

**CIANJ Talking Points**  
**May 25, 2010**

- Thank you all for coming. I'm so pleased I could be here to join such a diverse and involved group of professionals interested in health care and in the welfare of New Jersey's health-care system overall.
- We need this kind of community involvement—from health-care providers to specialized attorneys to pharmaceutical-and-life-sciences company professionals—to really improve the quality and efficiency of our entire system.
- And believe me, as the new Health Commissioner, having just made the transition from private sector to public sector, I know we're going to need to rely on the ingenuity, creativity, and expertise of New Jersey's businesses to enact *true* health-care reform.
- Last week, I attended a conference on the concept of “medical homes” at the New Jersey Hospital Association, with a group of professionals from around all sectors and facets of the health-care industry.
- That concept—that consumers have a focal point, a primary-care physician practice, to help manage their care, especially if they have a chronic disease—has been around for a long time. But baking the cake is more difficult than getting the ingredients, as they say.
- That difficulty is representative of making change in health care as a whole—improving the quality, efficiency, timeliness of care requires more than the sum of the parts, it requires comprehensive and systematic approaches to get different sectors to coordinate and collaborate...
- ...and that's why I'm glad to open a dialogue with this professionally diverse group today.
- I want to talk to you today about, the Department's mission and four initiatives that the Department is undertaking, all of which require that kind of coordination and collaboration—across types of providers, across types of health-care facilities, and at times, across entire business sectors.

**Quality of Care**

Part of the Department's mission is ensuring that our residents have the best quality of care.

***Quality and Patient Safety Culture***

As a doctor, I truly believe to improve the quality and safety of care delivered we need to have a culture of quality, safety and transparency. This culture must be championed by

the leaders of the healthcare facility to ensure staff feels comfortable reporting any adverse events.

But, we can't just talk about the importance of quality and patient safety. We have to use evidence-based tools and nationally recognized benchmarks to measure and evaluate our performance. We have to make sure that we are providing the best care in the most appropriate setting with a goal toward continuous improvement.

#### *Dartmouth Atlas Project*

Although NJ is a leader in quality, we spend the most money among the states on end of life care. The amount of Medicare program spent per patient with severe chronic illness varies substantially. New Jersey had the highest spending level during the last two years of life, almost \$40,000 per person. This is an area that NJ has room for improvement.

At the Department of Health and Senior Services, we feel strongly that public reporting of quality measures drives improvement. It encourages hospital executives to examine their performance against other institutions—locally, regionally and nationally—and to develop strategies and incentives to raise the bar on performance.

#### *Patient Safety: NJ Hospitals*

Every year we release several reports on how healthcare facilities are doing: Hospital Performance Report Card, Patient Safety Summary Report, Cardiac Surgery Report and we also collect data on the state Stroke Registry.

New Jersey is a leader in patient safety and quality. New Jersey has exceeded 15 out of 25 national standards, equal to national standards in nine measures based on hospital performance report for heart attack, pneumonia, heart failure, & surgical performance measures

My goal is to build upon the great work we've accomplished and work with all of our healthcare partners to achieve a higher level of health care quality for all who receive care in our health care facilities.

#### Physician Leadership

Part of improving the quality of care delivered in our state is having a robust, engaged physician community.

#### *Current State of Hospital-Physician Relationship*

Currently, the relationship between physicians and hospitals are disjointed. Doctors are focused on doing their practice in the best possible way, not necessarily working to meet the core mission of the hospital. The environment of practice is challenging for physicians—they feel loss of control, increasing accountability to patients, pharmacy, hospitals, regulators and their incomes are declining.

#### *Clinicians vs. Physician Leaders*

Clinicians are: doers, reactive personalities, deciders, value autonomy, independent and patient advocate, identify with the profession

Physician Leaders are: strategist, proactive, delegators, value collaboration, interdependent, organization advocate, identify with the organization

#### *N.J. Projected Physician Shortages*

Another challenge we are facing in our state is a shortage of healthcare providers. According to New Jersey Council of Teaching Hospitals by 2020 there is a projected shortfall of over 2,800 representing a 12 percent gap in the physician supply versus the likely population demand for services.

#### *Physician Leadership Task Force*

In order to address this lack of physician, I am creating a Physician Leadership Task Force to look at issues surrounding this shortage. The task force will create short-term and long-term goals to cultivate, attract and retain the best doctors. The task force, which will include BME, NJMS, NJHA and Council of Teaching Hospitals, will examine the environment of practice and how we can better align incentives, improve the environment of practice and maintain access to specialist.

#### Health Information Technology

When we speak about improving our healthcare system, we can't overlook the importance of health information technology's role in enhancing how care is delivered. There have been enormous advancements in medicine in the past two decades, as you all know. But one of the less-heralded, and perhaps more gradual, of these has been the use of real-time electronic data available at the physician's fingertips when they treat a patient. None of the other technologies can be used efficiently and properly unless we know—and see—the whole picture.

