NJ Health Care Access Study Commission

Jon S. Corzine
Governor

Heather Howard
Commissioner

Executive Summary

On January 11, 2006, Governor Richard Codey signed legislation (see Appendix 1), sponsored by Senator Loretta Weinberg, and Assemblymen Robert M. Gordon, Louis M. Manzo, and Neil M. Cohen, that created the New Jersey Health Care Access Study Commission. The Governor appointed 27 members to represent government, consumers, employers, unions, physicians, nurses, hospitals, health care associations and health care insurance plans. Matthew D'Oria, Deputy Commissioner for Senior Services and Health Systems in the New Jersey Department of Health and Senior Services, was named chairman. Ann Twomey was appointed vice-chair.

In addition to the principles that guided its deliberations, the Commission developed a comprehensive list of elements of a health care system that should promote the well-being of its citizens, address the concerns of providers and be fair to businesses and taxpayers. The health care system should:

- provide a comprehensive health benefit package to everyone that includes services across the life span of care - preventive, primary, acute, mental health, long-term and end-of-life;
- include parity for mental health and other services;
- promote health care quality and better, measurable outcomes;
- place patients and families at the center of the care process;
- maximize consumer choice of health care provider/s;
- provide care that is safe and effectively delivered;
- be affordable to individuals, families, businesses and taxpayers; as good health care is a shared responsibility;
- be cost-efficient with the maximum amount spent on direct patient care;
- be health and prevention-oriented emphasizing early intervention;
- eliminate disparities in access to quality health care;
- address the needs of underserved populations in urban and rural areas;
- address the need for adequate numbers of providers to guarantee access;
- foster a positive work environment for all health care workers that enhances retention in the workforce;
- provide adequate and timely payments to providers;
- foster a strong network of health care facilities, including safety net providers;
- ensure a continuity of coverage and care;
- standardize the use of information technology throughout the health care system to improve safety, improve outcomes and minimize system errors; and,
- enable patients and providers alike to participate in a system that is easy to use, transparent and reduces the mountain of paperwork.

The Commission developed eleven recommendations:

1. ***Address the Health Care for New Jersey (HCNJ) Proposal:*** proposes consideration by the Legislature of a New Jersey-specific health care coverage reform proposal called Health Care for New Jersey.
2. ***Develop a Coordinated Health Care Demonstration Project:*** calls for a health care demonstration project in several geographic areas to create a seamless, transparent system that serves the needs specifically of low-to-moderate income citizens.
3. ***Create the Office for Oversight of New Jersey's Health Care Workforce:*** advances the creation of an office for oversight of the State's health care workforce.
4. ***Address Critical Shortages of Nurses and Physicians:*** suggests measures for addressing critical shortages of nurses and physicians.
5. ***Increase Medicaid Rates for Health Care Providers:*** urges increased Medicaid reimbursement rates.
6. ***Improve Enrollment and Prevent Disenrollment in Public Health Insurance Programs:*** proposes streamlined forms for enrollees and encourages schools to gather information on those students who qualify for Medicaid or FamilyCare but are not currently enrolled to simplify the system of enrolling in public health programs.
7. ***Create A Guide to Health Care Literacy:*** suggests dissemination of a health literacy guide to help parents navigate the health care system and understand the vocabulary of health care.
8. ***Reduce Language Barriers to Improve Access:*** advocates that more action be taken to reduce the language barriers that often limit access to health services.
9. ***Improve Prevention and Disease Management:*** urges an emphasis on chronic disease prevention and increased disease management.
10. ***Improve Long-Term Care and End-of-Life Care:*** highlights the State's need to focus on improving the quality of end-of-life care.
11. ***Improve Strategies to Keep Coverage Affordable and Control Costs:*** offers ways to improve strategies to keep health coverage affordable and to control the seemingly intractable problem of ever-rising health care costs.

The recommendations submitted in this report are integral to "the goal of establishing a health care system that provides residents with access to health care regardless of income, age, employment or health status, and in which health care providers are able to provide patients with the quality health care that they need." Due to the complexity of the health care problems facing New Jersey, the Commission believes that these comprehensive recommendations should be considered in their entirety. Each plays an important role in shaping the new system. The Commission members recognize that the State's fiscal constraints are daunting, and may delay the implementation of some of the recommended projects. However, the cost of waiting to act may be larger than the investment necessary to effect change.

Introduction

The New Jersey Health Care Access Study Commission was established by Public Law 2005, Chapter 305, declaring, "There is an urgent need for an independent mechanism by which State policymakers can study and consider various options" for reshaping its health care system to better serve residents.

Governor Jon S. Corzine appointed 27 members to represent government, consumers, employers, unions, physicians, nurses, hospitals, health care associations and health care insurance plans. Matthew D'Oria, Deputy Commissioner for Senior Services and Health Systems in the New Jersey Department of Health and Senior Services, was named chairman. Ann Twomey was appointed vice-chair. Appendix 2 lists the four subcommittees appointed to sharpen the Commission's focus.

Matthew D'Oria, Chair
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Muriel M. Shore
NJ State Nurses Association

Jorge L. Verea
Primary Care Association, Inc., NJ

Henry Acosta
NJ Mental Health Institute, Inc.
Public Member/Advocate 1

Richard P. Miller
Public Member/Expert 1

The Commission heard presentations by:

- Senator Loretta Weinberg, sponsor of the legislation that created the Commission;
- Kenneth Thorpe, PhD, chair of the Department of Health Policy & Management in the Rollins School of Public Health of Emory University in Atlanta;
- Senator Joseph Vitale, chairman of the Senate Health Committee and a co-prime sponsor of the legislation;
- Dr. Jacob Hacker, Professor of Political Science at Yale University, and national consultant on health care; and,
- Hunterdon County Medication Access Partnership, a program that increases access to affordable prescription medication.

The Commission agreed that the State should be guided by several basic principles:

- Health care in New Jersey should be universal, with equal access regardless of age, gender, geographic area, health conditions, immigration status or ability to pay.
- Health care in New Jersey should also be comprehensive, including inpatient and outpatient care, mental health care, preventive care, emergency care, end-of-life care and prescription drugs.
- New Jerseyans should expect and receive high quality health care, no matter where they live or their financial status. Providers should be rewarded for positive outcomes and incentives should be provided for wellness and preventive care.
- All sectors of health care should be made more efficient. Duplication of services, medical errors, inept or non-existent use of information technology contribute to an inefficient system that serves neither patient nor health care provider and sends costs spiraling out of control. A greater share of health care expenditures should go for patient care, not administration.
- Responsibility for controlling costs and solving problems should be shared by government, insurers, providers, employers, and individuals, with transparency and accountability at every level.
- Affordability/Sustainability. The Commission recognizes that regardless of what health care reform is adopted, unless the delivery system is fundamentally changed (primarily workforce and practice pattern reforms), it will be economically unsustainable.

New Jersey's health care system is one of the most costly, confusing and fragmented in the nation. The Commission hopes that this report will assist State government in significantly improving it by affording the quality, efficiency and access to health care that New Jerseyans want and need.

Recommendation #1: Address the Health Care for New Jersey (HCNJ) Proposal

The "Health Care for America" model has been proposed by Dr. Jacob Hacker, a political science professor at Yale University and a nationally recognized expert in health care policy. The Hacker model proposes a hybrid form of universal coverage that maintains employer-sponsored and private insurance, while introducing a public option which would be available to the uninsured. It is viewed as creating a middle ground between the two competing proposals backed by advocates for universal coverage: a "single payer" system that relies exclusively on public insurance, and an "individual mandate" system that relies exclusively (or primarily) on private insurance.

