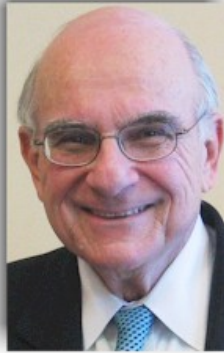


Interim report on rationalizing NJ hospital resources

By Christopher
Guadagnino, Ph.D.

Published August 2007

- React to this article in the [Discussion Forum](#).



Fred M. Jacobs, M.D., J.D., is Commissioner of the New Jersey Department of Health and Senior Services.

PND: What are the key recommendations of the interim report that was recently released by the New Jersey Commission on Rationalizing Health Care Resources?

FMJ: The interim report is not designed to provide recommendations yet, which will be included in the final report, expected to be issued in December. The report was done to illustrate to the governor a frame of reference with regard to what the characteristics of an essential hospital are, and how you would assess the financial viability of a hospital. You can plot those two things on a four-quadrant grid. On one axis would be increasing financial viability and on the other axis would be increasing essentiality of a hospital. A hospital in the upper right-hand quadrant would be most viable and most essential, and a hospital in the lower left quadrant would be least viable and least essential. The criteria for a hospital's essentiality would be the intensity of the hospital's use compared to other hospitals in its service area, such as the percent of emergency department visits, inpatient occupancy, total patient days; whether or not there is high level emergency care such as a trauma center designation, but not limited to a trauma center designation; and the provision of care to financially vulnerable populations in an area where there may be few other institutions or few medical practices – things like the number of Medicaid and uninsured patient discharges. Criteria of a hospital's financial viability include profitability, measured by operating margin; liquidity, which means the more money you have on hand to pay your expenses, the more likely you are to weather short term dips in revenue; and capital structure, which we measure as long-term debt to capitalization – the extent to which the value of a hospital's assets is offset by its long-term debt.

PND: What process was used in coming up with these metrics?

FMJ: We have engaged the services of Navigant Consulting, which has done a lot of this sort of work within the state of New Jersey. A lot of the suggestions were made by them, in association with the Health Care Facilities Financing Authority (HCFFA) staff, which was the contractor for Navigant and acts as staff to the commission. Members of the commission were chosen by recommendation of the governor's staff, and by other organizations within the state. There are 11 members of

the commission, more when you consider the ex-officio members – the commissioners of Health and Senior Services, Human Services, and Banking and Insurance. The commission's chairman is Uwe E. Reinhardt, one of the world's leading health care economists. Other members were chosen for backgrounds that bring value to the discussion. For instance, Risa Lavizzo-Mourey, who is the president and CEO of the Robert Wood Johnson Foundation, brought extensive experience in health care philanthropy and policy. We also have David Hunter, who is the president of the Hunter Group, a major hospital consulting and restructuring firm. Gerry Goodrich, who has been a deputy commissioner in the department in the past, now works for the Weill Medical College at Cornell University and previously worked for the St. Barnabas Healthcare System as system development executive vice president. Joel Cantor, who is the director of the Center for State Health Policy at Rutgers. Bruce Vladeck, who was the interim president of UMDNJ, and had previously been the administrator for what is now The Centers for Medicare & Medicaid Services. I mention only a few of the members, there are others who are quite prominent in their fields.

PND: How would threshold criteria for a hospital's essentiality and financial liability be set?

FMJ: That has not yet been determined. There are thresholds that HCFFA uses to decide whether hospitals should be placed on a credit watch, or are particularly vulnerable, and the HCFFA board meets in executive session periodically to discuss financially stressed hospitals. All hospitals report their financial data quarterly to HCFFA, which issues tax-exempt bonds that hospitals use to fund capital projects. The actual financials are easy to measure, particularly because we get audited reports. Essentiality is much softer because none of the characteristics of an essential hospital can be determined on the basis of "either they have a trauma designation or they don't." We know the percent of emergency department visits in their service area. We know how many Medicaid and charity care discharges there are, because they are reported. We know the medically underserved areas that are federally designated, and also what programs hospitals provide to the community. A general acute care hospital that does general medical surgical care and perhaps pediatrics and obstetrics, is one thing. A hospital that has cardiac intensive care, cardiac catheterization or cardiac surgery, a burn center, more intense obstetrics care such as regional perinatal services, high risk pediatric surgery, pediatric intensive care, cancer services, radiation oncology – those kinds of services would distinguish hospitals from those that provide general medical surgical care only.

