TEAM PLAYERS

New Jersey is still a state of small medical practices, but that's changing rapidly. Under the pressure of health care reform, doctors are rushing to consolidate—with each other and with hospitals. By Wayne J. Guglielmo

PHOTOGRAPHS BY MATT FURMAN

There's an old photograph of Francis Rombough that conveys the independent spirit of the man. Wearing lumberman's garb and leaning against a hollowed-out tree into which concrete has been poured—an old technique known as cavity work—he looks every bit the rugged westerner, although "Jack," as he was known to his friends and family, was a lifelong New Jerseyan.

In 1934, Rombough and his brother Alexander founded American Tree Experts, located in Montclair. In time, two of his sons, Richard and Ronald, joined the family business. A third son, Gary, spent summers helping out, but by college he had set his sights on another career. After earning a BS at Penn State in 1972, he was admitted to Albany Medical College, where he completed his MD degree; interested in the surgical specialties, he did his internship in general surgery at Mount Sinai Hospital and then returned to Albany for a residency in orthopedic surgery.

It was a far cry from tree work. But when he mulled his practice options, Gary Rombough recalled a bit of wisdom from his father: "If you can possibly do it, be your own boss."

Rombough took the advice to heart. In 1981, he established a solo practice in Verona; four years later, he moved to Montclair, opening an office on the bottom level of a three-story colonial, the top two floors of which were reserved for the family's living quarters. (Married twice, he has five children.) A novice at running his own business, he turned for tips to more experienced colleagues and trade journals. His staff was minimal: two secretaries and an X-ray technician.

By 2013, after more than three decades, he was still enthusiastic about his work and eager to practice for at least another 10 years, taking him into his early 70s.

But the business was changing. Under the pressure of rising costs and radical changes ushered in by the Affordable Care Act (ACA) of 2010, President Obama's signature health care law, medicine was morphing into a team sport. Rombough sensed the need for a larger staff and access to newer technology. Gee, I don't know if I'm going to make it alone for another 10 years, he thought to himself.

Rombough is not alone. Nationwide, doctors increasingly are abandoning solo and small private practices to become part of larger groups. Some join doctors run practices—either multispecialty or single specialty. Others opt for a hospital-affiliated group. Whatever the choice, the doctors gain access to the modern equipment, imaging devices, administrative support and financial and intellectual resources needed to stay current with the changing state of health care.

For Rombough, the right fit was Summit Medical Group, New Jersey's largest for-profit, doctor-owned multispecialty group, with more than 350 physicians in 76 medical specialties at individual and group offices throughout the state.
“There’s been some loss of autonomy but I can live with it.”

—Dr. Gary Rombough

Joining SMG on May 28 of this year, Rombough had immediate access to an electronic health records (EHR) system—a new necessity to carry out provisions of the ACA—as well as a level of administrative and clinical support that a solo practitioner can only dream about. Now, six months later, Rombough has made the transition from independent practitioner to large-group member. He uses the practice-wide EHR system (a fire damaged his old office this summer, but his patient records had already been stored on the company cloud), and enjoys access to the latest imaging technology, including a costly digital X-ray machine; centralized billing and other administrative support; and the camaraderie and clinical integration of a large multispecialty practice.

Reflecting on the change, Rombough is happy to be a clinician freed of the attendant hassles of running a practice. “Yes, there’s been some loss of autonomy,” says the son of a man who preached independence, “but I can live with it. Every day, things get better.”

Among the biggest changes taking place in American medicine today is a shift in how doctors are paid. Historically, they have been paid based on services provided. More procedures would mean more income. But to health care reformers concerned about runaway costs, this fee-for-service model looked unsustainable. They proposed a new model, spelled out in the ACA for Medicare reimbursement. In lieu of paying doctors (and hospitals) for ser-
VICES RENDERED, THE NEW MODEL REWARDS THEM FOR KEEPING THEIR PATIENTS HEALTHY IN A COST-EFFECTIVE WAY. IF DOCTORS SUCCEED—FOR EXAMPLE, BY GETTING MORE OF THEIR DIABETIC PATIENTS TO TAKE REGULAR EYE AND FOOT EXAMS OR REDUCING HOSPITAL ADMISSIONS FOR THEIR CHRONIC PATIENTS—they share some of the money they saved the system. IF PATIENT OUTCOMES WORSEN, THEY RISK LOWERING OR EVEN LOSING THEIR REIMBURSEMENTS. WHILE THE ACA RULES APPLY SPECIFICALLY TO MEDICARE, PRIVATE INSURERS ALSO SEE MERIT IN FEE-FOR-VALUE.