While Hacker's proposal was originally designed as a national plan, he subsequently has described how it could be adapted by individual states. This adaptation is referred to in this document as Health Care for New Jersey (HCNJ).

The HCNJ plan deserves serious consideration by the Legislature. This is especially true because of the attention the Hacker proposal is receiving at the national level, and its recent evaluation by the Lewin Group, a national health care consulting firm.[1]

Components of the Health Care for New Jersey Plan:

A. A publicly administered health coverage pool similar to Medicare that would provide a comprehensive set of benefits at modest cost to individuals without employer sponsored insurance;

B. Shared responsibility of employers to either provide comparable insurance for their workers or contribute a payroll-based amount to help pay for their coverage under the new plan;

C. Requirement that individuals without employer sponsored insurance either purchase private coverage or buy into the HCNJ plan at community rated premiums subsidized to ensure affordability.

The major components of HCNJ are detailed in the subsections below. Goals/advantages and key decision parameters follow each subsection.

A. Publicly administered plan

HCNJ would provide a public health coverage option based on the Medicare model, which would be available for individuals whose employer does not offer health insurance and who elect not to purchase private coverage.

This public option would be financed by employer contributions and State funding. Reimbursement would be based on Medicare rates, with adjustments made to encourage medical homes, quality improvement initiatives, and services not covered by Medicare.

The public option would offer comprehensive, high-quality care, including, prescription drugs, mental health, and preventive care. Employers who continued to offer employment-based insurance with private plans also would be required to offer benefits comparable to the public option.

Further, the public option would adopt affordability protections so that participating individuals would be offered premium waivers or subsidies based on their income. In addition, there would be caps on total out-of-pocket spending for costs other than premiums (deductibles, co-pays, and co-insurance).

In addition, the new public option would be charged with developing standards (often in tandem with Medicare) to monitor and improve the quality of care. This could include initiatives such as a model delivery system based on a medical home, sophisticated information technology systems with electronic health records, and guidelines for best practices.

The public option is designed to cut costs through emphasis on better primary care and prevention, reduced administrative expenses (versus private insurance), rate setting, and concentrated purchasing power. These costs might be reduced further if the State is able to partner with Medicare's purchasing power to bargain for lower prices for prescription drugs and other expensive medical services.

The Commission has identified the following goals/advantages to the publicly administered plan:

- Makes affordable health care coverage available to all NJ residents.
- Provides a comprehensive benefit package.
- Potentially generates cost savings based on consolidated administration and purchasing power of a large public entity.
- Potentially reduces the cost of covering expensive uncompensated care for the uninsured that is built into the State budget and current premiums for private coverage.
- Can be used as a tool to drive broader system improvements.
- Provides new competition to encourage more innovation in the private sector.

While the Commission does not have the resources to fully address the details of the HCNJ plan, the following are presented as key decision parameters for the Legislature to consider and investigate further when crafting the HCNJ plan.

Key Decision Parameters:

- Cost containment - To make coverage affordable and sustainable, the State needs to slow the rate of cost increase in the health sector. Considerations need to be given to reducing inappropriate and non-cost effective utilization, e.g., review of new technology and pharmaceuticals.

- Pricing dynamics - The public plan is intended to reduce costs system-wide through purchasing power and transparency. However, if reimbursement rates in the public plan are too low, this might result in cost-shifting to the private sector leading to decreased participation. The State needs to analyze and monitor potential cost-shifting to private plans and consider this dynamic in setting rates in the public plan.

B. Shared responsibility of employers

HCNJ would incorporate a "play or pay" provision, which is intended to ensure employers' continued shared responsibility for financing health coverage. The provision requires employers to either provide health care coverage to their employees that is comparable to the public option or pay a percentage of their payroll (Hacker has proposed 6%) into a fund. The employer payroll tax would be used to partially finance the public health insurance option.

According to census data, employers provided coverage for 5.8 million people in New Jersey in 2006, representing about 71% of the non-elderly population, while employers nationally provided coverage to 63% of the non-elderly population. Employer sponsored coverage in New Jersey and nationally is declining, however. In 2000, the non-elderly population covered by employer sponsored coverage was 76.5% in New Jersey and 68% nationally. During the same period, the Kaiser Family Foundation estimates a 74% increase in the cost of coverage nationally.[2]

In the current system, there is no financial disincentive to prevent employers from dropping health coverage for their employees. The "play or pay" provision is meant to introduce a financial incentive for employers to maintain employee coverage despite the creation of a public health insurance option.

The Commission has identified the following goals/advantages to the shared responsibility component:

- Maintains employers' shared responsibility for financing health care coverage by requiring that they either provide adequate coverage or pay an amount based on payroll into a fund supporting the public option.
- Reduces the amount of funding required for HCNJ in the State budget by creating a revenue stream of private sector funding.
- Eliminates competitive disadvantage to employers who provide coverage but compete with employers who do not, by requiring all employers to make some financial contribution toward health care costs.
- Since HCNJ includes an individual mandate, it may be perceived as more equitable to also include an employer mandate.

Key Decision Parameters:

- ERISA may place some restrictions on the HCNJ "play or pay" provision. The challenge for the State would be to structure the "play or pay" provision so that it could survive a legal challenge.
- Determination of comparability - The goal of the HCNJ plan would be to encourage private plans to offer benefits comparable to the public option. One challenge is that it would be administratively difficult to determine comparability because of design variation among the large number of private plans. Additionally, ERISA will likely place limits on requiring what benefits are provided in self-funded plans.
- Impact on employer decision-making - The HCNJ plan would create new considerations for health care purchasing for NJ employers. The State should consider potential employer decisions about sponsoring coverage, increasing/decreasing employee cost sharing, locating/expanding in NJ, etc.
- The Legislature should consider a rational and equitable means for calculating the employer payroll contribution. Further, the Legislature may want to consider an option to exempt small employers from the "play or pay" provision.
- Many NJ residents work outside of the state (e.g., in New York or Philadelphia). Changes in employer-based coverage in these labor markets can have a direct impact on HCNJ, especially if out-of-state employers drop coverage without requirement to pay NJ payroll taxes. Conversely, improvement in employer-based coverage for border-crossing workers would have positive impact by increasing coverage without state funds. Changes in out-of-state employer-based coverage should be monitored as part of the implementation of HCNJ.

C. Individual mandate

Under the HCNJ proposal, all New Jerseyans would be required to demonstrate proof of health insurance. New Jerseyans who do not have direct or family ties to the workplace and who are ineligible for existing public programs (Medicare, Medicaid, SCHIP) would be required to purchase health care coverage. They would have the option of gaining coverage through either the public option or through alternative qualified private plans, just as they do with the current Medicare system.

To ensure affordability, the public option would be subsidized for individuals on a sliding scale based on income. The subsidy should ensure that the combination of premiums and cost-sharing is limited to a set maximum percentage of household income (to be determined by the State).

Individuals and families currently covered by Medicaid and SCHIP could either be folded into the new HCNJ plan or continue as is. The former option would require a federal waiver, but would reduce fragmentation of public coverage. The latter would mean no changes in these existing programs.

The Commission has identified the following goals/advantages to the individual mandate:

- Reduces the number of uninsured individuals in New Jersey.
- Improves quality of care and health outcomes because individuals have coverage for preventive visits.
- Reduces charity care and uncompensated care.
- Maximizes federal match if all eligible families enroll in Medicaid and SCHIP.
- By ensuring that New Jerseyans will not pay more than is affordable, HCNJ would reduce resistance to an individual mandate.

