJ, and you're speaking of the different schools-- The Robert Wood Johnson is a school within the University of Medicine and Dentistry, and then the Geriatric Education Center is a school, if you will, within the University? Is that--

DR. HEATH: Yes.

ASSEMBLYWOMAN MURPHY: Okay.

DR. HEATH: The University involves eight separate schools.

ASSEMBLYWOMAN MURPHY: Right.

DR. HEATH: There is a Dental School, there is a Medical School in Newark, there's a Medical School in New Brunswick -- Piscataway. That happens to be the medical school that I'm affiliated with.

ASSEMBLYWOMAN MURPHY: Right.

DR. HEATH: There is a School of Nursing. There is a school of public health. There's a school of -- Graduate School of Biomedical Sciences. There is an Osteopathic School of Medicine. The Osteopathic School of Medicine is in Stratford. And that's the campus that has been able to obtain funding for a geriatric education center. It's all within the network of the UMDNJ system.

ASSEMBLYWOMAN MURPHY: And with all of those facilities that deal with medical features, if you will, there is no chair of gerontology or geriatric care or any such thing, is there, in the State of New Jersey?

DR. HEATH: There is a UMDNJ Chair of Geriatrics. That actually, right now, is based in Hackensack University, so it's not really within the UMDNJ system as much as it's based at the hospital in Hackensack. I hope to be able to have that Chair give testimony to our Advisory Council at some point in the future. That really is the extent of the UMDNJ dedicated involvement as it relates to geriatrics.

ASSEMBLYWOMAN MURPHY: And if I may, as one more, question, the difference between a chair of gerontology or a chair of geriatric medicine-- Am I using one of those terms incorrectly?

DR. HEATH: The distinction's probably more cosmetic and more rhetorical than it is in reality. From a technical standpoint, gerontology refers to the study of aging. Geriatrics refers to how you and I age. The cynical part

of me says that a gerontologist is fascinated with aging rats. It doesn't have a clue as to how to take care of his mother.

ASSEMBLYWOMAN MURPHY: Thank you, what a marvelous description. Thank you.

DR. HEATH: I just offended many, many gerontologists out there.

DR. ROBINSON: I was just going to say, as-- My take on it, from geriatric nursing, is that gerontology is the study of aging, and geriatrics is the study of the diseases of aging or the medical problems of aging. I've heard that, too.

DR. HEATH: Aging process--

DR. ROBINSON: Right.

DR. HEATH: --versus what to do about it.

DR. ROBINSON: Right, it's the practical application health.

ASSEMBLYWOMAN MURPHY: And they would both be considered to be part of the education piece, if you will, within the University of the scope of the--

DR. HEATH: Very much so.

MS. MICHELSEN: The gerontologist is often somebody with a sociology Ph.D. A geriatrician is an M.D., and sometimes that is what helps divide the line between the two.

ASSEMBLYWOMAN MURPHY: Thank you.

DR. HEATH: It gets even more blurred. The Robert Wood Johnson Medical School, as part of the UMDNJ system, has something called a Gerontological Institute. That institute actually bridges a number of

institutions and tries to bring a lot of the basic science researchers, biochemists, anatomists, interacting with the clinicians. They called it the Gerontological Institute frankly to try to bridge the cross disciplines; although, it does happen to be based in a medical school setting.

ASSEMBLYWOMAN MURPHY: Okay. I'm feeling, suddenly, very old. (laughter)

Other questions for Dr. Heath?

DR. ROBINSON: I would just like to say that I applaud everything you've said. And from a nursing point of view, hooray.

I think I would add the one thing that I applaud rewarding the individual for having attended the educational program, but I'm going to sound like a burned-out educator, but then there needs to be a way to hold people's feet to the fire to use the behaviors that they've learned. People will show you all of these continuing education credits for having attended programs on team -- working as a team member, interdisciplinary team tactics, and gerontology. And you watch them practice, and it's as if they've never been there. I don't exactly know the mechanism where (indiscernible) looking for this as educators. It's not only how many conferences you've attended and how many books you've read, but translate that into action somehow.

ASSEMBLYWOMAN MURPHY: Right. Are you living what you've learned?

DR. ROBINSON: Right.

ASSEMBLYWOMAN MURPHY: And I guess--

DR. ROBINSON: I guess that's the enforcer role that the State has.

ASSEMBLYWOMAN MURPHY: I think that's like legislating morality.

DR. ROBINSON: Yes.

ASSEMBLYMAN THOMPSON: I think maybe, as a member of the Council, you should now come up here and question your testimony.

ASSEMBLYWOMAN MURPHY: John, these are good ideas. And with the permission of the Council, as we sit today, education is what we've heard about. You have synthesized it. If you have no objection, you are going to find these things clearly placed in our report to the Governor.

DR. HEATH: That's why I tried to make it as concise as I could. It's not specific, and it's not specific in large part because it's very hard to get it specific. And that's why I think it's worthwhile somehow emphasizing concepts in some respects.

ASSEMBLYWOMAN MURPHY: No, I agree with you. I think we all do because what we've heard about education is to educate the world of the fact that we are getting older in addition to everything else. And we are talking about educating young people about dealing with their retirement as they begin their careers and educating people and sharing your advanced directives and your wills and all these things with the people you expect to do this business for you when you're done -- and educating people about a slew of things. So this is-- And this is a very important part that covers so much of that but in a very supportive way. It's creative, and it speaks of things that I would never have thought about because I don't know about them. But you and Joanne appreciate so much, as does Renee, because you're in the throws of thin, and I thank you for that perception and that vision.