But that's not to say that a hospital that provides general medical surgical care isn't essential in the region that it resides. Because of geographical characteristics, it may be very essential for that area, while a hospital with very high - tech services may be duplicative of other hospitals in close proximity. So, merely having them doesn't give you the qualitative judgment that you would also need to make. That's one of the reasons why the members of the commission were chosen so carefully – not to represent any constituency, that is not their role – but to bring their backgrounds to the table so as to exercise a judgment on these characteristics that are exhibited by hospitals.

PND: How can policymakers apply qualitative judgment systematically and objectively?

FMJ: The reason that the commission was formed in the first place was to offer a rational basis for determining the allocation of health care resources, and make it non-political. Now, it's very difficult to make it non-political. The existence, survival and viability of a hospital is essentially a political issue in the communities in which those hospitals exist. But having accepted that, what has happened in the past – and I think everyone agrees this is the case – is that hospital support has been rendered, to a very large extent, on the basis of political clout. Not to say that there have been many mistakes – I think the hospitals that have gotten support have needed it. But there's been no analysis by state policymakers, in a detailed way, about which hospitals really require that support in terms of whether that hospital is essential to the community or not. There is not a hospital in the state that doesn't have a cadre of supporters that would fight very hard to prevent it from going away. In the past ten years 17 hospitals have closed in New Jersey, and for every single one of them there has been an issue in the community about fighting to save that hospital regardless of whether it was not financially viable, or providing services that were duplicative or could be provided in a reasonable distance. One of the essential characteristics which is softer, and not listed in the report, is the travel time from one hospital to the hospital that may survive it in a region. That travel time depends a lot, particularly in the northern part of the state, on the time of day and the traffic patterns.

PND: Why not just leave it to the marketplace to make determinations of excess capacity and essentiality?

FMJ: That's an excellent question, because in fact that's what has happened. Market forces are allowed to continue in many of the areas of the four-quadrant graph presented in the report. But the market doesn't care about the public health. It cares about financial viability as the bottom line, regardless of how essential a hospital may be. Take the example of Jersey City Medical Center, which we think is a very essential hospital. The payer mix and financial metrics for Jersey City are such that, without substantial state support, Jersey City Medical Center would close, and we think that would be bad for the public health. The market and the political climate, while important, merely reflect in many cases a combination of the payer mix – Medicaid and charity care payment, which is insufficient to support hospitals where that represents a large percentage of their patients. We would like to wrap that all in a public health rationalizing argument so that, while we acknowledge those other characteristics as being important, the principal reason for hospital support would be its public health mission.

PND: Wouldn't politics remain in the process because even evidence-based funding decisions would still be up to the Legislature?

FMJ: To some extent, yes. I'm not going to be so naïve as to say there'll be no politics. In the end, both legislative and executive action will be needed. This commission is set up and organized under an executive order. There has been no appropriation from the Legislature for this, other than the budget we've managed to pull in from HCFFA and from the department. There's no legislative action at all, yet. The goal is to provide a report that presents, in a clear and logical format, a rational plan for the allocation of health care resources – hospitals and clinics, either federally qualified health centers or primary health care clinics. We've not taken on the role of physician practices, nor have we taken on the

issue of long-term care facilities, even though both have been advocated strongly to us. We simply don't have the time or resources to do that right now. We hope that the commission's report will be compelling enough so that the Legislature will take what action is required, the governor will take what action is required, and the appropriate legislative activity will ensue.

PND: It sounds as though the hope is that an evidence-driven, rational basis for decision-making will trump political interest.

FMJ: It informs political interest. I don't think anything trumps political interest, quite honestly. But certainly it informs the political decision-making and I give the legislators and the governor's office credit for wanting to do the right thing. It's hard to do the right thing when you don't have information to inform that decision, and you're totally dependent on advocacy groups and political action committees. So I think this will be a big help.

PND: What is the evidence that there is excess capacity in New Jersey hospitals?