Key Decision Parameters:

- The Legislature should determine an effective means of enforcing the individual mandate that is efficient but not punitive.
- The Legislature should address the challenge of determining affordability. This may involve considerations beyond income level, including outstanding debt and other hardships.
- The cost containment issues mentioned in Component A should also be considered as a mechanism to promote affordability of mandated coverage for individuals with limited means (in addition to system-wide efficiency and sustainability).
- The Legislature should evaluate the option of incorporating the Medicaid and SCHIP population into HCNJ.

Action Steps:

If the Legislature decides to pursue HCNJ, it may wish to pursue the following specific steps:

- Invite Professor Hacker to assist in drafting legislation. In October 2007, Professor Hacker made a presentation to this Commission, and he also met with representatives from Governor Corzine's office and Senator Vitale's office. At that time, he expressed a willingness to assist New Jersey in the future, including helping to draft proposed legislation.
- Obtain a comprehensive analysis of the cost of implementing the proposed Health Care for New Jersey legislation from a well-respected consulting group. Other states that have considered implementing universal health care reform legislation have commissioned such studies. For example, in January 2005, the Lewin Group provided an estimate of the cost of providing universal coverage under California Senate Bill 921. As noted above, the Lewin Group has also published a comprehensive cost impact analysis of the national Hacker plan (Health Care for America).

Recommendation #2: Develop a Coordinated Health Care Demonstration Project

The New Jersey health care system is costly, sometimes confusing and very fragmented. This Commission is not the first to make that observation. In its recently released report, the New Jersey Commission on Rationalizing Health Care Resources noted that New Jersey and many other states do not have a "rational health system" that serves all the state's residents.[3]

Specifically, the quality of care for low-income residents in New Jersey is dependent upon a patchwork of safety net providers. Hospital emergency departments and Federally Qualified Health Centers (FQHCs) are often the central point of entry for this population. The resulting care can be episodic, which reduces quality, promotes inefficiencies and raises costs.

In some regions of the state, the system has reached the crisis stage. Hospitals, especially those in inner cities, are confronted with limited reimbursement for charity care and an ever-growing uninsured population that needs care but has no other place to turn. FQHCs are growing rapidly and are great access points, but they also have the same constraints which can at times limit their ability to act as a true medical home.

The Commission recognizes that all providers are important components of the health care continuum and that the right care at the right location improves quality and reduces costs.

Studies show that systems -- which rely on a strong primary care base and a patient-centered medical home for all -- promote high quality and cost effectiveness in preventive care, care networks and chronic disease management.[4-23] It is important to expand the primary care networks to reduce the emergency department visits by people who do not have a primary provider.

The primary care provider is the foundation for cost-effective, high quality patient care. Yet the number of primary care physicians coming out of medical schools and the number of advanced practice nurses are not keeping pace with the need. In an Atlantic Monthly article in December, 2007, author Shannon Brownlee looks at the numbers and kinds of doctors entering health care. [24]

"Medical schools are now graduating more and more specialists and fewer and fewer primary care physicians. Between 1997 and 2005, the number of U.S. medical graduates entering family practice residencies fell by 50%, as young doctors headed for more lucrative specialties like orthopedic surgery and radiology…As the total number of doctors rises and the proportion of primary care doctors falls, we're likely to see the quality of care deteriorate further and the cost of care increase rapidly," writes Brownlee, a Senior Fellow at the New America Foundation.

On the nursing side, New Jersey colleges/universities graduate approximately 260 advance practice nurses a year, which is not enough to keep pace with the growing demand.

There has been little exploration of ways to expand beyond FQHCs the primary care network in the state, which could potentially fill the described access crisis and deliver high-quality care at lower costs.

The Commission believes the following demonstration project, which emphasizes primary care as the core of managed patient treatment, can become a model. The Commission further believes that with improved management of care, medical services can be provided at lower costs to a larger segment of the population and thus improves access.

Action Steps:

- Design and sponsor demonstration projects in several geographic areas to coordinate and integrate hospitals, primary care providers, FQHCs, pharmacy services and other health services into a seamless, coordinated network to provide low-income patients with a model delivery system. The state would issue the Request for Proposals (RFP).
- The state will provide three-year seed grants to hospitals and primary care providers within these pilot areas to develop a coordinated approach to managing indigent care. The effectiveness of the project will be evaluated during this time.
- Each patient would have an electronic health record and providers in the network have to be able to access these records to participate.
- Payment rates should be increased by the state for participating providers on selected services such as counseling and follow-up for chronic conditions.
- Patients will have a medical home, a single provider or group for preventive and on-going care, including mental health services.
- There will be transparency and accountability between patients and caregivers.
- A 1115 waiver approval for the demonstration project will be required from the Centers for Medicare and Medicaid Services (CMS).
- Local health departments in coordination with social services and pharmacies will ensure access to medications. Medications for chronic conditions such as asthma and diabetes should be free to patients.
- The demonstration project focuses on the collaborative care model that involves all health care providers, including hospitals, physicians and nurses.

  The vision for the health care demonstration project is based on efficiency, patients as partners in a healing environment and improved quality outcomes.

Efficiency

1. The new model will be efficient and more of the premium dollar will go to patient care. Currently, only 80 to 85% of the premium dollar pays for health care where this model will increase that percentage to more than 90%. Large amounts of data will move electronically and inexpensively.
2. On the practitioner level, unnecessary and cumbersome procedures will be eliminated through electronic verification of eligibility, benefits and payment.
3. Card swipe technology, electronic data interchange, and electronic banking will be implemented to eliminate paper processes and promote transactional efficiency.

Patients as partners in a healing environment

1. This health care model will promote the concept of a medical home for each patient. Patients will understand there is a single provider (physician/office, physician group practice, ambulatory care center or clinic) where they will receive on-going care, including preventive care. All medical records and information will be stored electronically and be able to be transmitted to any other provider involved in their care.
2. This project will support the chronic disease model. Practitioners and patients will be linked to the community and community resources; patients will be motivated to take control of their illness.
3. There will be transparency and accountability both for patients and providers. Patients will know how much practitioners are paid; practitioners will know how much is spent on administrative functions; and there will be one fee schedule, open for all participants to view. Measures of quality, cost, and outcomes will be available.

Safety, Quality and Improved Outcomes

1. The use of point of care electronic databases and electronic reference systems will help educate patients and help health care providers practice evidence-based care.
2. Patient safety is enhanced through drug interaction monitoring systems, disease registries and tracking systems for laboratory services and x-rays.
3. After the infrastructure is in place, the system will be able to measure, manage and provide incentives for quality outcomes.
4. The system will demonstrate the impact of health care provider services on patient outcomes.

Recommendation #3: Create the Office for Oversight of New Jersey's Health Care Workforce

New Jersey, like the rest of the nation, faces shortages in the supply of several classes of health care providers including but not limited to registered nurses, home health care aides, and primary care physicians among others. The state is projected to have a 25% nursing shortage by 2010 and similar shortages are expected in various allied health professions, specifically radiology technicians and clinical support staff.[25] The nursing and physician shortages are addressed in Recommendation #4.

Although specialized advisory councils exist for nurses, medical education and physician supply, there is no such body that monitors and addresses shortages across the health professions. The lack of an integrated body to oversee the state's health care workforce is problematic for several reasons:

1. Shortages in multiple provider areas create competing demands on state resources.
2. A growing number of patients have multiple and complex illnesses that require team-based approaches to medical and health care services. The team imperative is lost when work force planning is done in silos across professions.
3. Changing technologies and treatment regimens can alter the mix of professionals required to treat specific diseases (e.g., a new drug-based therapy reduces demand for surgeries and increases demand for care management). Only a comprehensive workforce office can respond appropriately to these changes.

