P U B L I C H E A R I N G

before

THE SENATE COMMITTEE ON AGING

on

Premature Discharge of
Senior Citizens from Hospitals

April 2, 1986
Long Branch
Municipal Building
Long Branch, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Frank Pallone, Chairman
Senator Leanna Brown

ALSO PRESENT:

Diane Lynch
Office of Legislative Services
Aide, Senate Aging Committee

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SENATOR FRANK PALLONE (Chairman): Good morning. We are going to begin the hearing. Can we have everyone's attention, please?

First of all, I want to thank all of you for coming for what I think should prove to be an interesting public hearing. My name is Senator Frank Pallone, Jr., and I'm the Chairman of the Senate Committee on Aging. And this morning, hopefully, we will have Senator Leanna Brown, who is another member of the Committee, who will be joining us. I don't believe that the other members of the Committee will be able to come; but there is that possibility, and when they do come, I will, of course, introduce them when they come in.

We also have with us some members of the OLS, which is the non-partisan staff of the Legislature. To my left is a Committee Aide, Diane Lynch; and also, Norma Svedosh, who is to her left. And we also have some of the partisan staff here; Barbara Cantrell, to my right, from the majority staff; and Rosemary Pramuk, from the minority staff, who's over on the left.

This public hearing is being held to examine charges raised in recent Congressional testimony that some hospitals are prematurely discharging elderly patients due to Medicare's current prospective payment system. And this is the system which regulates hospital prices based on the diagnostic-related groups, or better known as DRGs.

In New Jersey, our all-payer DRG system has worked so well that it has become a national model. So, we're not here today to criticize DRGs or the system. But we are here to examine how the current DRG system is administered, and whether any of our State's elderly have been prematurely released due to administrative decision-making.

This issue has been raised in Congressional testimony, and most recently, in the March 13th issue of The New England Journal of Medicine, "Summary of Major Study of Medicare" done

by the Harvard Medicare Project. And, quoting from the Harvard study, it states: "Medicare's current prospective payment system may promote discrimination against certain groups of patients. It may make the elderly less desirable patients than privately-insured patients, thus leading to a tendency to discharge older persons, sicker and quicker." Unquote.

I hope that this is not happening in New Jersey. Our Committee wants to make certain that our elderly are released from the hospital when their doctor determines that they are ready to go home. I've introduced legislation that will require hospitals to give patients, upon admission to the hospital, a copy of their Medicare Bill of Rights, recently developed by the Federal Department of Health and Human Services. This information will help elderly patients and their families understand the system.

There's another reason why we're holding this hearing today. We know that Federal budget policy has a direct impact on our State budget process in the era of new federalism. We've learned, through our experience with Gramm-Rudman -- which has come up in practically every budget hearing that I've attended -- that when budget cuts are made in Washington, New Jersey taxpayers may be asked to pick up the cuts through State tax dollars. If Medicare reduced the number of hospital days or home-health care visits that it will cover, then people will look to our State government for assistance. So, it's clear that we at the State level have a direct interest in Federal policy decisions.

It's also clear that we have a role to play in helping to shape that policy. It's for that reason, and because, in many respects, this is both a Federal and State issue, that I'm very pleased today that Congressman James Howard, who is our Congressman from the district that you're now sitting in -- from Monmouth County as well as Ocean County -- has agreed to come here today and is our first witness. I don't think I have

to say anything about Congressman Howard, because he's well known in our area. He's represented our area for over 20 years, and I certainly think that he's the best Congressman in the United States. So, without further ado, Jim Howard.

C O N G R E S S M A N J A M E S J. H O W A R D: Thank you very much. Mr. Chairman, I consider you the best State Senator in the United States.

Thank you very much, Mr. Chairman. I'm very pleased to be able to appear before the New Jersey Senate Committee on Aging this morning, to relate my thoughts on the effects of government cost-cutting measures on the health care of senior citizens, and more specifically, the serious problem of early hospital discharges among the most vulnerable segment of our population.

I've been deeply concerned about this situation since I received, recently, the results of a Medicare survey I conducted among thousands of older citizens in the third Congressional district. While I'll submit more detailed results of the survey for the record, let me say in summary that it reveals senior citizen health care is suffering under the diagnostic-related group payment system and its Medicare policing arm, the Peer Review Organization, or PRO.

The PRO is a private corporation composed primarily of physicians under contract with the Federal government to oversee and reduce hospital admissions and lengths of stay. Federal PRO regulations were implemented in 1984 by the Health Care Finance Administration, and now Medicare expenses in states and regions around the country are being monitored by PRO doctors.

Under the PRO regulations, the Medicare program reimburses hospitals for treatment based not on length of stay, but according to standard charges for specific medical procedures. This has the unfortunate effect of encouraging early hospital discharges, because the reimbursement is the

same no matter how long the patient stays in the hospital. More generally speaking, my survey revealed that 75% of the 3,182 senior citizens responding were under a doctor's care for the treatment of a condition requiring regular visits. From this group of 2,398, the following was learned:

--75.3% of them had received notice -- or were being reimbursed by Medicare for their condition;

--22.8% of them had received notice that their treatments were being limited; and

--15.3% received notice their treatments were no longer eligible. That's 38.1% either reduced or eliminated.

--Of those who had emergency admissions or planned hospitalization, 16% said they were subject to PRO review, and 10.6% believe they were discharged too soon as a result of PRO involvement. A very high percentage of those senior citizens under a doctor's care for treatment of a condition reported their medical care would be adversely affected if Medicare payments were eliminated or restricted.

--72% said they couldn't afford treatment if their payments were eliminated, and 32% said they wouldn't seek treatment at all if payments were eliminated or restricted.

--Over 75% of all individuals responding indicated they do not believe it is in their best interest to allow a Medicare carrier's medical staff, or the PRO, to have a direct influence on either the medical care recommended by the treating physician or the attending physician in a hospital when admitted in an emergency; or determining when patients are to be discharged; or determining if part of the patient's hospitalization was, quote, "unnecessary," unquote.

Most seriously of all, five individuals alleged that the death of a friend or a family member was related to his or her premature discharge from the hospital. One Monmouth County woman wrote, and I quote, "Medicare decided my husband couldn't stay longer in the hospital. Had to transfer him to a nursing

home, and he died four days later. The doctor had no control of keeping him" -- that means their own doctor, in the hospital.

Who's to blame for this situation? The PROs claim they are only following the provisions of their contracts. The Federal law establishing the PRO system requires that insuring quality health care of Medicare recipients be as much a function of the PRO as cutting costs. But in practice, this quality assurance has been virtually ignored, and all the emphasis is placed on cost control.

PROs complain they do not have enough money to accomplish both goals, and so they've eliminated the quality assurance and put their emphasis on cost control. The acting administrator of the Health Care Finance Administration, which oversees the PROs, indicated in a recent letter to me that he felt it was the hospital and physicians who were responsible for the problems of premature discharges. He said that in the scope of the work for the new PRO contracts, the agency is emphasizing, and I quote, "even more strongly the need to detect cases of premature discharge, and the need to bring sanctions against hospitals or physicians that engage in this practice."

I believe he's blaming the wrong parties. Hospitals and physicians have the interests of their patients foremost in their minds, and are struggling to deal with the PRO mandate in a way that is medically sound, compassionate, and consistent with the law. They're caught in the middle between trying to assure proper care and responding to extraordinary PRO pressure to reduce admissions and lengths of stay.