THERE IS A CATCH, HOWEVER: THE NEW REIMBURSEMENT MODEL REQUIRES A GREATER LEVEL OF ORGANIZATION, INTEGRATION AND ELECTRONIC-ASSISTED COMMUNICATION THAN MOST SMALL PRACTICES CAN MUSTER. AN EHR SYSTEM, FOR EXAMPLE, CAN COST A PRACTICE AS MUCH AS $100,000, ALTHOUGH THE FEDERAL GOVERNMENT WILL DEFRAY SOME OF THAT COST THROUGH ITS EHR INCENTIVE PROGRAM.

“IF YOU AREN’T EQUIPPED TO PARTICIPATE IN PAY-FOR-VALUE AND DATA-DRIVEN PAYMENT SCHEMES, YOU EITHER MAKE A BIG INVESTMENT OR JOIN SOMEONE WHO’S ALREADY MADE THAT INVESTMENT,” SAYS ANTONIO VALLE, CEO OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION, A COLORADO-BASED TRUST GROUP FOR PRACTICE MANAGERS.

SECOND, NEW JERSEY IS SERVED BY AN UNUSUALLY LARGE NUMBER OF HEALTH INSURERS, MAKING IT DIFFICULT FOR ANY ONE OR TWO TO CORRAL THE MARKET AND LIMIT PHYSICIAN REIMBURSEMENTS. “REIMBURSEMENT HERE WAS NOT AS BAD AS OTHER PARTS OF THE COUNTRY, SO DOCTORS DIDN’T NEED TO BE PART OF A LARGER GROUP TO GAIN ECONOMIC CLOUT,” EXPLAINS JOHN D. FANBURG, CHAIR OF THE HEALTH SERVICE DIVISION OF BRACH EICHLER, A MULTIDISCIPLINARY LAW FIRM BASED IN ROSELAND. “THEY COULD RETAIN THEIR AUTONOMY IN AN INDIVIDUAL OR SMALL PRACTICE AND STILL MAKE A LIVING.”

BUT EVEN WITH ACCESS TO WORLD-CLASS MEDICAL RESOURCES AND MULTIPLE INSURANCE CARRIERS, NEW JERSEY DOCTORS ARE FINDING IT DIFFICULT TO MAINTAIN INDEPENDENCE SINCE THE ROLLOUT OF OBAMACARE. LIKE DOCTORS IN OTHER PARTS OF THE COUNTRY, PHYSICIANS HERE ARE ASKING THEMSELVES: HOW CAN I BEST PARTICIPATE IN THE NEW MEDICAL ECONOMY, WITH ITS VALUE- AND DATA-DRIVEN PAYMENT SCHEMES? CAN I AFFORD THE NEW TECHNOLOGIES THAT MAKE PARTICIPATION POSSIBLE? CAN I AFFORD THE ADMINISTRATIVE COSTS OF RUNNING A SMALL PRACTICE? AND MOST CRUCIAL, CAN I DELIVER THE BEST PATIENT CARE UNDER THE NEW SYSTEM?

NEWLY MINTED DOCTORS DON’T HAVE MUCH CHOICE. IN A RECENT SURVEY, THE HEALTH CARE RECRUITING FIRM MERRITT HAWKINS FOUND THAT MORE THAN 90 PERCENT OF NEW DOCTORS “WILL BE EMPLOYED BY HOSPITALS, MEDICAL GROUPS, MONROE TOWNSHIP
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Robert Brenner, a family physician and chief medical officer of Summit Medical Group.