Action steps:

- The state should create an Office for Oversight of New Jersey's Health Care Workforce. The Office, with input from the existing professional monitoring groups, would be responsible for monitoring the supply and demand of independent practitioners; that is, professional health care workers who have independent decision-making powers in regard to patients. This would include physicians, physician assistants and advanced practice nurses, among others.
- Based on this monitoring, workforce recommendations would be made to address current and emerging health needs of New Jersey residents. The Office should provide an annual report to the Governor and the Legislature.
- For professions that are deemed to be under-supplied, the Office will make recommendations to increase supply or redirect demand as appropriate. The range of recommendations may include training subsidies, reimbursement reform, regulatory/licensure changes, publicity about shortage areas or other actions that analysis may warrant.
- Although the supply and demand for nurses might be monitored by surveying institutions that employ them, the Commission recommends that monitoring take place on an individual level to ensure that all nurses are accurately counted regardless of where they work.

Execution of this component should be informed by, and potentially coordinated with, the approach currently used by the Board of Nursing and Collaborating Center.

- The Office should consider examining related issues such as workplace conditions which include understaffing and patient workloads. Poor workplace conditions can influence retention of health care workers and ultimately affect patient care.
- There should be continued discussion on where to locate the office, which might be in the state Department of Education or the state Department of Labor.
- Because of its overlapping functions, the Office should include representatives and/or solicit input from professional licensing Boards, professional associations representing the disciplines, the Department of Education, the Department of Labor, the Department of Banking and Insurance, the Department of Human Services, the Department of Health and Senior Services and the Commission on Higher Education. The Office should also coordinate with related but more specialized bodies such as the Advisory Graduate Medical Council of New Jersey and the New Jersey Collaborating Center for Nursing at Rutgers College of Nursing.

Recommendation #4: Address Critical Shortages of Nurses and Physicians

Nurses

There is a serious nursing shortage in New Jersey today and even a worse one projected into the next decade. According to the New Jersey Collaborating Center, the registered nurse (RN) supply force in 2010 will be 55,000 with the demand projected to be 74,600.[26] By the year 2020, the RN supply will decrease to 44,900 with the demand at 87,300. That means there will be a 33% increase in demand from 2000 to 2020.

Numerous research studies as well as surveys of registered nurses document the multiple effects of nurse staffing levels - on patient care outcomes, on nursing "burn-out' and retention rates, and on the costs to the health care system.[27-29] Poor patient outcomes, increased medical errors and higher mortality rates are linked to short-staffing. Over and over again, nurses report unsafe staffing and workload as main reasons why they consider leaving the profession. This turnover rate adds to the shortage, and increases significantly replacement and training costs for RNs. In its 2005 report, a special advisory panel to the Governor addressed the issue of establishing nurse to patient ratios as one of its highest priorities.[30, 31]

Nursing leadership in New Jersey has worked on various legislative proposals in the past to address nurse education/practice issues. For more information on one of the most significant reports authored by the nursing community, see Appendix 3.

The following action steps can improve the nursing picture for years to come.

Action steps:

- Address the nurse faculty shortage, especially in baccalaureate and graduate nursing education programs in an effort to increase nursing student enrollment at the undergraduate and graduate levels.
- Support the establishment of Doctoral Programs in Advanced Practice Nursing in New Jersey.
- Address the disparity of nurse faculty salaries based on doctoral and master's education and experience. (Compare to medical schools, law schools and business programs).
- Encourage the development of a state-wide hospital based clinical scheduling system so faculty can more easily place students for clinical practice. The web-based system would identify clinical facilities by name, clinical areas, with dates and times of availability for student clinical placements. Faculty could access locations via the web.
- Create incentives for educational facilities and health care agencies to utilize joint appointments and other professional joint sharing agreements to bridge academia and service in the education of nurses.

- Require safe staffing in hospitals, the basis of which should include nurse education and experience.
- Require the New Jersey Department of Health and Senior Services (NJDHSS) to re-examine its current hospital nurse staffing regulations.
- Overhaul state grants and loans for nursing students to allow for full time study without interruption. Abolish financial limits based on the number of credits which often slows down the student's progression through the nursing program.
- In an effort to recruit a more culturally diverse student nurse pool, evaluate the current New Jersey Board of Nursing requirement that a school's accreditation standing is based on the results of the National Council Licensure Examination (NCLEX) exam pass rate of at least 75% each year within a three year time period for first time test takers.
- The NJDHSS should establish licensing requirements requiring hospitals to establish job descriptions for nurses based on education and experience. One way to accomplish this is to require clinical ladders within institutions.

Physicians

The Avalere report highlights the declines in the last five years of the number of licensed physicians practicing Obstetrics/Gynecology, General Surgery, Orthopedics, Gastroenterology, Cardiology, Infectious Disease and Neurosurgery.[25]

While New Jersey is no different from other states in terms of the aging population requiring more care and the aging physician workforce retiring, the state does have some unique challenges. New Jersey physicians are the third oldest in the nation, the most foreign-trained, paid the lowest amount by Medicaid, receive no direct reimbursement from charity care funds and have no caps on insurance awards, among many factors that influence morale.

Particularly troublesome is that medical schools are producing fewer and fewer primary care physicians. As Robert Doherty, Senior Vice-President at the American College of Physicians, noted in a March 2007 Physician News Digest article, "Care that is managed and coordinated by a personal physician with the right tools will lead to better outcomes."[32] Furthermore, he says that personal primary care physicians achieve better outcomes for lower costs.

In New Jersey, there are only 16.8 family physicians for every 100,000 people compared to the national average of 26.4.[33]

Fellowship training programs for sub-specialists in disciplines such as Neurosurgery or Pediatric Cardiology are generally funded outside of Medicare. When teaching hospitals were highly profitable, funding was self-generated. In today's environment, New Jersey has few fellowship programs. This is one of the primary factors cited by our medical residents as the reason they leave the state after completion of their residencies.

The New Jersey Council of Teaching Hospitals conducted a survey of residency directors of the state's teaching hospitals in 2006. The survey results indicated that almost 60% of the medical residents completing training in New Jersey were leaving the state to practice or for fellowship training in a subspecialty.

Action Steps:

- Remove Economic Barriers to Help Recruit Well-Trained Physicians. New Jersey should be at least as friendly as other states in attracting specialists. Medical malpractice rates must be studied to determine what measures will be effective in making these rates more affordable to practitioners.
- Retain Residents. Many graduating medical/surgical residents leave New Jersey to seek more advanced fellowship training. These fellowship positions should be funded within the state using private and state dollars. New residency positions should be created for the specialties needed.
- Recruit More American Residents to Train in New Jersey. To be competitive with recruitment efforts from other states, New Jersey should offer comparable medical school loan forgiveness programs where the forgiveness is tied to practicing for a designated period of time in the state.
- Increase the Number of New Jersey Medical Students. The University of Medicine and Dentistry of New Jersey (UMDNJ) should expand its class sizes as much as possible. We should embrace the Caribbean medical schools and create a comprehensive, integrated New Jersey medical school/residency program under the auspices of UMDNJ.
- Develop a detailed Physician Assessment, Recruitment, and Retention Plan, which should be studied and approved by the Advisory Graduate Medical Education Council of New Jersey (AGMEC).