I've submitted testimony regarding my survey results to the House Select Committee on Aging, which is working on legislation that will force greater PRO accountability in assuring proper care of the patients. Other progress has been made since my survey was taken last June. The Federal

Department of Health and Human Services took the action in late February of requiring hospitals to provide detailed information abut how Medicare patients can appeal their hospital discharge notices if they think they're being asked to leave too soon.

Under Medicare rules, hospitals must inform Medicare beneficiaries 48 hours in advance of a PRO-initiated discharge. If patients feel they're being asked to leave the hospital prematurely, they can file an appeal by telephoning, or in writing, with the PRO. Under the current law, the PRO must review the case and arrive at a decision within three working days of receiving the appeal. I've cosponsored legislation to require that the PRO complete its review in two days. This way, the patient will learn the decision of the PRO while still in the two-day grace period, and will not be forced to pay for his hospital stay out of his own pocket while he awaits that decision.

Finally, I'd like to urge that the New Jersey Department of Health, which I understand will be represented here today, undertake a detailed study of the question of premature hospital discharges. The Department does have the authority to make specific inquiry into the health care histories of patients who complain of premature hospital discharges. Many in government point to the decline of hospital use as a measure of the success of cost-containment efforts in the Medicare program. But it's unconscionable that cost containment should come at the expense of the health and longevity of our older citizens. And cost is not necessarily being eliminated, but simply shifted to others, primarily to our nation's retired, who are being told that they must shoulder a much greater portion of ever-increasing health costs or forego recommended treatment.

That's the end of my formal statement, Mr. Chairman. I do have -- which I'll submit to the Committee -- a copy of the results of the survey that I took here in Monmouth and

Ocean County, for the record.

And, just in closing, I'd like to say that there is something maybe less tangible involved in this, because we are dealing with our senior citizens. They are very, very concerned about their health, of course, and also concerned about the fact that most of them barely have enough money to get along on, and are very, very frightened at the prospect that, all of a sudden, a large bill would come to them -- even though this does not come to them, it's just money that will not be paid to the hospital. They are not really assured of that.

I had a case in Ocean County during the past year, of a couple. The man is in his 90s -- mid-90s, woke up at two o'clock in the morning with a severe nosebleed that would not stop for several hours. She certainly did not panic. The wife, who is 90 now, waited several hours before calling their own doctor. Their physician sent the man to the hospital. He was there for several days, and while he was there, it's fortunate that he was -- that their own physician did send him to the hospital, because he did have a relapse and a situation involving his heart -- perhaps very much due to the loss of blood -- could have been involved. I'm not a physician, I don't know; but it's a good thing that he was there when that happened. And it turned out much later that the PRO decided that that man should not have been in the hospital, and that they would not pay any part of it.

Now, despite all the facts of trying to cut costs and take care of treatment, in this elderly couple's mind, there is a great fear. And there is a fear by the wife, especially, that if her husband should develop this, or some similar situation, would she be afraid to bring him to the hospital, because of a situation with PROs. And that is what's pervading the senior citizen community around here, and I think it's something we must consider.

The insecurity -- and there are a few things, as I told the Chairman before we came in, I think what the average citizen in this country, there are places where we feel we are out of our element, that we want to know and have confidence in the person we deal with. I know for myself, that's with an auto mechanic. Whenever my automobile is being worked on, if I don't know the auto mechanic, I am very afraid I may really be being taken, 'cause I don't know any better. I believe that it also deals with the person who repairs our television sets. If you know them and have confidence, all right; if you don't know them, you figure, "I may be being taken."

And I think, with our own physician, also -- and I think it's very frightening for all of our people, especially our senior citizens -- if they have their own family doctor, and they realize that a situation exists that some stranger, some person who has not seen the patient or been in the area at all, may overrule their own physician. I think that that is a very frightening thing, and I hope that we can straighten this out. We want to cut costs; we know the costs are very heavy and this was put in Federal law for a purpose, but let's get it back on track and realize that cost cutting is secondary to proper health care for our senior citizens.

And thank you very much, and I want to congratulate you for (audience applauds) holding these hearings, because I believe that the State can do a great deal to help in this situation.

SENATOR PALLONE: Thank you, Congressman. I want to thank you in particular, because I know you took time out from your busy schedule to come down here today -- and also point out that the survey that you did was the basis for my wanting to sponsor this hearing, because I felt that there was a problem there.

And I should also point out that some of the people that participated in the survey, I believe, are here today --

at least one, perhaps others -- and will be testifying to, basically, detail from their own personal experience what was put in that survey. So, thanks again. I appreciate your comments.

CONGRESSMAN HOWARD: Thank you very much. I certainly appreciate being here. (audience applauds)

SENATOR PALLONE: Let me just say that we're going to try to intersperse some people from State agencies with physicians -- private physicians as well as with some members of the public who were directly affected, or who had relatives affected, as we go along. We're going to try to-- Rather than have any set order, we're going to try to just kind of intersperse people from the categories. And also -- that I've had some requests, particularly from some physicians who will have to go early, and so I'm going to try to get those people on early so that they can get back to their responsibilities.

Some of you also may have received -- I don't know if a copy of this list with the speakers has circulated in the audience, but that isn't the order that we're going to necessarily follow -- just so you know -- and there are people who aren't on the list who have also been added and who will be testifying.

And for the reasons I just gave, I would like to start out with Dr. Ralph J. Fioretti, who's the Chairman of the Medical Society of New Jersey.

D R. R A L P H J. F I O R E T T I: Thank you, Senator, for inviting me here today. I welcome this opportunity to speak for the Medical Society of New Jersey.

I am a certified family physician. I was Chairman of Bergen County's PSRO for nine years. I still make house calls.

I'd like to start my talk today by making this statement. I never want to hear a physician make this statement: "I'm sorry, it is too expensive to keep you alive." Our position in the Medical Society is this: The

health and welfare of patients shall be the first consideration, not allowing economics, politics, race, or religion, or any other circumstance to take preference.

Now, we have the PRO legislation. The enactment of this law, in its haste for cost containment, is having a serious impact on the quality of care to our senior citizens. As taxpayers, we applaud the efforts to cut out waste, and as physicians, we have done what we could to comply with the law. But now, this law is doing harm to our patients. In the Medical Society, we have taken the position of the advocate of the senior citizens and the adversary of the PRO.

Some of the original criteria in the PRO contract was this -- and what I'm going to tell you now is ridiculous, and it has been changed: "No herniorrhaphy can be performed unless the man has worn a truss for six months." Because of this, we appointed a Criteria Oversight Committee to correct these criteria. And they have been changed somewhat.

I have appointed a task force speaking to senior citizens, telling them the changes in the health care delivery system and that they are now the victims of rationing of health care. I daresay that this hearing today is in great part due to the concern of senior citizens on the deterioration of quality of care being delivered to them. We have explained to them how physicians have been pressured and coerced into early discharge.

Let me give you a scenario of what I face every day, in my practice. A 75 year-old man has a stroke. He's admitted to the emergency room of a hospital. From the emergency room, he's admitted to the hospital. He's in the hospital about two weeks, maybe three weeks. His stroke is stabilized; he has a left-sided hemiplegia -- or paralysis; he's lost his ability to speak. Now I must send him home.

To send his home -- his wife is arthritic, or has Alzheimer's disease. Or, he has no wife, his kids are

scattered all over the country, so we can't send him home. We must now admit this man to a nursing home. The cost of a nursing home now is between $700-1000 a week. This is a middle-class senior citizen. He's paid his dues, he obeys the laws, he's gone to war, he paid taxes. He must now go to a nursing home. He has a modest pension, he owns his own home, and maybe he has $30,000 in the bank. He must now spend down to the poverty level before he gets any help from the Federal government.