While SMG and other groups are growing rapidly in New Jersey, small practices still predominate. In 2009, the most recent year for which reliable numbers are available, New Jersey had approximately 9,100 physician offices employing 70,000 medical professionals and other staff, according to a report commissioned by the Medical Society of New Jersey (MSNJ). With roughly 27,500 patient-care physicians statewide, that’s an average of only three doctors per office. “It’s a far cry from my colleagues in other parts of the country like the Midwest, where multi-doctor practices are the norm,” says MSNJ CEO Larry Downs.

Experts say there are two main reasons New Jersey has lagged other parts of the country in consolidation. Here, and on the East Coast generally, there are plenty of specialists and high-quality medical resources, such as imaging centers and rehabilitation facilities. “Even the rural areas on the East Coast are not that distant from world-class medical services,” says David Gans, senior fellow in industry affairs at the Medical Group Management Association, a Colorado-based trade group for practice managers.

Second, New Jersey is served by an unusually large number of health insurers, making it difficult for any one or two to corral the market and limit physician reimbursements. “Reimbursement here was not as bad as other parts of the country, so doctors didn’t need to be part of a larger group to gain economic clout,” explains John D. Fanburg, chair of the health law division of Brach Eichler, a multidisciplinary law firm based in Roseland. “They could retain their autonomy in an individual or small practice and still make a living.”

But even with access to world-class medical resources and multiple insurance carriers, New Jersey doctors are finding it difficult to maintain independence since the rollout of Obamacare. Like doctors in other parts of the country, physicians here are asking themselves: How can I best participate in the new medical economy, with its value- and data-driven payment schemes? Can I afford the new technologies that make participation possible? Can I afford the administrative costs of running a small practice? And most crucial, can I deliver the best patient care under the new system?

“With the support I get, I’m able to pick up on details I wasn’t able to previously.”

—Dr. Shayna S. Jones
community health centers, academic medical centers, or other facilities." Fewer than 10 percent of the job placements are in independent settings, such as partnerships or solo practices. A decade ago, 45 percent of new doctors went to work in small or solo practices.

As for veteran doctors, some, like Rombough, have bid adieu to independent practice. Others are trying to ride things out, hoping that recent changes in health care will fade in time like a bad head cold. Others, closer to retirement, are just hanging on until they can exit.

"I hear so many physicians these days say, 'I can't wait for [my children's] college tuition payments to be over so that I can retire early," says Debbie Puccio, president of the New Jersey Medical Group Association.

The trend, though, is clear. The New Jersey Hospital Association, the state affiliate of the American Hospital Association, reported a 16.5 percent increase from 2008 to 2012 in the number of doctors and dentists employed by hospitals in the Garden State. Nationally, the increase was 20 percent.

Typical of the trend is the hospital-affiliated Valley Medical Group. It has grown from 90 physicians in 2010 to 203 physicians as of September. The group is part of the Ridgewood-based Valley Health System.

Doctor-run medical groups, particularly multispecialty groups, are showing a similar surge. "This year, between residency, fellowship and acquisition, we'll probably end up on-boarding about 140
doctors," says Jeffrey D. LeBenger, an otolaryngologist and chairman and CEO of SMG, which is on track to becoming a 500-doctor group. Another doctor-run multispecialty group, Advocare, which serves New Jersey and eastern Pennsylvania, has grown from 30 physicians in 1998 to more than 600 primary-care doctors, specialists and nurse practitioners.

Doctors who have joined a larger group have generally seen the move as positive for themselves and their patients, although no transition is seamless.

Precisely because they are peer-owned (and sometimes peer-managed), doctor-run groups appear to be easiest for doctors to adjust to, despite the guidelines for patient care they often impose on members. "We're not policing them or telling them how to do such and such," says SMG's Brenner. "We're offering them operational support." SMG shows its doctors how their patients are doing compared to those treated by other doctors. "When doctors see their patients are at the bottom of some list," says Brenner, "you wouldn't believe how quickly the dial moves in the right direction."