Dentists

The Commission believes that an oral health care component is critical to improving the overall health condition in New Jersey. The Commission understands that dentists are experiencing similar difficulties to those issues enumerated in this report ranging from extremely low Medicaid reimbursement rates to shortages in dental auxiliary personnel to a broader lack of proper oral health education. Certain oral health programming is already being done by the New Jersey Dental Association and others to help improve conditions in this state. Therefore, the Commission recommends that an oral health component be examined in the future and that many of the action steps herein should be refined to include, where appropriate, a dental component; and that those organizations who are focused on dentistry and oral health should be consulted prior to any recommended action steps being enacted.

Recommendation #5: Increase Medicaid Rates for Health Care Providers

New Jersey's Medicaid rates for providers (physicians, physician assistants, dentists and advanced practice nurses) are among the lowest in the country. According to the 2006 New Jersey Health Care Almanac by Avalere Health,[25] across all types of physician services, New Jersey's Medicaid program pays an average of 56% of the average rate paid by all Medicaid programs in the country. Compared to Medicare's payment rates, New Jersey's Medicaid rates for physician services appear to be even lower, amounting to 35% of Medicare payment rates for all physician services.

The Commission acknowledges that a Medicaid rate increase to pediatric providers took place on January 1, 2008. It was the first rate increase to physicians in approximately 20 years. Governor Corzine added $10 million in state funds for Medicaid reimbursement rates for 2008 and the federal government's matching funds brings the total to $20 million for pediatric providers. Medicaid fee-for-service providers who treat patients under 21 years of age will be reimbursed at a rate four times higher than previous rates.

But the fees for providers treating adult patients remain excessively low, forcing physicians to leave the program or not accept more Medicaid patients, who are largely the working poor. Inadequate payments for services also prevent physicians from investing in staff and health information technology to support quality measurement initiatives.

With fewer primary care providers, specialists and sub-specialists accepting Medicaid patients, the risk of not having enough providers throughout the state is growing.

Action Steps:

Develop a strategic plan to change reimbursement within state health care programs that will:

- Increase Medicaid provider fees to at least reflect the national average. The Commission recognizes that the New Jersey Commission on Rationalizing Health Care Resources also recommends that Medicaid rates for practitioners be at least 75% of Medicare rates. The increases should be applied to fee-for-service and managed care.
- Tie future provider rate increases to measurable improvements in access to quality care.

Recommendation #6: Improve Enrollment and Prevent Disenrollment in Public Health Insurance Programs

New Jersey should streamline enrollment and retention policies for individuals and families in the state's public health insurance programs without compromising the programs' integrity. Many people who qualify for Medicaid and NJ FamilyCare are not enrolled for a variety of reasons - complicated enrollment procedures, lack of awareness, affordability of premiums and varying levels of efforts by hospitals to enroll charity care patients in public health programs. Furthermore, there is no mechanism to prevent eligible individuals from losing coverage during recertification.

Action Steps:

- Since most program enrollees do not experience large income gains from year to year, the state should administratively recertify most current enrollees in subsequent years.
- To discourage people from remaining in a public health program when they are no longer eligible, enrollees must be given clear instructions on how to report income changes followed up with clear audit and enforcement procedures.
- The state should explore the use of tax records to ensure that individuals who are no longer eligible do not remain in public programs. The enactment of this approach will require privacy safeguards, coordination with tax authorities, and enabling legislation.
- The New Jersey Department of Education requires schools to keep track of information about children, including insurance coverage. This information should be mandatory so that children without health insurance and whose families qualify financially can be enrolled in the State Children's Health Insurance Program. (SCHIP).
- The form to apply for Charity Care, Medicaid and FamilyCare should be simplified (one page). Individuals should receive help in completing the application and appropriate follow-up.

Recommendation #7: Create a Guide to Health Care Literacy

Many individuals, particularly in underserved populations, do not know how to navigate the health care system and are unsure when to take action when a child is sick. Nor are they aware of how to deal with the health needs of aging parents and others for whom they have responsibility. Furthermore, people from many backgrounds often do not understand the vocabulary of health care.

NJDHSS recognizes the importance of providing health information in clear, understandable language. Health information can include instructions from a physician to a patient on how to care for themselves, instructions from a pharmacist on taking medications, discharge instructions to a patient being released from a hospital, information contained in patient education brochures, pamphlets and flyers. Health information is also provided on websites, at health fairs and other public venues.

There are many factors that influence health literacy, i.e., how someone processes and acts on the health information that they have obtained. Those factors include age, disability, education, language, culture and emotion. It is important that health care providers are aware of the factors that can influence the way their patients receive information and adjust how information is delivered to diverse patients accordingly.

In March 2007, the Office of Minority and Multicultural Health in NJDHSS brought in a health literacy expert to conduct a two-day workshop to train staff of NJDHSS who develop health materials on the importance of easy-to-read health information, the principles of plain language, how to develop simple, clear, concise health materials and a checklist for assessing document readability. All materials produced by the NJDHSS should meet these standards.

Action Steps:

- NJDHSS should develop a web-based guide to health literacy resources that targets families and individuals across age groups. A specific section of the resource listing should focus on meeting health care needs of families with young children. A recent California pilot program showed a 41% drop in missed school days and a 48% drop in unnecessary emergency room visits after parents received training in clear, understandable language about what to do when their child gets sick.[34] The website guide should also include information on resources in New Jersey.
- The web based literacy guide should also include information in clear, understandable language to help families cope with the unique health needs of aging parents. This guide should include specific sections on where to seek help in New Jersey.
- The literacy guide should list and define commonly used health terms that people will hear in physician offices and hospitals. The more educated about health care people become, the better equipped they will be in understanding and managing their health and the health of their children and parents.

- The website should post information on training for providers to increase awareness of the factors that influence how patients receive information and address how information is delivered to diverse patients.
- Materials on the web-site can be printed and distributed to FQHCs and made available to all other providers as a printed document to give patients. Information should be disseminated through local community and neighborhood associations, including churches and synagogues.
- The NJDHSS can investigate sponsors for developing the web-based health literacy guide and cover printing and distribution costs.

Recommendation #8: Reduce Language Barriers to Improve Access

New Jersey is a diverse state with many languages spoken in urban pockets and neighborhoods throughout the state. The numbers of people who speak little or no English represents a growing patient population for the health care industry, according to Hablamos Juntos, a program sponsored by The Robert Wood Johnson Foundation.

The inability to speak English, in particular, has been empirically associated with less care-seeking and diminished access.[35-37] Also, language access in health care means providing access not only at the many junctures within a single patient encounter (including triage, appointment-scheduling, registration, wayfinding, pharmacy, and lab) but also across the continuum of care, which may involve multiple referrals and settings.

Language influences how patients access and experience health care. Because of language barriers, patients often have the following problems:

Problems for Patients:

- Lack of awareness of existing services;
- Difficulty in making appointments and finding out relevant information when they do seek care;
- Inability to communicate adequately with health care support staff;
- Low patient satisfaction which creates a reluctance to return for care;
- Non-English speakers are less likely to receive preventive services.

Problems for Providers:

- Difficulty in making an accurate diagnosis;
- Difficulty in convincing patients to comply with a treatment regimen they may not understand;
- Limited success in health education efforts.

Action Steps:

- Appoint a task force to assess the impact of language abilities on access to health and mental health care services. The task force should be charged with developing specific and measurable recommendations to address the issue of minorities' access to health care. These recommendations may identify shortages of trained professionals with language skills in specific health or mental health care services. The commission could also designate a state entity for the interpretation and translation of all health and mental health care related forms.