The acute care section is only one part of this whole health care delivery. There is no home care. Have you ever seen the quality of the people who are assigned to home care? I think you should look into this. Our Federal government, right now, has cut down on home care. I can't believe that the American people, when they find out what short-changing they're getting on health care, are going to put up with it.

Let me give you another example, of a female patient with bone cancer -- multiple myeloma -- was in the hospital for 21 days. Her days, under the DRG, had expired. She was told she has to go home now. She was given a pump to treat herself at home. She was alone. They sent somebody at home with her who knew very little about the pump. The pump got stuck. Three days later, she collapsed. She was readmitted to the hospital. A week or 10 days later, she died.

Ladies and gentlemen, I'm for cost containment. But compassion has gone out of this system, and I'm so happy that you're addressing this today. (audience applauds)

SENATOR PALLONE: Dr. Fioretti, could I just ask you one question? One of the concerns that we have is the fact that under this DRG system -- and the reimbursement system for Medicare -- that if the person is prematurely discharged and they have to be placed in the community or into a nursing home, but particularly back at home or in the community, as I said, that there isn't necessarily Medicare -- will not necessarily

cover the services that have to be performed in the community, in the home.

So, in other words, on the one hand, that Medicare is not -- you know, the system -- or the reimbursement system is making it so that hospitals, in some instances, are discharging prematurely. At the same time, when they do, in fact, go back home or back into the community, there isn't any -- there are problems covering the payments for the home health care services.

DR. FIORETTI: Yeah. We call that the area of no-care. It's like no-man's land. It's a vacuum. You really have-- You can't have one section -- you know, the acute care section treatment is the most expensive. And we understand that. But most of us feel that we are being pressured, that our patients are being sent home 24-48 hours, truly, before they're stable. As a clinician and speaking to doctors across the State, we all feel this way.

It's very difficult to document. How many people die at home four or five days after they've been discharged? Nobody's making that -- is doing that study. I've talked to the ombudsman in this State, and he stated to me that nursing home operators told him patients that they're getting in nursing homes now are very, very sick. They're not just custodial care or whatever. This is a lot more.

It just saddens me to-- The system is being generated by cost. You've got to think of the other side of it. It's very difficult. We as physicians are being asked to implement a system that we can't live with it, in conscience. It's just not going to happen. And I honestly believe that when the senior citizens truly find out what a shortchanging they're getting on health care, the legislators will not have a place to hide.

SENATOR PALLONE: Okay. I appreciate your comments. Thank you for coming.

We have Dr. Christopher Riley, also from the Medical Society -- Chairman of the Peer Review Oversight Committee.

D R. C H R I S T O P H E R R E I L L Y: I'm pleased to appear before the Senate Committee on Aging. And you've already made some of my comments about the gap that exists between the hospital care and the care after discharge from the hospital.

I'm convinced, however, that hospitals and physicians do not allow patients to be discharged before they are medically able to go, for the most part, because our conscience would bother us. And care would be deteriorating further than it is, if that were the case.

But no discussion of DRG is complete without a discussion of the PRO organization. This is an organization with no consumer advocate on their Board of Trustees, no representative of the Hospital Association, no representative of the Medical Society of New Jersey. And yet, they are the organization that determines whether or not an admission is appropriate or not appropriate.

We wrote to the various hospitals from the Peer Review Oversight Committee, asking them about how many cases were denied, which means, then, the hospital does not get paid and they are not allowed to bill the patients privately. We found out that between 50-100% of the cases are appealed, and that between 50-100% are partially or completely reversed. In a system where there's that much reversal of the initial review, there has to be a problem.

Many hospitals did not answer our survey. I have the feeling that they are afraid to be whistle blowers, and then subsequently, subjected to more rigid review. Let me give you one example. We have a case of a woman that was admitted to one of our New Jersey hospitals with a fractured pelvis, stayed there for about 12 days, and when this case was reviewed, despite the fact that this patient had lost control of her bowels, urine, and other problems, the statement was made that

the admission is denied and she could have been treated at home with analgesics, which is aspirin, Tylenol, and maybe some codeine. That doesn't make sense. She couldn't walk with a fractured pelvis. It took a doctor's time out from his practice without reimbursement -- an entire morning -- to have the opinion reversed, and two days later, he was reviewed for his quality of care, and it wasn't up to standard. Now, that's ridiculous.

We also sent a survey -- we sent a form to some ambulance squads, and on this form we listed the name of the head of the County Board of Social Services. In one of the counties, we got this telephone call -- and I will not identify the person, but she said she was in near-hysteria. She said I did not authorize the use of her name on premature discharge forms. She said she could lose her job if they thought she had -- that was her idea. She wants her name removed.

These are some of the problems that we are seeing. We had one case where there was a denial, when an oncologist treating a leukemia patient saw the patient in the afternoon and the patient had five grams of hemoglobin -- when you realize that the normal hemoglobin is three times as much, this patient had very little blood left in his system -- chose to admit the patient in the evening, gave blood transfusions and sent the patient home within 12 hours. But it didn't fit into the cookbook, and it was denied because it went past midnight; and they said he should have waited until the morning to admit the patient, thereby putting the patient in danger during that 12-hour period.

Something has to be done to correct these problems. Thank you.

SENATOR PALLONE: Thank you. I just wanted to say to you that just from my own experience in the Senate office, that we have had occasion where people have come in and wanted to appeal decisions with the PRO. And I've always encouraged them

to do that, and most of them have been overturned -- and some of them significantly. So, it definitely is happening.

Thank you again. Okay, again, I'm going to try to call some people that have to leave early. And, the next person we have is Craig Becker, who's the Vice President of the New Jersey Hospital Association.

Are the microphones working? Can everyone hear in the back? (audience responds) Not too well? It is on, though? Maybe if we moved them a little closer-- And speak louder, if you can.

C R A I G B E C K E R: Mr. Chairman, thank you. Craig Becker from the New Jersey Hospital Association. I want to thank you for allowing us to testify today.

I have with me Betty Lou Miccio, who heads up our Professional Practices Department. She's the one who's been living and eating this whole issue for the last two years, and I asked her to please make comments and to address the problem as outlined.

B E T T Y L O U M I C C I O: Thank you. Can you hear me?

SENATOR PALLONE: I think you better speak into that one.

MS. MICCIO: Good morning. Mr. Chairman and members of the Committee, I am Betty Lou Miccio, the Vice President of Professional Practice at the New Jersey Hospital Association. We would like to take this opportunity to thank you for giving us the chance to speak to this very important issue.

As we all know, the Federal government has instituted major changes in Medicare, including the prospective payment system and PROs. These changes have apparently caused problems in some states, and the changes have raised concerns in this State too. But in the five years that New Jersey has been on a prospective payment system -- and not just for Medicare -- there has been no evidence to show that patients are being discharged from hospitals too early. (interference from public address system renders part of statement inaudible) That's not

to say that there are not concerns and fears about these changes. The government has created a system that no longer allows people to recover in the hospitals, as they once did. Patients, then, are discharged by their doctors to recover elsewhere, perhaps using home care or nursing home services .

Medicare patients who are acutely ill -- and their condition requires continued hospitalization -- are not being discharged by their physicians, and can remain in the hospital for as long as necessary to receive those services -- and this is important -- that can only be provided in a hospital setting. Being discharged before a complete recovery is a change, frankly, that we are all having to live with, hospitals, physicians, nurses and patients alike.