For this story, New Jersey Monthly met with four physicians who have made the jump. Two of the doctors, ob/gyn Shanya S. Jones, 40, and otolaryngologist Karen A. Wirtshafter, 55, left independent practice to join large, physician-run, single-specialty groups. Bruce Arnowald, 54, an orthopaedic family physician, and cardiologist Gerald Sotsky, 55, joined hospital-affiliated medical groups. Here, they reflect on their experiences:

Dr. Shayna S. Jones
LifeLine Medical Associates
Since 2007, when she completed her residency in obstetrics and gynecology at Saint Barnabas Medical Center in Livingston, Jones has been riding a roller coaster.

Her first job ended abruptly after the small practice she joined realized it couldn't afford to pay her salary, malpractice insurance and health benefits. In mid-2008, Jones was approached by a solo practitioner, an ob/gyn who was starting a job with Planned Parenthood and wanted someone to take over the office in Livingston she shared with a second doctor. Jones signed on. The next year, she and her new office-mate moved to a bigger office. Then came what Jones calls her "crazy period." By then married with a young son, she was running her practice, preparing for her oral boards in obstetrics and gynecology, and delivering babies in the middle of the night.

About 30 percent of her patients were on Medicaid, the government health care program for low-income individuals and families, which made referrals to other practitioners difficult. In 2010, Jones became pregnant with twins, one of whom she would lose late in her pregnancy. Emotionally and physically spent, she took time off to recover.

In May 2011, she returned to the Livingston practice and also took over the practice of a doctor retiring in Maplewood. The new practice accepted only private medical insurance, which made life a little easier. Still, she was shuttling between two offices and juggling burdensome administrative tasks. That August, a former residency colleague informed Jones that her practice—the Women's Care Source in Morris-town—wanted to add a sixth physician. The practice was part of LifeLine Medical Associates, a single-specialty group founded in 1997 by Dr. John Felz to, among other things, gain leverage in negotiations with managed-care companies. LifeLine—which today has 100 physician members—had a system-wide EHR and a behind-the-scenes financial team. To Jones, it indeed seemed a lifeline. "A huge lightbulb went off in my head," she says. "Aha, so this is how people survive—by having someone else do the administrative and other work for them!"

Felz, president of LifeLine, says group practices have become indispensable. "Medicine has traditionally been a cottage industry in which doctors were autonomous and independent and did the best they could," he says. "Today, though, we can only make health care better if we put a bigger in- (Continued on page 138)
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In December 2011, Jones joined Women's Care Source and, thereby, Lifeline. She closed her Livingston office and now works only out of Springfield, where the Maplewood office relocated in September. In December, she anticipates becoming a full Lifeline partner, meaning she will share in its profits.

Shayna Jones is finally happy. Her patients tell her she seems more relaxed and responds to them in a more timely and effective manner. “With the support I get,” Jones says, “I’m able to pick up on details I wasn’t able to previously.”

Dr. Karen A. Wirtshafter
ENT & Allergy Associates

The daughter of a primary care doctor who practiced in Burlington County, Wirtshafter joined a two-person practice with offices in Denville and Dover after completing her residency in otolaryngology at Montefiore Medical Center/Albert Einstein College of Medicine in New York in 1991. She made partner five years later and successfully weathered changes in group personnel for almost two decades.

By 2006, however, cracks began to show. Managed care was driving down group revenues. The woman hired to manage the practice was “lovely,” Wirtshafter says, “but had no specific training in administration, billing or the tools one needs to navigate the very complex world of health care today.” One of those tools was an EHR system, which the practice could ill afford, nor did it have the capital to move into a larger office with more exam rooms, which it desperately needed.

“The problem with being in a small practice,” says Wirtshafter, “is that any big expenditure comes out of the bottom line, which is to say, your pocket.” To add to the stress, the 2008 presidential election had raised the specter of health care reform. “A lot of rumors were flying around in terms of what we [doctors in private practice] would need to do,” she says.

Then her husband, a general surgeon, told her about ENT & Allergy Associates. The concept was straightforward: Formed in 1998 by the merger of 12 physicians from three groups and eight locations, the group gathers otolaryngologists and allergists “under one umbrella, one governance program and one EHR,” says CEO Robert Glazer. Currently, the umbrella covers more than 160 doctors in more than 40 separate offices in northern and central New Jersey and New York State.