- Provide guidance and support to licensed health and mental health care facilities to implement strategies in four areas: assessment (facility conducts a thorough assessment of the language needs in the community); developing a written policy on language access for each facility; staff training to ensure staff understands and can execute policies and monitoring to ensure the policies are working.
- Work with organizations to create a state-wide event or workshop that bring together health care professionals to discuss language barriers and present best practices. Information on the impact of language barriers on patients and providers has been developed by The Robert Wood Johnson Foundation's Hablamos Juntos Program. The program is located at the Tomas Rivera Policy Institute at Claremont College in Claremont, California.

Recommendation #9: Improve Prevention and Disease Management

New Jersey's continued success as a state depends on the health of our residents. It is in its best interest to align state policies to create a health care system that optimizes the health of our population, reduces health disparities, and eliminates unnecessary costs. And yet, the state healthcare system, like the nation's, struggles to provide quality health care at an affordable price. Research shows a number of factors contribute to high costs and poor health outcomes.

The U.S. has the highest per person healthcare spending among industrial countries but, the U.S. ranks 28th in life expectancy and 37th in health system performance, according to a World Health Organization report for the year 2000.[38] Although life expectancy is influenced by many factors outside of the health system, the U.S. also performs poorly in healthcare-specific outcome measures such as mortality amenable to medical care, which is defined as mortality associated with conditions such as bronchitis and leukemia that are heavily influenced by the availability and quality of medical care.[39]

Chronic illness is on the rise. Half of Americans have one or more chronic illnesses.[40] Obesity rates have doubled and diabetes is on the rise. Three-fourths of U.S. health spending is devoted to chronic illness.[40]

Poorly managed chronic illness is a major source of avoidable costs. Although established protocols for chronic care management exist, a number of organizational and financial barriers prevent these protocols from being followed.[41] As a result, fairly routine medical problems lead to more complex and costly emergency room visits,[42] preventable hospital admissions,[43] and repeat admissions.[43-46]

Action Steps:

- Promote Prevention: Reducing a patient's out-of-pocket expenses is one way to encourage individuals to get recommended preventive care services or better manage their chronic diseases. The premise is that increasing access and compliance with primary care and screenings will reduce long-term costs associated with advanced disease states and hospitalizations. Reductions or eliminations of co-payments should occur without corresponding reductions to provider payments. Like Vermont, New Jersey's State Health Benefits Plan should create a set of clinical performance measures for each chronic condition and reduce out of pocket expenses for participants for each clinically recommended service. As described in a recent Health Affairs article, prominent health economist Ken Thorpe argues that Vermont's use of an innovative chronic care delivery model, new IT tools, and reductions in hospital cost shifting will significantly reduce the rate of health care spending in the state.[47]
- Provide Incentives for patients who engage in healthy behaviors.
- Promote Wellness: Public awareness of individual responsibility for health, wellness and

preventive behavior should be promoted by partnering with public health officers, providers, schools and other organizations. Employers should be encouraged to provide workplace wellness programs. The state should continue to initiate strategies to improve childhood nutrition and physical activity.

- Manage Chronic Disease: Promote better management of chronic diseases (such as diabetes, asthma, and cardiovascular disease) through patient coaching, testing, and disease management programs, and consider putting drug treatments for those conditions into the lowest cost formulary tiers to encourage compliance. Proven chronic care management should be integrated into all state programs and enrollees should be encouraged or required to participate. Medicaid should analyze characteristics of high cost patients often referred to as "frequent flyers" who are at greatest risk of future hospital admissions and develop preventive care strategies to avoid costly episodic care. Studies have shown that even sizable investments in the improved health of potential high cost patients can be offset by savings from reduced hospital admissions.
- Establish Medical Homes: Improve acute care and chronic disease management by ensuring that all New Jerseyans have a medical home with a primary care physician and by encouraging participation in case management and disease management programs, particularly in the Medicaid/FamilyCare population. The State should support hospital pilot programs to establish Emergency Department Diversion programs which would allow for proper case management so that patients can be routinely referred to outpatient clinics, FQHCs and primary care providers for non-emergency care. Funding for these programs would also allow hospitals to employ health care providers to ensure that patients comply with follow-up care in order to decrease inappropriate emergency department utilization.
- Improve Care Management: Research has demonstrated the potential of various care management programs to reduce costs and improve health outcomes simultaneously.[23,48] However, these benefits are not always guaranteed, especially if physician involvement and financial incentives are not well coordinated.[49] In addition, the targeting and implementation of these models is often challenging and can be resource intensive, especially in the start-up phase. To facilitate the use of proven care management methodologies, the state should work with an expert panel to identify best practices in disease management and case management for specific populations (e.g., Medicaid, commercially insured). Reimbursement incentives should be provided through Medicaid and the State Health Benefits Program to encourage providers to use the identified practices. Findings from the deliberations of the state's expert panel should be made public for use by commercial payers.

Recommendation #10: Improve Long-Term Care and End-of-Life Care

Elderly residents of New Jersey deserve to have as many options as possible when it comes to long-term care. Nursing homes should not be the only choice for older seniors who often want to receive services at home rather than in an institutional setting. There are 45,000 people receiving long-term care services in New Jersey.[50] Nursing home residents make up roughly 60% of that population, and clients receiving home and community based services make up the rest.[50]

Due in some part to the Independence, Dignity and Choice in Long-Term Care Act (2006), the State has increased the availability of home and community based services to New Jersey's aging population. Research shows that opportunities remain to improve services provided to clients in need of long-term or end-of-life care.[51]

Also, there are growing questions about how to treat patients facing the end-of-life. A study by Dartmouth Institute of Health Policy and Clinical Practice in New Hampshire showed that Medicare patients in New Jersey undergo more tests, see more doctors and endure more procedures at the end-of-life than patients in any other state, even though they do not live longer or suffer less than patients in similar circumstances in other states.

Action Steps:

- Focus on quality of long-term care: Continue to improve the availability of home and community based services and evaluate the utilization of managed care plans to administer long-term care services for Medicaid members. In other states, managed long-term care has led to increased utilization of home and community based services and realized state budget savings.

  For example, the Lewin Group's review of research on managed long-term care reports estimated savings of 17% in Texas, with accompanying increases in utilization of adult day programs and personal assistant services and decreases in emergency room utilization and inpatient stays.[52] New Jersey spends $4 billion annually (state and federal) on long-term care for Medicaid beneficiaries. This is nearly half of total spending on the Medicaid population. While 75% of the Medicaid population is enrolled in managed care plans in New Jersey at this time, Medicaid clients in long-term care are not. The New Jersey Legislature directed the New Jersey Department of Health and Senior Services in the 2009 Appropriations Act to evaluate and use private managed care plans to administer long-term care services. The report cites the experience of other states using managed care organizations "to better control the rise in long-term care costs by monitoring patients in both institutionalized and home settings, managing their care, and making sure health expenses are appropriate."
- Hospice Care: Develop strategies to foster clinically, ethically, and culturally appropriate end-of-life care, including palliative and hospice care based upon best scientific evidence.

- Advanced directives: Offer patients the opportunity to complete an advanced directive, upon entry to a nursing home, home health, or other critical point of access. Advance directives should be promptly communicated to health professionals providing care to the patient to ensure that the patient's wishes are known. Providers at all levels should be educated about the need to honor these directives.