It is valuable, I think, to look at New Jersey's five-year experience under this State's version of the national system, before inaccurate conclusions are drawn about hospital care in our State. For example, in 1983, three years after our system began, the Department of Health did a study on premature discharges, using Federal agents -- the Peer Review Organizations.

The study of 72% of the discharges did not find a problem with early discharges. Also, because there were concerns about what could occur with our system, a mechanism was established where any case suspected of being adversely affected by the payment system could be referred to, and reviewed by, physicians at the State's Medical Society. I checked with them yesterday, and to date there has not been one case received by them.

And the organization that has a contract with the Federal government to conduct review, including those for premature discharges, have reported several months ago that they had identified only one confirmed case of premature discharge in the entire State.

Even Pennsylvania Senator John Heinz, the proponent --

as you know -- of the sicker-quicker argument, has said, and I quote him now: "New Jersey is an exception. That State has been a leader in health care cost containment since they initiated the first DRG model in the nation. They have been sensitive to the needs of both the provider and the patient. Unfortunately, the national DRG system hasn't shown that same kind of sensitivity." Close quote.

I think we should all be very proud of our track record in New Jersey, and not be too influenced by what is happening in other states. Now, that is not to say that we should let our guard down. We are required to comply with a system that is mandated by the Federal government, and we should all be vigilant for quality and work together to bring attention to what, perhaps, is the real issue and concern -- the availability and accessibility of services required after discharge.

Let me close, Mr. Chairman, by emphasizing a couple of points. This is the government's program, and we are all bearing up under it. While the Federal government has not explained the impact of these changes to their beneficiaries, they have been very pointed with hospitals. They have told hospitals just how much they will get paid for services regardless of how much those services may cost. The physician is the one that orders those services, and it is the doctor that makes the order and the determination for discharge. We cannot believe that physicians would discharge their patients too sick, and I believe those studies referenced do give testimony to quality of care in our State. Thank you.

SENATOR PALLONE: Thank you. Before I ask you a question, I just wanted to mention that Senator Leanna Brown is here, and I do appreciate your coming down, because I know you came all the way down from Morris County, and I'm very glad to see that you're here in Long Branch, which is my hometown.

Just wanted to ask you-- You got into one area there

that I thought was particularly interesting. You mentioned that the system "no longer allows people to recover in hospitals as they once did. Patients, then, are discharged by their doctors, perhaps using home care or nursing home services." But once again -- and I guess I'm asking the same question, which is, if there is -- if it's necessary, because of the system -- you seem to feel that they're not prematurely discharged, but in any case, there are definitely people who need further care when they go back to their home or to the nursing home or whatever. Is there a problem in terms of Medicare covering those services that now have to be performed at home, which maybe previously were performed in the hospital?

MS. MICCIO: Yes, that's exactly the point that I was trying to make. The system is shrinking and Medicare intends to have exactly that occur. The problem seems to be that it's being shrunk from both ends, and when the patients are being discharged requiring those services, while the services may be there, they may not be sufficiently reimbursed to provide what is required by those patients.

SENATOR PALLONE: And could you elaborate on that a little? I mean, what type of services -- home health care in particular -- end up being covered? I guess it's not so much a problem if the person is in the nursing home, but more in the community.

MS. MICCIO: More in their own home--

SENATOR PALLONE: Right.

MS. MICCIO: --returning to their family, requiring physical therapy, respiratory therapy, nursing services and so on. I have had some personal experiences with some six in-laws, where on earlier days, they were able to come home and were given the necessary services because it was reimbursed. That is not the case anymore. The nursing services were available for a couple of days, then, to have them continued -- and they were needed - out-of-pocket expenses came into play.

SENATOR PALLONE: Okay. Well, thank you. Questions?

SENATOR BROWN: Yes, thank you, Mr. Chairman. We've had a very tragic event up in my home County of Morris. So, excuse me for being late, but when a friend's child is found slain in the Passaic River, it's very mind-boggling.

On to the current subject -- which is terribly, terribly important -- here this morning. I think, as we look around the State of New Jersey -- and we're concerned about the economy, and we're concerned about the environment, and we're concerned about education. Nothing, though, is worrying all of us -- whether we're young or old or middle-aged -- more than health care costs, because certainly, we know that a few weeks in the hospital can devastate all of us financially.

I'd like to ask the question a little bit differently, because the stress here, to date, has been on premature dismissal of senior citizens. I had, again, a personal experience with my father in May, who went -- 82 years old, celebrated his birthday in the hospital -- in for tests. Very frankly -- and I don't know how many in this audience have shared this experience -- but my father's experience was that it was unbelievably slow -- that he waited, and waited, and waited, and waited. And very frankly, at the end, when the hospital was penalized by the DRG system for only paying so many number of days, I was very pleased, because frankly, my father could have been out of that hospital a lot quicker.

So, I'd like to ask the question sort of in reverse. What record do you find in New Jersey, at this moment, of hospitals being penalized for keeping seniors in longer than they need to be? Again, nobody wants to be kept in the hospital longer than necessary, and I think we do injustice to some of our people if we keep in, so I think the concept of what we're doing here in New Jersey makes a great deal of sense. And if there's some fine-tuning that needs to be done -- but again, are we having situations with seniors in our

hospitals in New Jersey, where hospitals are penalized for keeping the seniors in too long?

MS. MICCIO: The only situation that I can give you, in terms of evidence and in terms of data, that may partially address your concern, is in those situations where the senior is to be discharged to a nursing home, but those services are not available. In other words, placement in a nursing home can not be obtained.

The hospitals, in many cases -- and we do have a number of hospitals that care for a lot of senior citizens that do not have sufficient nursing home beds available in their community -- those hospitals are, in fact, required to retain those patients until placement can be found. Since the care required is not acute, acute payment is not received.

SENATOR BROWN: Do you think there's any justification for saying that maybe a senior is occupying a bed in a hospital, and because that person may be older, can wait a little bit longer for care, can wait a little bit longer for treatment? I mean, an area that interests me strongly, Mr. Chairman, is whether or not we need to strengthen, in hospitals, the people who are trained to deal with the elder patient, because I think it is a different type. And I was just amazed -- this particular hospital had one nurse that had an understanding -- had a training in gerontology. And thank goodness that nurse was there to be sort of a liaison between here -- this elderly patient, and the rest of the hospital.

MS. MICCIO: I would not feel that there is any evidence to support that because a patient is a senior citizen, that their care is any different than anyone else, and that they are required to wait any longer. In fact, there are incentives in the system that would penalize a hospital if there were delays in care that were picked up by either the review organization or the hospital themselves.

SENATOR BROWN: Thank you for your testimony. Thank

you, Mr. Chairman.

SENATOR PALLONE: Thank you, Senator.

MR. BECKER: If I could just comment, Senator, on that also. One last remark is that hospitals provide the shop for physicians, and it truly is the physicians who make the determination on how quickly or how slowly a patient is discharged from a hospital. We're proud of the fact that we provide good services, but in the final result -- the end result, it is the physician who makes the determination.

SENATOR PALLONE: Thank you very much for your testimony. (audience applauds) Is Dr. Lewis Mufson, from -- he's a local physician, from Monmouth Medical Center -- Jersey Shore-- Is he here? (no response) Okay. How about Dr. Steven Lamazow, Executive Director of MEDICAL?