Overall, the health industry is lagging in the use of information technology. But once it is implemented HIT can allow us to achieve real health reform by reducing redundancy and waste

Many of you may know that at the VA, they developed one of the first Electronic Health Systems in the nation. They invested \$4 billion in its development—yielding about \$7 billion in savings. That's because the VA's facility-to-facility EHR, VistA, allowed us to treat the whole patient, not just the disease.

I have been fortunate enough to benefit from VistA for years...obtaining patient data at the point of care whether or not I had seen that patient before. It helped tremendously.

#### *HIT: The Critical Link*

HIT gives us the tools to render personalized healthcare, improve care coordination, decrease redundancy and waste, improve quality, outcomes and transparency, practice evidence-based medicine, and empower patients. As the National Coordinator for Health IT, Dr. David Blumenthal, wrote in the New England Journal of Medicine, HIT is “not as an end in itself but as a means of improving the quality of health care, the health of populations, and the efficiency of health care systems.”

#### *HIT In NJ*

In New Jersey, we are taking small steps toward implementing HIT. The State HIT Plan was released Oct. 2009. New Jersey was awarded \$11.4 M in federal funds to work with 4 regional Health Information Exchanges (HIE). Additionally, we are developing plans for statewide HIE this year--linking regional exchanges and providers in a secure network.

#### *ARRA*

The Recovery Act provided major fuel for health IT initiatives—perhaps one of the biggest federal infusions ever, relative to the size of the sector. Incentives—or bonus payments, we’ll call them—are available for all physicians starting next year, and I’d encourage everyone to take advantage of them. Only then will we have 21<sup>st</sup>-century medical practices. Up to \$63,750 over six years for Medicaid providers (physicians, NPs, midwives, PAs, dentists who have 30 percent or more Medicaid patient mix; or at least 20 percent for pediatricians) who demonstrate that they are “meaningful users” of “certified systems.”

As a Medicaid provider, your “clock”—your year 1—can start any time between 2011 and 2016. Up to \$44,000 is available over for years directly from CMS for non-Medicaid providers; if you adopt in 2011 or 2012, you stand to gain all \$44,000, but the amounts diminish a bit if you adopt in 2013 or 2014.

As Health Commissioner, I want to help practices not only adopt, but adopt in ways that improve the workflow, the diagnosis, and the treatment. Through the Health IT Commission, through guidance from our Department, and through events like this one, I aim to help physicians and practice managers overcome those traditional barriers they believe exist with health IT. I believe Health IT will bring about real health reform and will allow us to treat the patient so much more comprehensively, and help us achieve that “continuum of care” that we all talk about.

#### Supporting NJ Seniors

At the Department much of our work focuses on improvements to the healthcare system for our residents, however, we are also working to ensure older adults have access to high quality long term health & supportive services in least restrictive environment so they can maintain their independence and dignity.

We have all heard the expression “Home is Where the Heart Is,” well, for most people, home is also where family, friends, neighbors, houses of worship, fond memories and other trusted sources of comfort and support reside. It is no surprise that older adults in need of long-term care prefer to get help in their homes and communities rather than in a nursing home.

According to an AARP, 92 percent of Americans 65 years and older, who participated in their survey, said they wanted to live out their lives in their current homes; even if they should need help caring for themselves 82 percent said they would prefer not to move from their current homes.

In New Jersey, we've made significant progress in giving seniors options to nursing home care and in shifting the State's spending from predominantly nursing home care to a balance of nursing home and "home and community-based services"—that is, home care, adult day care and assisted living.

### *GO*

Since January 2009, DHSS has used the Global Options (GO) for Long Term Care program to provide a cost-effective alternative to nursing home placement. GO, the Medicaid home and community-based waiver program, was designed to meet the care needs of participants, yet control overall spending. The Governor has demonstrated his supported for the GO program with additional funding of 14.4 million in this year's budget.

This investment is not only wise fiscally, the average Medicaid rate for a nursing home is \$63,541 per year vs. \$17,112 for the Medicaid GO waiver, it will give a greater number of seniors access to wider range of in-home long-term services and the ability to live in the community as long as possible with independence and dignity.

### *PACE*

Another option the state offers for seniors to stay in the community is an innovative program called the Program of All-Inclusive Care for the Elderly, or PACE. PACE allows elders at highest risk of nursing home placement to get a full range of services, both at home and at a PACE center, that will allow them to live safely in the community. We are about to open our third PACE site and hope to ultimately serve up to 3,000 people.

Through the implementation of programs like this as a state, we've been able to move from spending 90% of state funding on nursing homes and 10% on home and community based options---to spending 70% on nursing homes and 30% on home and community based options. This is a reflection of the seniors' desire to age in the community not in nursing home care.

### Closing

As I stated at the outset, achieving change requires comprehensive and systematic approaches and collaboration. There is great work to build upon in our state, we've made great strides in quality, access to care and giving seniors options. But we must continue to strive for the best healthcare system possible; this will require innovative approaches and collaborative solutions. I look forward to partnering with all of you as we work to improve access to high-quality, efficient care in our state and promote quality of life for our senior population.