Recommendation #11: Improve Strategies to Keep Coverage Affordable and Control Costs

Higher health insurance costs result from the failure of the health care system to insure all residents. In 2005, roughly 1.3 million or about 15% of New Jersey residents did not have health insurance.[53] When the uninsured seek care in New Jersey's hospitals, the bill often goes unpaid. These costs are then shifted to other payers, such as employers, increasing the cost of health insurance by as much as 20% nationally.[54] In addition, 10-12% of the costs of charity care provided by New Jersey hospitals to low-income uninsured residents are likely avoidable with earlier access to primary care.[55] The Kaiser Family Foundation study found a nearly 90% increase in the cost of health insurance since 2000.[2] The Towers Perrin 2007 Health Care Cost Survey expects that the average cost of employee health coverage for the nation's largest employers will increase to $8,748 per employee in 2007.[56]

Healthcare costs are consuming larger portions of the nation's gross domestic product (GDP). Currently, the United States spends more than 15% of its gross domestic product, or $2.1 trillion, on healthcare.[57] This number is projected to reach $4.1 trillion by 2016 or one out of every five dollars in the US economy.[57]

Employers continue to pay the bulk of these high costs. The Kaiser survey reported that employers in the Northeast pay on average 83% of health insurance costs for single employees and 80% of costs for families, with coverage rates varying depending on the type of plan.[2] Ultimately, the majority of these costs are borne by workers through reduced or stagnating wages and the reduction of other fringe benefits.[58]

Action Steps:

- Affordable Health Insurance: Provide lower cost policies that cover essential healthcare services for small businesses purchasing in the regulated insurance market. This means a review of benefit mandates, flexibility in the structuring of cost sharing and other reforms to ensure affordability. Such policies could be offered to small businesses that have not offered health benefits in the recent past. The Mandated Health Benefits Commission's responsibilities should be expanded to include the review of the impact of various health benefits coverage mandates on small employer health insurance premiums.
- Minimize Cost Shifting: Slow the rate of growth of health insurance premiums by reducing the number of uninsured New Jerseyans and increasing Medicaid reimbursement rates to minimize the cost shift. Appropriate Medicaid reimbursement levels, for both Medicaid managed care and fee-for-service plans, should reduce cost-shifting from public to private programs and assure covered individuals access to care. This program, which serves our State's neediest population, is negatively impacting the commercial insurance marketplace due to low reimbursement levels which have the effect of shifting costs to private patients.

This cost shifting creates higher premiums for employers and contributes to cost escalation which prices some individuals and employers out of the market. Increased reimbursement to providers would also incentivize more providers to accept Medicaid patients. Expanding the Medicaid provider network has two advantages: first, a greater array of providers is available for existing members, which can help to reduce costly emergency department utilization and improve access to care overall; second, the expanded network encourages Medicaid enrollment among eligible individuals who are currently unenrolled, thereby providing access to the benefits of a medical home and reducing dependence on charity care. The Department of Banking and Insurance should evaluate how recommended changes in Medicaid reimbursement (managed and fee-for-service) affect commercial insurance premiums and recommend adjustments as necessary.

- Encourage FamilyCare/Employer Partnerships: Wherever possible, our scarce Medicaid funds should be used to help eligible people buy into employer-based coverage so that they are in the mainstream health care system. To accomplish this, policymakers should streamline the Premium Assistance Program to allow the contributions of an employee and his or her employer(s) to be combined with a possible state subsidy to purchase insurance that neither the employee nor employer could afford on their own. The Medicaid/FamilyCare program should consider more tailored benefits packages which are more closely tied to the specific needs of the participants.
- Review Regulatory System: The state should re-examine public policies that have the potential to drive health care costs higher. Inadvertently, the state's laws and regulations may contribute to the high cost of health care. To ensure that the state's legal and regulatory climate helps residents have access to the highest quality care and most efficient care, a commission or work group should be charged with reviewing the oversight of all aspects of health care. These responsibilities are shared by the Department of Health and Senior Services, the Department of Human Services and the Department of Law and Public Safety, among others. This re-examination should include a review of New Jersey's legal, regulatory and legislative climates, including medical malpractice health insurance, benefit mandates, and the Certificate of Need requirements. The goal of this group should be to provide the proper balance to the system by considering what is necessary to ensure the health and safety of NJ residents against what is unnecessary and overly burdensome and may contribute to higher health care costs.

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Appendix 1

P.L. 2005, CHAPTER 305

AN ACT establishing the "New Jersey Health Care Access Study Commission."

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that:
   a. The number of people in this State who do not have health insurance has increased significantly over a period of several years;
   b. Nearly 1.2 million New Jerseyans, or almost 14% of the State population, were with out health care coverage in 2001;
   c. The uninsurance rate in New Jersey among both non-elderly adults and children is still high for those whose annual incomes are less than 100% of the federal poverty level even with the Legislature's recent expansion of the NJ FamilyCare Program, which will provide health care coverage to low-income families;
   d. Racial and ethnic, as well as income, disparities in access to health care threaten com munities across the State, as they do across the entire nation;
   e. Dollars that could be expended on providing health care services are being diverted to meet administrative costs and not patient needs;
   f. The current health care system too often puts the financial bottom line ahead of patient care and threatens the financial viability of those health care providers who attempt to provide a safety net that meets the treatment needs of the uninsured and poorly insured; and
   g. There is an urgent need for an independent mechanism by which State policymakers can study and consider various options for achieving the goal of establishing a health care system that provides State residents with access to health care regardless of income, age, employment or health status, and in which health care providers are able to provide patients with the quality health care that they need.

2. a. There is established the "New Jersey Health Care Access Study Commission" in the Department of Health and Senior Services.
   The purpose of the commission shall be to study and develop specific recommendations regarding the most effective means of achieving the goal of establishing a health care system in the State that provides access to health care for State residents and which:
   (1) is affordable to individuals, families, businesses and taxpayers, and removes financial barriers to needed health care;
   (2) is as cost-efficient as practicable by expending the maximum amount available on direct patient care;
   (3) provides comprehensive benefits that include benefits for mental health and long-term care services;
   (4) promotes prevention and early intervention;
   (5) includes parity for mental health and other services;
   (6) eliminates disparities in access to quality health care;

(7) addresses the needs of people with special health care needs and underserved populations in both urban and rural areas;
(8) promotes health care quality and better health outcomes;
(9) addresses the need to have an adequate number of qualified health care providers to guarantee timely access to quality health care;
(10) provides adequate and timely payments in order to guarantee access to health care providers;
(11) fosters a strong network of health care facilities, including safety net providers;
(12) ensures continuity of coverage and care;
(13) maximizes consumer choice of health care providers; and
(14) is easy for patients and health care providers to use and reduces the volume of paper work from its current level.

b. The commission shall consist of 28 members as follows:
(1) the Commissioners of Health and Senior Services, Human Services and Banking and Insurance, and the State Treasurer, or their designees, who shall serve ex officio; and
(2) 24 public members, who shall be appointed by the Governor no later than the 60th day after the effective date of this act, as follows: one person upon the recommendation of the New Jersey Hospital Association; one person upon the recommendation of the Hospital Alliance of New Jersey; one person upon the recommendation of the New Jersey Council of Teaching Hospitals; one person upon the recommendation of the New Jersey Primary Care Association, Inc.; one person upon the recommendation of the Medical Society of New Jersey; one person upon the recommendation of the New Jersey State Nurses Association; one person upon the recommendation of the Health Professionals and Allied Employees; one person upon the recommendation of the New Jersey Academy of Family Physicians; one person upon the recommendation of the American College of Emergency Physicians, New Jersey Chapter; one person upon the recommendation of the University of Medicine and Dentistry of New Jersey, who shall be an expert on multicultural health issues and racial and ethnic health disparities; one person upon the recommendation of the New Jersey Association of Osteopathic Physicians and Surgeons; one person upon the recommendation of the New Jersey Dental Association; one person upon the recommendation of AARP; one person upon the recommendation of the New Jersey Business and Industry Association; one person upon the recommendation of the New Jersey State AFL-CIO; one person upon the recommendation of AAHP-HIAA; one person upon the recommendation of an insurance carrier providing a managed care plan under the Medicaid program; one person upon the recommendation of a health service corporation; one person upon the recommendation of Legal Services of New Jersey; one person upon the recommendation of The Center for State Health Policy at Rutgers, The State University of New Jersey; and four members of the public who have a demonstrated expertise in issues relating to the work of the commission, two of whom shall represent organizations that have a demonstrated record of advocacy on behalf of

medically indigent persons and persons with mental illness, respectively. Vacancies in the membership of the commission shall be filled in the same manner provided for the original appointments.