D R. S T E V E N L A M A Z O W: Thank you, Senator, for permitting me to speak today.

Let me just identify myself. First of all, I am a practicing neurologist in Essex County. In the past, I've been politically aware -- actually, about a year ago, I sponsored a meeting between the Federal AARP legislative body and the local physicians in Montclair, and hopefully, we had some influence in them, and they did seem to change their views to some degree concerning DRGs.

I also am the Executive Director of a lobbying organization called MEDICAL, which stands for--

SENATOR PALLONE: I'm just going to interrupt you because some people are saying they can't hear. Why don't you speak into that? Yeah, that seems to be the better one.

DR. LAMAZOW: I am also the Director of a recently-begun organization called MEDICAL, which stands for More Educated Doctors In Courts And Legislatures. We're concerned about political issues in reference to doctors.

My other hat is that I am also the medical editor at WPAT radio, and I have also been doing some medical affairs

programs -- public affairs programs -- with them, with people on both sides of the issues.

Now, DRG is an issue which, as a practicing physician, is close to my heart. With all due respect to the people who just testified, some of their assertions are clearly wrong. Let me give you my horror story.

A 65 year-old woman is admitted to the hospital for a cataract. The criteria states that a woman -- anyone with a cataract can not stay in the hospital previous -- the day previously, and it must be what they call a same-day stay. This woman is a diabetic, with a history of heart disease. She's cleared by a cardiologist who states that it's okay to have the surgery. She has surgery. She is taken home that night and at the dinner table, she suffers a cardiac arrest. She's brought to the hospital, and after about a 10-day hospitalization, dies of effects of brain damage from her heart stopping.

Now, this was a medically unstable patient. Perhaps she would have had a cardiac arrest after the stress of any surgery. But the criteria in this regard stated unequivocally that if this patient was brought into the hospital the day beforehand, or kept a day afterwards, their admission would be denied.

Now, these criteria are set up by the PROs, the physician review organizations, and it is my understanding -- and, as the head of the Medical Society stated -- that their obligation is strictly financial. The Physician Review Organization which was chosen for Essex County was chosen on the basis of being the least expensive -- the one that saved the most money, the cheapest. Not necessarily the one with the highest quality, but the one who saved the most money for the State, for the reimbursers.

Let me tell you about their criteria. Their criteria were put together by I don't know whom, because many times, I

look at their neurological criteria and they're basically false; they're wrong, they're inadequate. And unfortunately, the people who put the criteria together are not the people who are treating the patients. Many times, the-- And we have to live by these criteria, and it is the feeling of myself and my colleagues that many of these criteria were put together by people who strictly had economics in mind, and not medicine in mind.

Now, why haven't these cases appeared before the State? Well, first of all, physicians as a rule are not terribly politically aware. That's one reason I'm doing what I'm doing. Physicians like to treat patients. They found that the morale in medicine and the morale of physicians, at least in the State of New Jersey, is so poor at the present time because we feel that there's so much restriction put upon us in practice that most people have just plain given up.

The ability to appeal a case is incredibly tenuous. You have to go and make an appeal -- you have to go someplace, and then you have to have an argument with them. And sometimes they'll deny you and sometimes they won't. It's a very, very difficult situation to appeal.

And, there's no standard place to appeal to in each county. I mean, you can go to the State and appeal, but physicians are not into that. They're into treating patients and taking care of patients, and hoping that their patients get better without having to put up with the political rigamarole.

Now, what happens to the patient? Well, here's what happens to the patient. If the patient is decertified, they get a letter -- a nameless letter while in the hospital. Now, imagine yourself 65 years of age or greater -- or even not 65, because one point that I must make is that in New Jersey, these decertifications -- although elderly people are very important in this -- these decertifications affect everybody: people who are involved in automobile accidents, young people with

leukemia. It's not just the elderly in the State, it's everybody who can be decertified.

Now, imagine yourself with a disease. Your doctor says you have to be in the hospital because you're ill. You receive a letter in the mail, or a letter delivered to you by a member of the hospital, saying you cannot stay any longer -- if you stay any longer, your entire stay will be denied and you'll have to pay for it out of your own pocket, regardless of whether you have insurance or not. This is what's happening.

So, when a physician comes into the room, and we're concerned-- Let's say I bring a patient in who may be having an impending stroke, or having a problem, and it may not fit entirely into the criteria. The patient comes to me and says, "Doctor, look at this letter. I can't stay here anymore." It's hard to function with that, because then, in order to appeal this situation, you have to wait.

The other situation -- if you ignore it -- is something called a retrospective denial. Now, a retrospective denial means you can go about treating your patient and doing what you have to do. And then, three weeks later, you receive a letter in the mail, and the patient receives a letter in the mail, stating that "your entire stay has been denied;" that nobody's going to pay for the four days of hospitalization and you're responsible for it out of your own pocket, and the hospital has to take a loss on it for everything.

And, the percentages that it talked about is that on randomly reviewing cases, they've told physicians that if one case in 25 -- if four percent of your cases deviate from standards of criteria, then you will be sanctioned. This is the kind of things we're dealing with.

Basically, I think I've said everything I can -- every point I wanted to make. The need is for first of all, qualified medical criteria. People who -- from the State Medical Society designates -- Board certified people in their

specialties, making decisions about how the people in the State of New Jersey should be treated medically, not a financially-motivated organization. Criteria need to be changed, and drastically so.

There's so many issues in health care these days that affect us, that it's hard to enumerate them at this time. But I'll be happy to answer any questions you have at this time.

SENATOR PALLONE: Well, Doctor, let me just-- Is there some way -- I don't know if you feel that you want to answer this question, but is there some way that the DRG system can be changed so that individual circumstances get involved in the reimbursement rate? In other words, the way I understand it now, part of the problem is that an average rate is used for a particular category of illness or a particular category of treatment; and that the hospital isn't going to get paid beyond that average. And therefore, there may be -- at least, there's a feeling there may be some incentive to discharge early because you're not going to get paid for the extra time. Is there some way to tinker with that so that we avoid a possible problem with premature discharge?

DR. LAMAZOW: Well, there is a category called outliers. These are people who are -- who may have a stroke, and for some reason have to stay in the hospital for months upon months with severe illness. Now, those people have been excluded from the DRG, because they stay a particular amount of time. And those people -- people with catastrophic illness, where the cost of illness-- I don't know the exact statistics, but it's something like 10% of the admissions encumber 50% of the cost.

Now, another danger of the DRG system that you brought up is that for instance, let's say a patient who has a heart attack has now been allotted 13.2 days to stay in the hospital. Now, if he stays 10 days, if he stays 18 days, the hospital still gets paid for 13.2 days. Each hospital has a

Utilization Review Committee, and they'll come and they'll put some pressure upon you, and they do put-- Regardless of what everybody says, every physician in this State has felt pressure from hospitals and Utilization Review Committees to discharge patients early. I don't care what the State tells you, that is the truth.

What happens is-- Well, now maybe you're pressured to put the patient out a day or two earlier. So, next year, what do you know, the hospital has saved some money, and instead of them keeping them 13.2 days, they've kept them 11.2 days. Now what happens is, the State will readjust the DRG and say, "Well, now that you've been so good, the average day is 11.2 days." And this goes back, and it's going to shrink to the point where people are going to be thrown out of hospitals to the point where it's too early.