ASSEMBLYMAN THOMPSON: I would equate a great deal of the testimony we've heard today and throughout the hearings we've been having to my thoughts about the questions we've recently from Gannet News Services about public access to information.

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN THOMPSON: There really are two problems there. One problem there that they have related to access and likewise that we have is assuring people know what the rules are and that they're followed. In other words, knowing what is available and following it, the education part. The other part -- tinker with the system. You need to tinker with it to improve services, improve access, etc., but a major portion of problems is not so much that you need new regulations, or etc., but that you have to see that people are aware of the regulations, that they're followed, that they know what to do, etc., the educational as you say.

ASSEMBLYWOMAN MURPHY: Absolutely.

DR. HEATH: Let me give you an example of that. When I talked to some colleagues about this, one response that I had was that "why don't you just tell the State that before you renew your license, whether it be physician, nursing, whatever, you have to have X credits? In other words, just make a pure stick so to--" Another person, when I mentioned, "Hey, did you hear what Fred said," said, "Well, that would be ridiculous. That would be the best way to turn people off to the that particular topic because you're setting up -- you're forcing something down a person's throat." There may be situations in which a governmental interest would be critical for that. Driver's licenses -- you really do need to have this core knowledge. But wouldn't it be better to

not necessarily make it a requirement for licensure, but make it a positive aspect of it -- that "since you have your professional license, did you know that this is one of the exciting things out there that your discipline is involved with and, not only that, you can interact with other disciplines under the (indiscernible) of the State promoting it?"

ASSEMBLYWOMAN MURPHY: We have dealt with sticks in government for such a long time in the main that dealing with carrots is a little more awkward. We don't seem to handle it as well. It's not as easy to see, I don't think.

ASSEMBLYMAN THOMPSON: But it's similar to something I used to tell people when I was Director of Clinical Lab Improvement regarding the laboratory regulations we had out there. My view, with regards to the regs that we had, it is true, probably for 80 percent or more of the laboratories, we didn't need any regulations. They knew what was right. They were going to do it right. But it is that small minority out there (indiscernible) or not, they're going to try to cut every corner, they're going to cheat and not do things properly, and etc. And the same thing would apply here relative to whether or not you require it or you don't. A major portion of the physicians would, undoubtedly, take advantage of it if you put it that way. But some others that very much need it, the ones who probably need it the most, are the ones--

ASSEMBLYWOMAN MURPHY: That's right.

ASSEMBLYMAN THOMPSON: --are the ones least likely to do it.

ASSEMBLYWOMAN MURPHY: Yes, those are the parents that don't go to the drug awareness meetings because their kids will never get involved.

DR. ROBINSON: What nursing homes-- I just had a thought about competition and how to use that to spur people on. I've been working with nursing homes, trying to train them to understand and use continuous quality improvement methods. And what they have said is that they would appreciate or they appreciate this as an effort on the part of the State -- the Department of Health to improve quality to kind of raise the bar and to compete with one another. You know, they're looking for the State to identify and reward best practices in nursing homes, best practices of individuals, or departments, that sort of thing so that they can model themselves after those emplers and then maybe go beyond them. So that's a strategy as well.

ASSEMBLYMAN THOMPSON: They utilize a carrier approach. I think you have to do something else. Dr. Heath was suggesting there has to be some method of evaluating to give added recognition to those who take the extra step. So they've got kind of a gold star by their name that they can refer to that shows, "Hey, I did this," as opposed to somebody who opted not to.

DR. HEATH: Health systems do that on a regular basis when you see what the quality report is. I'm thinking, in particular, to your system when I see those newspaper ads. It's used in a very positive light.

ASSEMBLYMAN THOMPSON: Was that in the Medical Society that you do have some individuals who are classified as a diplomat of something or other because they did something extra? That's what you would need to do.

ASSEMBLYWOMAN MURPHY: It's the parking lot with your name on it for the employee of the month award. And it sounds so silly, but that parking lot is something people fight for -- that parking space because it's always very close to the door, and in the winter-- But it is just that kind of thing, yes. We do have to be more conscious of letting people know how valued their extra steps are.

DR. HEATH: It's especially important, I think, when we realize that so many of the services -- again maybe I'll come back to the New Jersey EASE. New Jersey EASE has a toll-free telephone number. I have a sneaking suspicion that the person who answers the telephone line ain't making a tenth of what my salary is, and yet the stress that that person may be under probably equals what my job is.

ASSEMBLYWOMAN MURPHY: And that person is the first person--

DR. HEATH: You can't pay that person what I make.

ASSEMBLYWOMAN MURPHY: That's right.

DR. HEATH: But at least you can reward them and give them time off the phone and allow them their chance to support that individual for it.

ASSEMBLYWOMAN MURPHY: Because they are the first--

ASSEMBLYMAN THOMPSON: But if you can make a jump shot you get paid a lot more.

ASSEMBLYWOMAN MURPHY: But they're the first link, and if they don't do their job well, that person is lost. So the importance of that first phone call--

What is it they say? You can only make one first impression.

DR. HEATH: One chance to make a first impression.

ASSEMBLYWOMAN MURPHY: One chance to make a first impression, yes. And I think that's really what they are for New Jersey EASE, they're the first chance.

Thank you all for being here. I'm so appreciative.

John, thank you so much for this wonderful work. We're very grateful to you. You are going down in history or at least in the report on paper.

Thank you very much, the meeting is adjourned.

(MEETING CONCLUDED)