c. The Commissioner of Health and Senior Services or the commissioner's designee shall serve as chairperson of the commission. The commission shall organize as soon as practicable following the appointment of its members and shall select a vice-chair person from among the members. The chairperson shall appoint a secretary who need not be a member of the commission.

d. The public members shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties and within the limits of funds available to the commission.

e. The commission shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for its purposes.

f. The commission may meet and hold hearings at the places it designates during the sessions or recesses of the Legislature.

g. The Department of Health and Senior Services shall provide staff support to the commission.

3. The commission shall report its findings and recommendations to the Governor and the Legislature, along with any legislative bills that it desires to recommend for adoption by the Legislature, no later than January 1, 2008.

4. This act shall take effect immediately and shall expire upon the issuance of the commission report.

Approved January 11, 2006.

Appendix 2

NJ Health Care Access Study Commission: Subcommittee Topics

1. The Cost of Health Care

Medical costs, administrative costs, fraud, waste and affordable insurance.
Chair: Christine Stearns, New Jersey Business and Industry Association

Members:
Robert Farina
John Glasel
Richard Goldstein
Valerie Harr
Suzanne Ianni
John Koehn
Ann Twomey

2. The Quality of Health Care

Accurate and timely data, wellness and preventive care, chronic care case management, pay for performance and physician practice patterns.
Chair: Terry Shlimbaum MD, New Jersey Academy of Family Physicians

Members:
Matt D'Oria
William Felegi
Richard Goldstein
Suzanne Ianni
Brian Litten
Keri Logosso
Ira Monka
Christine Stearns

3. Access to Health Care

Coverage and enrollment of the uninsured, language barriers, transportation, workforce and shortage of specialty care.
Chair: Derek DeLia, PhD, Rutgers Center for State Health Policy

Members:
Henry Acosta
Paulette Eberle
Holly Gaenzle
Richard Goldstein
Suzanne Ianni
Keri Logosso
Ed Niewiadomski
Debbie Salas-Lopez
Josh Spielberg

4. Alternative Insurance and Health Care Delivery System Models & Financing
The single payer system, universal coverage experiments in other states and an all payer system for hospitals.
Chair: John Glasel, Health Care for All/NJ

Members:
Marilyn Askin
Robert Farina
Richard Goldstein
Suzanne Ianni
Brian Litten
Richard Miller
Muriel Shore
Josh Spielberg
Ann Twomey
Jorge Verea

Appendix 3

More Information on the Nursing Shortage

New Jersey nurses have been very aggressive in addressing the nursing shortage and making recommendations to the Legislature and the Governor in three key areas: education, recruitment and retention. A March 2005 report, *Remedies for the Nursing Shortage,* was sent to Governor Richard J. Codey and was based on testimony from public hearings, experts on specific nursing issues and the Advisory Council for the Promotion of the Profession of Nursing in New Jersey.

Recommendations from that report include:

Education

1. Establish a statewide nursing curriculum model in the associate degree nursing programs.
2. Require vocational schools to establish partnerships with community colleges and universities so students can receive college credits for general education courses.
3. Subsidize nursing faculty salaries so they are comparable with health care industry standards.

Recruitment

1. Institute state-sponsored scholarships for nursing students at all levels and loan forgiveness programs for new nursing graduates working in New Jersey.
2. Create a joint marketing initiative between the NJ Department of Labor and Workforce Development and health care entities, including educational, provider and professional organizations, and unions focusing on all types of nursing programs.
3. Fund a recruitment specialist/marketing team to promote nursing in conjunction with the New Jersey Collaborating Center for Nursing at Rutgers College of Nursing.

Retention

1. Fund an on-going comprehensive survey of Registered Nurses and Licensed Practice Nurses, administered by the New Jersey Collaborating Center for Nursing in collaboration with the New Jersey State Board of Nursing, to measure, monitor and forecast the supply of New Jersey licensed nurses.
2. Provide incentives to employers and academic institutions to establish mentoring programs for new nurses to support and encourage them to continue practicing in New Jersey.
3. Fund and implement a major demonstration project to study the impact of specific nurse-to-patient ratios on patient outcomes in acute care hospitals in units without mandated New Jersey nurse-to-patient ratios.

For the complete report, visit http://www.njccn.org/latestnews.asp.

Information on how nurse staffing ratios affect patient outcomes:

After adjusting for patient and hospital characteristics, each additional patient per nurse was associated with a 7% increase in the likelihood of patients dying within 30 days of admission and a 7% increase in failure to rescue.[1]

Nurse staffing shortages are a factor in one out of every four unexpected hospital deaths or injuries caused by errors.[2]

Hospitals with a higher proportion of RNs had lower severity-adjusted mortality rates.[3]

A study of medication errors in two hospitals over a 6-month period found that nurses were responsible for intercepting 86% of all medication errors made by physicians, pharmacists and others involved in providing medications for patients before the error reached the patient.[4]

A 2007 study examined the relation between RN staffing levels, RN contact hours, RN perception of organizational climate, hospital magnet status and hospital profitability to incidence rates of several hospital complications of patients admitted to ICUs. It reported that RN staffing levels are negatively correlated to rates of blood infections, ventilator-associated pneumonia, 30-day mortality and pressure ulcers. And all those conditions, as well as urinary tract infections, are also negatively correlated with RN contact hours. Profitable hospitals are positively correlated to incidence rates of urinary tract infections, ventilator pneumonia and pressure ulcers. There was no correlation to magnet status. Patients in hospitals where nurses perceived a more positive organizational climate had a slightly higher chance, 19%, of developing a blood infection, while they were 39% less likely to develop a urinary tract infection.[5]

More RN direct care time per resident day was associated with fewer complications including; pressure ulcers, hospitalizations, and UTIs. There were fewer incidences of weight loss, catheterization, deterioration of daily abilities, and greater use of oral nutritional supplements.[6]

A study of 2,470 patients who stayed at the University of Geneva Hospitals found that 23% of the 936 patients who underwent mechanical ventilation developed ventilator-associated pneumonia (VAP). The researchers found that a high nurse-to-patient ratio was strongly associated with a decreased risk for late-onset VAP.[7]

Information on the nursing shortage, recruitment and retention:

Each additional patient per nurse (above 4) is associated with a 23% increase in the odds of nurse burnout and a 15% increase in the odds of job dissatisfaction.[1]

Hi-Desert Hospital in Joshua Tree, CA went from 50% vacancy rate in its nursing staff to 1% vacancy rate six months after establishing ratios of 1:4 on day shift and 1:5 on second shift.[8]

Applications for registered nurse licenses in the state of California increased over 60% in the three years after passage of the nurse-patient ratio law.[9]

In a national survey of nurses, 83% of respondents said that improving staffing ratios would be "very effective" in improving job satisfaction, recruiting and retaining quality nurses.[10]

References for Appendix 3

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The Commission acknowledges the support of Rita Manno, of Manno Consulting LLC, in preparing this report.