Yes, there is some abuse in the system; yes, people did stay in hospitals longer; yes, the system has cleaned up to some degree since DRGs came in. There has been abuse. People would admit -- use hospitals as nursing homes, use hospitals to admit people randomly. This was seen, and this has cleaned up. And, that is a definite benefit of cost-containment and DRG measures. This has taken the tack that even though this is cleaned up, a lot of the people at the other end of the spectrum -- people who need to be there, people who are being rushed out of hospitals -- are not getting the kind of care, and I definitely agree with the people who say there are not a lot of support systems.

You will find, as head of a Committee for the Aging -- if we just look at demography, you'll see that the average age of the population of the United States is increasing rapidly because of the baby boom, etcetera. Intermediate care facilities and chronic care facilities will be the crisis of the future. There will be no place to put these people. And, if a system could be devised where intermediate care facilities

-- to take some of the burden off the high cost of acute care, the $500 a day admissions -- to find some way to treat people in an intermediate system, where they would not necessarily be abandoned and sent home to a family that can't take care of them. That would probably be a reasonable way to do things.

The DRG system itself, I just don't know enough to be able to tell you what the solution is. If I was, I'd be in Washington. I don't know the answer. But, the system has benefit, it has detriment; and I think the points that I made earlier are the things that need to be changed most acutely. Physician morale-- It used to be that a doctor wanted his children to be doctors. You know, that was-- "You're going to follow in my"-- I would not want my child to be a doctor under these circumstances, because of the constraints put upon the medical profession these days by hospitals, by-- You have a problem. We go into a hospital, the hospital says, "Admit your patients because we need the money to admit the patients." But then they say, "Once you admit them, you can't keep them there long, because if you keep them too long, we'll lose money on them." And there's a hospital crisis in New Jersey, as you're very aware -- beds are being reduced, small hospitals are being urged to close. It's a-- I don't know the answer, but I think intermediate care is also very important. I think I've said too much already.

SENATOR PALLONE: No, you haven't. I appreciate your testimony. Senator Brown?

SENATOR BROWN: Yes. Thank you very much for coming here today. At least in my area, physicians are well organized and do make the effort to outreach with their legislators on a regular basis, so I do think that many doctors are extremely tuned in to the political system. And we need that, because we need your help in solving the problems.

My brother-in-law happens to be a physician on the West Coast, and I believe there is a great difference in the

length of stays that people are confined to hospitals on the East Coast versus the West Coast. We are still, in medical circles, looked upon as being very conservative on the East Coast, as a general rule, with the amount of hospital rules that people are assigned. My basic question to you is that, do you think, given a position of legislative responsibilities, would you be interested in keeping the DRG program, or would you throw it out, if you only had those two choices? One, to keep; two, to throw it out. You know what the eye doctor says: "Is it better with A or is it better with B?" as he tests your eye. Is it better with DRG or better without DRG in the State of New Jersey?

DR. LAMAZOW: I think the DRG has been generally beneficial in the State of New Jersey, but I believe it definitely still needs modification, and the input of the treater -- of the people who are in the pits every day, taking care of patients, the family doctors who have people dealing with him across the desk, 20 patients a day; the people in the hospitals, the specialists who deal with people on a day-to-day basis. It's not a cut-and-dry answer. DRG has been beneficial. The hospital DRGs appear to have worked very nicely as far as regulating hospital costs, but again, the system has reduced the morale of the treaters and in many instances, is detrimental to the care of patients.

SENATOR BROWN: I think the morale situation is a whole different one, and let me tell you, for some of us on the other end of the spectrum, that wait, and wait, and wait, and wait, and wait for physicians' services, that our morale gets very low, too. So, somehow, we will interchange and work together to improve this situation.

But my last question to you, as far as the DRG is concerned is, I can't believe that your Medical Society and so on hasn't had communications with the Commissioner of Health, volunteering your services in specific areas.

DR. LAMAZOW: Well, my organization is a fledgling organization. And I have had numerous-- I am fairly friendly with Frank Watson, who is the past President of the New Jersey State Medical Society. And, we've had long conversations in this regard, and he was there to testify at my meeting about DRGs.

We are becoming politically active and politically aware, and we want input into this situation. And, hopefully, between interactions between the legislators and the physicians, we will be able to effect something which is mutually beneficial to both of us. And I feel very bad about the fact that your father had to stay in the hospital -- your father-in-law, or your father had to stay longer than he should have. Unfortunately -- and I think most people will concede that -- physicians have various degrees of efficiency and various degrees of quality, and sometimes people are faster at getting things out than others. So, sometimes it's a necessary evil for reasons, perhaps-- What if something would have shown up on one of the tests, and had been overlooked, and your father-in-law would have gone home and found that he was sick, or found that there was a problem and that he had to go back into the hospital? So, obviously, there is no simple solution to the problem. There are both sides of both issues, Senator.

Thank you.

SENATOR PALLONE: Thank you again, Doctor. I appreciate your testimony.

I wanted to-- As I said, I'm going to try to intersperse this with some individuals as well. So, I'd like to have -- if Mr. Schibell, Andrew Schibell, as the next speaker?

A N D R E W S C H I B E L L: Mr. Chairman, members of the Committee. I hope the rest of the public here can-- Can you hear me back there? Which mike were they speaking on?

SENATOR PALLONE: You've got the right one.

MR. SCHIBELL: Got the right one?

SENATOR PALLONE: I think that's the best one. You just have to talk close to it, if possible.

MR. SCHIBELL: Well, I hope they can hear me for the simple reason -- I've come here this morning and I've listened to a few doctors, and I've listened to a member of a hospital staff give their version of what's taking place with this problem which we have facing the elderly.

Well, I'm not a doctor, nor am I associated with any hospital. I am a licensed accountant in the State of New Jersey. I have spent a good portion of my life in the field of financing and taxes. And I think I'm in a position to understand what is going on when we hear the word budgetary, or deficits and so forth and so on, that our State and Federal government is trying to put over and let the people believe. Well, we have a problem with the elderly here, and the release -- of premature release when they're admitted in the hospital.

Well, they say the proof of the pudding is in the eating. Like I've said before, I'm not a doctor or anyone associated in that field. But it so happens, I received some correspondence from Representative Howard a short time ago, and that's why I'm here today. I happen to be an individual that witnessed this plan that's in existence. I was admitted into the Monmouth Medical Hospital on January 29th, 1985 for a hernia. I went into surgery about 10 o'clock in the morning. About an hour and a half later, I was put into the recovery room, and then put up into the patient's room. And I know my doctor, before admitting, had to receive approval for the operation. Then, after the operation, it was found that instead of being a simple hernia, it turned out to be a double hernia. So, he had to get permission to keep me in there overnight, otherwise he would have to send me home.

Well, all right. They kept me in there overnight, so I went in there on the 29th, about 8 o'clock in the morning.

And I was released on the 30th. I believe it was shortly after dinnertime, about 12:30. So, within the short period of time I was in there, I was operated and I was released for a double hernia.

Now, I've heard the statement the young lady associated with the hospital staff say, that in the survey in the State of New Jersey, they found no one had been released prematurely. Now, I don't know where they got these figures, but with my experience of government budgets, State budgets and so forth, I've learned, as a practicing accountant, to take most of them with a grain of salt. If these people had really obtained authentic information, they would have found that there were many, many people released prematurely, where they should have been retained in the hospital. Well, I was released, as I said, on the 30th, after I was in there about a period of 30-some hours, in the hospital.