The group is structured like a law firm. New doctors, whether recruited out of residency or from private practice, come in as associates and after six years become eligible for partnership and a share of the group’s net revenue. “After three years, our associates are making more money than most partners in other practices,” Glazer says. “And when they become partners, they do even better.”

In 2008, Wirtshafter and her partners (one retired before the merger) joined ENT & Allergy Associates. Almost immediately, they were moved out of their Denville location and into a larger, brand-new office in nearby Parsippany. Like all offices in the group, it’s plugged into the system-wide EHR.

Besides the EHR, Wirtshafter enjoys having a tech expert on call to solve computer issues, a central HR department to handle staff problems, a central office to do the billing, and consultants at Mount Sinai to turn to for unusually complex cases. She’s grateful not to be practicing in a small group. “I think it would be very difficult,” she says.

Dr. Bruce Aronwald
Barnabas Health Medical Group

After 25 years in private practice, Aronwald, an osteopathic family physician, liked to think of himself as a “forward thinking” doctor who regularly looked ahead to anticipate changes in the field. He had started with one office and gradually added doctors, nurses and ancillary services, forming Morristown Medical Group, which today consists of six doctors and 25 full-time employees in three locations.

In 2002, Aronwald started the state’s first concierge practice, a form of care in which patients pay an annual fee or retain for enhanced access to the physician of their choice. (Only a portion of Aronwald’s patients are enrolled in his concierge practice.) He also started consulting/management company to help other physicians set-up similar practices. And in 2006, his group was one of the first in the state to use an office-based EHR.

But by 2012, with health care models changing, Aronwald concluded it would
be hard to continue as an independent stand-alone group.

Aronwald was recruited by several hospital systems, but was drawn to Barnabas Health, the largest nonprofit health care system in the state. Despite its size, Aronwald felt an immediate personal connection with "the Barnabas people." In November 2013, he and his partners became affiliates of the 600-doctor group.

Most of the changes in his practice have been administrative—the "back end stuff that patients don't experience but were necessary changes." Fewer changes have occurred in patient care. "We've been doing a good job for many years, and I think Barnabas recognizes that and was attracted to us initially because of that," says Aronwald. "They've been very hands-off."

Dr. Gerald Sotsky
Valley Medical Group

Before joining Valley Medical Group three years ago, Sotsky and his four partners offered a range of services to their cardiac patients, from general cardiology to complex interventional procedures. Still, they had to refer patients with certain medical problems to specialists in other groups—a cardiac surgeon for bypasses or a cardiac electrophysiologist for electrical abnormalities of the heart, for example. "It's probably not the best way to take care of patients," says Sotsky.

After 23 years in private practice, Sotsky and his partners decided it was time to merge with a larger system in which doctors, he says, "pool resources and intellectual information and create a whole that's bigger than the sum of its parts."

Valley seemed like the perfect fit. As attending physicians, Sotsky and his partners already admitted most of their cardiac patients to the Valley Hospital in Ridgewood and had been active in many of the hospital's quality initiatives.

"If you're a physician group," says Marc Goldstein, president of the Valley Medical Group, "you are going to look for a hospital that will provide good quality care at the lowest possible cost and work hard to keep patients out of the hospital and out of the testing arena unless it's medically necessary." What Valley looks for, Goldstein says, are established, specialized groups like Sotsky's to broaden its reach in the new medical economy.

Three years after joining Valley, Sotsky chairs its cardiac services and directs the hospital's coronary care unit. He appreciates the group's fully integrated EHR, its billing and administrative service and its intellectual resources. "We're in the process of bringing on a congestive heart failure specialist—a sort of super interventionalist who treats valvular and other heart disease," he says. "No one small group would have been able to do this."

Sotsky says membership in the larger group has come with no loss of autonomy. Hospital officials don't tell him how to practice, he says, and they take his input seriously. Besides, he adds, "with so many government and insurance regulations, is anyone truly autonomous at this point?"