FMJ: To the extent that such evidence exists, it is reflected in the percentage of maintained beds that hospitals have and the census of these hospitals. For example, in Trenton there are presently three hospital facilities, none of which has an occupancy over 45 percent. It's very difficult to run a hospital profitably when less than half of your beds are filled. There is very good evidence that many hospitals in New Jersey are running at a percentage of maintained beds that is too low to make them survive. It's like a factory that's only working at half of its capacity. Unless you've got a payer system that pays you very well for the product that you produce at a factory, or the care that you provide in a hospital – which, by the way, we do not have – you can't make it on a census like that. You've got to have a higher census – it should be closer to 75 to 80 percent – that's what our experts say to us. When we calculate what the ideal hospital need is, we use a census projection of 83 percent as capacity in an area. Exceed that percentage and it's hard to run the hospital – it's too crowded and there's not enough room for flow. Lower than that and you have excess capacity. Balanced against that is the need for surge capacity in the event of a public health disaster or crisis, such as a pandemic influenza epidemic or a major bio-terrorism or chemical warfare attack.

PND: How many hospitals in the state would need to close to get to the 83 percent ideal?

FMJ: I don't know that yet, but I don't know that they need to close as hospitals. They may need to reconfigure themselves into a less acute or different kind of facility. We're not there yet at making recommendations as to which hospitals close, and we may never recommend which hospitals close. This is not, after all, a hospital closure commission. We are about bringing information to the debate that will inform that decision, not only for regional and local political leaders, but also for hospital boards of trustees who in the end have the ultimate responsibility for deciding on the fate of their community's hospital. It is, in the end, up to the board. The board may be forced into decisions because, if there's no money there's no way to pay your bills, your payroll, your bond holders and debt service. But the boards, the governor, the legislators – all of them that I've met, and I've been to 60 hospitals in New Jersey since I've been here – want to do the right thing. The environment in which they work

makes it sometimes very difficult.

PND: How does physician impact fit into the decision-making?

FMJ: Physician impact is a huge issue. One of the subcommittees that we've formed is dealing with the issue that a hospital's cost of providing care is to a very great extent driven by physician practice. It isn't the hospital administrator that admits anybody and it isn't the hospital board that writes any orders. All of this is delegated to the medical staff. So, to the extent that a physician practices inefficiently, that practice adversely impacts the hospital's economic survival and impacts the community's access to that hospital. Our subcommittee has begun to talk about what incentives can be given, what training can be given, what penalties can be imposed for physicians who practice inefficiently – in terms of unnecessary admissions, inappropriate and unnecessary inpatient procedures that could be done as outpatient, inappropriate use of technology, excessive use of consultations. I don't think we're going to put physicians out of business because we do have a recognized shortage in primary care and some specialties as well – obstetrics and neurosurgery, just to name two. Mammography and radiology also is becoming under-supplied, and there are probably others on a regional basis throughout the state. We need to recognize that residency programs in New Jersey need to be upgraded to attract high quality candidates and make it attractive in the community for them to want to stay. Many residents in New Jersey's medical training programs complete their training programs and leave the state because practice opportunities are better for them elsewhere. Part of that is the issue of tort reform and medical malpractice premiums – that's a huge issue in some specialties. That has to be factored in as well.

PND: What are the next steps for the commission?

FMJ: Over the summer there will be three public hearings in the three geographical regions of the state – north, central, and south. By the end of the summer we hope to have very good public input. There is an opportunity to make comments to the commission on its website, www.nj.gov/health/rhc. We will need to start thinking about the format for a final report in the early fall if we're going to have a completed document by December. That's our mandate and that's our goal.

[Obtain Medical Specialty Own-Occupation Disability Insurance On-line](#)

© 1996-2008, Physician's News Digest, Inc. All rights reserved.

Local Medical News

Philadelphia Metro Edition	Eastern PA Edition	Western PA Edition	New Jersey Edition
Cover Story	Cover Story	Cover Story	Cover Story
Spotlight Interview	Spotlight Interview	Spotlight Interview	Spotlight Interview
News Briefs	News Briefs	News Briefs	News Briefs
Editor's Notebook	Editor's Notebook	Editor's Notebook	Medicine & Computers
Commentary	Commentary	Commentary	Medicine & the Law
Medicine & Computers	Medicine & Computers	Medicine & Computers	Medicine & Business
Medicine & the Law	Medicine & the Law	Medicine & the Law	Personal Finance
Medicine & Business	Medicine & Business	Medicine & Business	
Personal Finance	Personal Finance	Personal Finance	