Well, I went home, and I'm telling you, it was very, very painful. They seem to overlook the fact that when you operate on an individual, and you're tearing tissue apart, it's going to take time for that tissue to mend. It's going to have to heal, and if they're going to have to do anything, they've got to permit that individual to spend time in the hospital while that tissue is healing. Well, with me they didn't do that. They sent me home within a period of a day or so. Well, I went home and I was in agony for about four days.

Now, I didn't come up here to misrepresent any facts. I'm a tax accountant; this is my busy season. But, due to the fact that Senator -- Representative Howard wrote to me, I figured it would serve the purpose and would be an opportunity to let the public actually know what is actually happening in this field.

I was in torture for four days. So, I had to get ahold of my doctor. He had to give me a much stronger sedative than what they had given me upon release from the hospital. So

after about a week, all right, I did recuperate. But it was absolutely unnecessary that I should have been released from that hospital within a period of a day and a half, and suffer from four to five days when we have institutions of hospitals, where their purpose is to alleviate suffering.

Now, I don't know who composes this PRO Board. But I heard Representative Howard state that the individuals on this Board weren't composed of any doctor, wasn't composed of any members of medical boards. I presume that it's a usual practice -- it was a political appointment, and in the usual procedure, individuals, through political appointments, in many cases are not qualified for the positions required. So I think that in this case they should make an intensive study, and if conditions are as such that these members are not qualified for that post, they should eliminate them and put members on that Board that are familiar with medical practice, for the simple reason -- and all due respect for the agent -- I don't think they should be abused in the matter that they are being abused at the present time by this Board, which is instituting regulations which are not practical.

Well, I haven't had any written correspondence. This talk is given right off the cuff. As I came up here this morning, I received notice of the meeting yesterday. I didn't have time to prepare a speech in any manner, but you can see that the proof is in the pudding. People come up here and they can say that we've heard this and we've heard that, but I haven't heard this or that. I have witnessed what has taken place, and you can draw your own conclusions that what I see, and what is going on -- I think they're taking advantage of the elderly, and I think that something should be done to alleviate that situation. Thank you. (audience applauds)

SENATOR PALLONE: Thank you, Mr. Schibell.

I just wanted to ask -- is Mary Stickle here? She had requested that she go on early as well. No? Okay.

I'm just going to go on down the list. I see some people raising their hands. If you haven't -- if you would like to testify and you're not on our list, then please come up and-- (unidentified audience member speaks inaudibly, away from microphone) You're on the list. Okay. I'm just trying to go in a certain amount of order. I know that some individuals have to get out earlier than others, so I'm going to try to proceed on that basis.

AUDIENCE MEMBER: Will there be a question and answer period after?

SENATOR PALLONE: You can say whatever-- You can-- Would you like to testify? You're on the list. No, not now. I just have to do a few others right now who have to leave.

AUDIENCE MEMBER: Well, there's a point that I think, while the doctors are here--

SENATOR PALLONE: Well, why don't we take you next? The next person I have to allow is Miss Faith Goldschmidt, and then we'll do you next.

AUDIENCE MEMBER: (indiscernible) only want two minutes.

SENATOR PALLONE: All right. Faith Goldschmidt, who is the Director of Reimbursement Systems Development, Evaluation Research for the Department of Health. I know you have to leave early, that's why I want to get you on.

F A I T H G O L D S C H M I D T: Good morning, Mr. Chairman, members of the Committee, and guests. I'm Faith Goldschmidt, Director of Reimbursements Systems Development, Evaluation and Research, New Jersey State Department of Health. I am one of the two directors who administers New Jersey's DRG Program -- Diagnosis Related Group program -- and within my program is housed a team responsible for overseeing the quality of care assurance under New Jersey's DRG system.

SENATOR PALLONE: I don't mean to interrupt you, but I'm being -- hands are being raised in the back, so try to

talk closer there, and maybe a little louder.

MS. GOLDSCHMIDT: Is that better? No?

SENATOR PALLONE: Maybe you better hold it in your hand, and see how that works.

MS. GOLDSCHMIDT: Better? Can you hear me? Good.

I would like to thank you for calling this hearing. Quality of care assurance is a primary concern of the Department of Health. Certainly, any system of containment of hospital costs cannot be effectuated at the expense of quality of care.

My testimony is fairly lengthy. I will try not to bore you, but I think that it's important that you understand, first of all, the Department's DRG system in New Jersey, and secondly, Medicare's prospective payment system -- what has happened, public perceptions, and things that need to be done.

So, I will start by doing a really brief background of New Jersey's DRG system. All diagnosis-related groups are, are just a means of grouping patients into 468 categories based upon diagnoses and other clinical attributes. Patients within each DRG are expected to consume similar amounts of resources, so an average rate can be set of resource consumption -- that's the DRG payment rate.

In New Jersey, the DRG rates are set by the Department of Health, from all hospitals' historical data. Every patient whose length of stay falls within a range of days typical for that DRG is billed the DRG payment rate. I will discuss the exceptions, of which there are six categories, in a few minutes.

Hospitals assign the DRGs and they bill the payers. Again, New Jersey's system is an all-payer system. That's important to remember.

New Jersey implemented its DRG system, which we also called Chapter 83, over a three-year period from 1980 to 1982. By the end of 1982, all 90 New Jersey acute care general hospitals were utilizing New Jersey's DRG system to bill

patients and to collect management information.

With prior per diem systems, an incentive existed to encourage retention of in-patients, because each patient paid the same amount per day. The longer the patient stayed, the more money was collected. In addition, insurance companies tended to pay without too much question.

With an average rate, the incentive changes considerably. The incentive becomes to decrease resource consumption by discharging the patients as soon as they are medically able to leave, and by reducing unnecessary services. Because of these incentives, strong quality of care assurance care mechanisms were implemented in New Jersey to prevent abuse of the system.

In October of '83, Medicare took pieces of New Jersey's system and implemented its prospective system nationwide. New Jersey has retained its own system of payment through a Medicare waiver; however, Medicare's utilization review mechanisms have been functioning in New Jersey for Medicare patients in place of Chapter 83 mechanisms since October of 1984, and I'll discuss that in a minute.

It's important to discuss the quality of care assurances under Chapter 83, New Jersey's system, and under Medicare's prospective payment system. There are several unique features of the New Jersey system which help insure that quality of care issues are not put aside because of the cost-containment focus. I will focus upon only those which affect the length of stay and care in the hospital; otherwise, we will be here for three weeks.

First of all, the rates. We have mechanisms to adjust the rates to make sure that hospitals receive appropriate amounts to care for their particular case mix. Hospital rates in New Jersey are set using every hospital's historical data. And they are hospital specific. We have 90 rates for each DRG in New Jersey. This individualization insures that each

hospital's rates are more reflective of its own experience than the rates set under the Medicare system.

Under Medicare, there are 18 rates for each DRG across the country. In addition, New Jersey hospitals can appeal their rate if there are changes in medical practice, in the scope of teaching and other items as defined in the regulation. Hearings are held and the rates can be adjusted.

Secondly, outliers. I know outliers was mentioned previously; I'd like to elaborate on that. New Jersey has several categories of atypical hospital patients called outliers. Outlier categories are a high length of stay, low length of stay, clinical DRGs, same-day stays, transfers out, and low-volume DRGs. Patients in these categories are considered atypical in terms of length of stay or resource consumption, and they are billed an amount other than the average DRG rate.

I would like to focus on the high length of stay outliers. In New Jersey, once a patient's length of stay exceeds the range of days that's considered typical for that DRG, the patient becomes a high length of stay outlier. The last day of the range of days is called the high trim point. If the patient has to stay in the acute care setting for a valid medical reason, the patient stays, whether or not the stay exceeds the high trim point. In New Jersey, the type of payment simply changes.