Not all practice linkups are successful; in fact, some mergers fall apart. "Right now, I have one situation where the doctor is trying to unwind and another where the hospital is," says attorney John Fanburg. In the first case, he says, the hospital is not managing the practice the way the doctor, a female primary care physician, expected, while, in the second case, the hospital thinks the doctors aren't pulling their weight economically. "In each instance," Fanburg says, "the hospital has been very cooperative. The attitude is, 'We're still in the same community—let's move on together.'"

Still, Fanburg expects consolidation to continue in New Jersey and elsewhere. He tells doctors, "If you're in a one- or two-person group, you can't manage, can't afford the infrastructure you need to survive economically in this environment. Now what kind of larger group is best for you? Let's talk about that. What you don't want to do is to work until you wake up one morning and think, Oh my God, what happened here?"

Is independent private practice a dinosaur? "In the near future, I don't see the end of private practice," says Valley's Marc Goldstein. "Five to 10 years from now, though, I don't think it's a sustainable model. Kids coming out of residency and fellowship don't have the desire to work 14 to 16 hours a day and be entrepreneurs. They're looking for employment. So these late- and mid-career practices will wind down, and they won't be replaced."

Wayne Guglielmo reports on health-care issues for New Jersey Monthly.

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EBOLA

Their predictions range from extremely remote to highly possible. Opinions are also divided on the state's readiness to handle Ebola, should the disease find its way here.

"IT'S ONLY A PLANE RIDE AWAY," says Dr. Manal Youssef-Bessler, founder of the Infectious Disease Center of New Jersey in Livingston. Indeed, in late September, a man who flew into Dallas from the West African nation of Liberia became the first case of Ebola diagnosed in the United States.

Youssef-Bessler doubts that New Jersey, or the nation as a whole, is 100 percent prepared. "A lot of questions are being raised about if we have a case here," she says. "How are we going to handle specimens? Where do these specimens go? Do we have a solid protocol in place? I personally don't believe that we do in every single hospital in New Jersey."

Dr. Christina Tan, the state's official epidemiologist, disagrees. "New Jersey's hospitals," she declares, "are prepared to deal with the possibility of a case of Ebola or any other emerging viruses coming into the state."

While stating that "the likelihood of our getting an Ebola case is very low," Tan, the assistant commissioner for epidemiology, environmental and occupational health at the state's Department of Health, recognizes that "we can never rule out the possibility of it showing up somewhere, and we understand the precautions that hospitals have to follow."

Working with the CDC and county health departments, the state has established an emergency response system for screening, reporting and caring for an Ebola patient, not unlike systems put in place during earlier health scares, including anthrax, H1N1, MRSA and SARS, Tan says. The CDC recommends that hospitals and health care workers employ contact and droplet precautions when dealing with a suspected case of Ebola virus. In its current form, Ebola is highly transmissible through bodily fluids, but not through the air around patients. At deadline, four Americans who contracted the virus in West Africa—all U.S. medical or aid personnel—had been flown to hospitals in Atlanta and Nebraska where high levels of biocontainment
were in place.

The World Health Organization (WHO) projected that 20,000 people could be stricken with Ebola worldwide by early November. The CDC predicts about 550,000 reported cases by January, if the disease is not quickly contained. With thousands of U.S. military troops and medical personnel traveling to West Africa to lend aid, infectious-disease specialist Dr. Lincoln Miller says that unchecked cases will likely end up Stateside, with New York and New Jersey hospitals being among the places where an infected person might turn up. He disagrees with the assessments of the CDC and the New Jersey Department of Health that any hospital with the ability to quarantine patients can handle such a case.

“I really think they’re downplaying it,” he says. “It would be more useful to say that [patients] should be sent to places that are already prepared to handle it.”

Adding to the concern about Ebola at Cooper is the sizable Liberian community in Camden and neighboring Philadelphia. Many of these immigrants work in the area’s health care system, according to Fraimow. Liberia has been one of the most severely affected countries in West Africa, along with Guinea and Sierra Leone, and to a lesser extent Nigeria and Senegal.

With a significant West African population in New Brunswick and the surrounding area, St. Peter’s University Hospital faces a similar challenge. In mid-September, the New Brunswick hospital started reaching out to representatives from the state’s Liberian and Sierra Leonean communities to educate them about the disease and warn against unnecessary travel to their home countries, according to hospital director of public relations Phil Hartman. Like St. Barnabas, St. Peter’s has asked its physicians to be prepared and to make sure the medical staff is ready.

Like St. Barnabas, St. Peter’s has asked its physicians to be prepared and to make sure the medical staff is ready. Its equipment needs to be sure it is ready for an Ebola patient. Amy Gram, a registered nurse and director of infection prevention at St. Peter’s, has equipped a cart in the emergency room with disposable leg and shoe coverings, gloves, goggles, gowns, masks and face shields. She also forwarded a host of Ebola alerts from the CDC and the state Health Department to all front-line personnel at the hospital. The alerts provide guidance on identifying symptoms, taking travel histories, handling specimen samples and other matters. The challenge, says Gram, is to make sure people read the dense updates.

“These reports are three and four pages long. Realistically, are people going to wade through all that?” Gram asks. “I send out a summary and try to highlight the important parts.”

Updates on the crisis were being issued so frequently by the CDC that the state Department of Health reduced the flow to weekly reports while referring people to a website for more frequent updates. “We’re sending out alerts and hospitals would print them out, and everyone thought those were the guidelines,” says Donna Leusner, spokesperson for the Department of Health. “Then they’d be outdated a few days later.”

Dr. Ted Louie of Highland Park Medical Associates is an infectious-disease doctor with a subspecialty in travel medicine. He advises international travelers what shots they need and what to avoid while traveling abroad. His advice for anyone considering a visit to West Africa right now? Don’t.

“The safest thing would be to not even go there,” Louie says. “But if you have to, be sure to have no physical contact with anyone who appears to be sick. Avoid hunting, or being close to bats or primates. And don’t go to any funerals.” (Ebola is particularly virulent when people touch an infected corpse and can be contracted by contact with bush animals.)

Louie also urges travelers in international airports to keep more than three feet away from anyone who seems sick. Ebola has a 2- to 21-day incubation cycle, but is contagious only when symptoms appear. These include high fever, severe headaches, sore throat, vomiting, diarrhea, abdominal or chest pain and hemorrhaging. Anyone who has traveled to West Africa, even if they were unlikely to have been exposed, should closely monitor their health for 21 days after returning. While there is no approved vaccine or cure for Ebola, patients whose cases are caught early, and who receive plenty of fluids and nutrition, have a better chance of survival.

Fraimow says he would not be surprised if a team from Cooper mobilized to go to West Africa—especially considering the UN resolution urging countries to send medical personnel and supplies then. Such was the case following the Haiti earthquake in 2010. Louie expects some of his colleagues to join the effort, something he says he would have considered “if I was 25 and didn’t have a family.”

“Infectious-disease physicians in general are very interested in what the rest of the world is doing,” Louie says. “They have this very altruistic outlook. So there probably will be no shortage of doctors willing to help out.”

“Infected disease physicians have an altruistic outlook. There will be no shortage of doctors willing to help out.”

As co-chief of the infectious-disease department at St. Barnabas Medical Center in Livingston, Miller is taking no chances with the virus, which has a fatality rate around 50 percent, according to the WHO. During a recent assessment of his hospital, Miller identified about a dozen negative-pressure rooms that could handle Ebola patients. These are specially ventilated isolation rooms normally used for tuberculosis sufferers. However, he was concerned that the adjoining rooms, where staff would be decontaminated, may not be sufficient to contain Ebola contaminants. He is looking into getting more space and equipment to handle the threat. He has already ordered better gowns and goggles for the infectious-disease team. “I wouldn’t want anyone to go in there without full protection,” he says.

Similarly, Dr. Henry Fraimow worries about staff at Cooper University Hospital in Camden, where he is the hospital’s epidemiologist. Noting a heightened anxiety among the employees, Fraimow says he is working “to be proactive and educate them so they feel more comfortable.” To that end, he has held weekly staff meetings for discussion of Ebola and enterovirus D68, a respiratory illness spreading its grip on the Northeast. He also has started holding daily meetings with the district health departments to ensure they are prepared.

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