Medicare has two outlier categories under PPS: high length of stay and very expensive cases. Both types of cases have to be thoroughly justified by the fiscal intermediary, and the total dollar amount is capped.

Thirdly, maybe the most important quality of care assurance mechanism is utilization review. In an average rate system, as we mentioned, there are incentives to discharge patients early and to decrease the amounts of services. In 1980-81, the Department certified the existing, independent

Professional Standards Review Organizations (PSROs) to review all patients under New Jersey's DRG system.

The PSROs became know generically as Utilization Review Organizations, UROs. There are now five UROs functioning in New Jersey. Under Chapter 83, UROs review all hospital patients on both a concurrent and a retrospective basis, either themselves or through delegation of review to a hospital.

Concurrent review includes certification that the acute care admission is appropriate, and that treatment rendered throughout the stay is appropriate. Ideally, hospital discharge planning begins early in the stay, so that by the time the patient is ready for discharge, any necessary arrangements have been made.

As to the other speakers, I would like to emphasize that it is the attending physician who admits the patient, orders hospital services, and discharges the patient. If there are valid medical reasons why a patient must stay in an acute care setting, or at an acute level of care, the patient stays. Neither the average length of stay of a DRG nor the high trim point determines when the patient is discharged.

The second part of a review under Chapter 83 is retrospective. Samples of medical records bills and other information are reviewed thoroughly. The purpose of retrospective review in New Jersey is to focus in-depth upon practice patterns, trends, and areas of concern. The UROs also conduct special studies for the Department of Health.

In 1983, during Federal hearings on New Jersey's experience, concern over quality of care was discussed. The Commissioner of Health directed the UROs to study alleged early discharges to determine if inappropriate early discharges were occurring because of New Jersey's system. The study was completed and the results distributed in the summer of '84. A copy of the study is attached to the testimony.

Essentially, the study showed that any problems that occurred were not caused by New Jersey's DRG system. The problems included poor discharge planning, unnecessary testing, etcetera, which occur regardless of the payment system. Educational efforts were undertaken.

As an update, the Department keeps in contact with the UROs on this issue. They have indicated that there still do not seem to be inappropriate early discharges caused by New Jersey's system. We have heard anecdotal stories, and we have received a few cases to send to review. And again, these cases have been fully reviewed. The treatment was found to be appropriate. One of the major problems seemed to be lack of explanation, a lack of understanding or caring to explain to the patient. DRGs have focused attention upon hospital practice and physician practice, and that can be a very good thing.

In October of 1984, Medicare designated one Utilization Review Organization in each state to do review for Medicare patients. As you've heard, in New Jersey it's PRO of New Jersey. We have two areas of concern with the Federal review guidelines. First, the review itself: Under the current guidelines, only retrospective review is done, and only a sampling of cases. There is no concurrent review.

New Jersey's concern is that two segments of its hospital in-patient population, Medicare and Medicaid, as of February of this year, no longer are subject to the same quality of care review as the non-Federal patients. PRO of New Jersey has indicated that small pieces of the Chapter 83 review have been retained because of its own desire to provide more thorough review than that required by PPS. But, there is a double standard now in place in New Jersey, for quality of care review -- one for Medicare and Medicaid patients, and one for non-Federal patients.

The second concern are mechanisms to affect change.

There are differences between PPS and Chapter 83, to affect positive change, and hospital, physician, and payer behavior. In New Jersey, there is, and has been, direct interaction, education, and cooperative efforts between the UROs, hospital administration, payers, physicians, associations, societies, patients and the Department of Health. Education and positive interaction are extremely important to all concerned parties, and direct "hands-on" involvement by the regulatory agency is vital to the success of any system.

For example, in New Jersey, there is a patient appeal mechanism. A patient can appeal his or her bill based upon equity of charges, medical necessity, or DRG assignment. There is also a mechanism for rapid turnaround at the Department of Health to screen and handle complaints and referrals on various issues. The prospective payment system does not have a State level group that rapidly can respond to system problems, nor does it have the extended interaction and networking which has occurred in Chapter 83.

To summarize Part 11 and quality of care assurance, New Jersey's DRG system does include mechanisms to ensure that patients are not inappropriately discharged, and the quality of care does not deteriorate. With the concern over what is happening outside of New Jersey under Medicare's system, it is appropriate to remind everyone of these mechanisms, to hear the comments, to make any necessary improvements, and to continue to encourage open communication on an ongoing basis.

The last part of this are three issues that I would like to mention very rapidly, which should be brought up in a hearing on quality of care.

The first is public perception. Health care consumers have been used to past patterns of medical practices, and it is difficult to rapidly change public perception. A great deal of education must be undertaken. Patients have been used to staying in acute care hospitals, probably longer than is

medically necessary. A discharge earlier than in the past is not necessarily a bad thing. If a patient is medically able to leave an acute care hospital, then it is to his or her advantage to leave, provided appropriate discharge plans have been made. Patients tend to have fewer hospital-acquired problems, such as hospital-acquired infections, the earlier they are discharged. However, patients also have a right to be informed of changes in practice patterns, the reasons for the changes, and the name of a contact person or group to call for help. The patients also have the right to be treated with respect.

Perhaps even more, massive educational sessions and "gripe" sessions could be held to help health care consumers focus on the changes occurring in health care, especially in terms of medical practice, discharge patterns, and review. At this point in time, I think talking about it would be more beneficial to all of us than reading about it in a pamphlet.

Secondly, alternative care: Nursing homes, long-term care facilities, rehab facilities, and home-health care had been used to dealing with patients that are just about able to walk home. Sicker patients can be appropriately treated for by these organizations, provided that these organization can obtain the money and staff to do so. Patients can access the necessary services, and insurers adequately cover these services.

Acute care hospitals should be for the acutely ill patient. Alternative health care systems must be fully developed to complement changes in health care that have already started to affect the health care consumer.

And the last issue is the inappropriate early discharges -- the other type of early discharges, the type where the patient is not medically able to leave the hospital. It is these inappropriate early discharges that are of grave concern. As discussed, New Jersey has not seen a problem

caused by the DRG system in New Jersey supported by hard data. The Department feels that its dual system of utilization and review and close interaction has prevented such abuses in New Jersey; however, there is a question of such instances as outside of New Jersey in Prospective Payment Systems, and the question has spilled into the State. Education of consumers and relatives can play a key role in this issue.

Senator Heinz of Pennsylvania had done a study on early discharges under PPS, and the Feds just released mortality rates on March 13th. There was questions about both of these studies, but the essential question remains: are there quality of care problems under Medicare's prospective payment system, and are there mechanisms to investigate these problems and address them?

In New Jersey, the Department of Health already has used the UROs to study premature discharges. We have started an in-depth analysis of mortality rates in all New Jersey hospitals. We plan to investigate this issue through the UROs as a special study, not only of Medicare patients but also, of all patients. We had not specifically investigated mortality prior to this because there did not appear to be a problem, given there was no feedback from the networkings or from the UROs. Since the Federal numbers were released, it is appropriate to move into such a study and get detailed information.

In conclusion, the Department of Health feels that quality of care has been protected in New Jersey for Chapter 83 patients through a variety of mechanisms. We also feel that ongoing education and involvement of all parties concerned are key elements. We will be interfacing with the Federal government to mesh the two systems of quality of care review. We would be very happy to work with the Committees, the attendees, and interested parties to provide education, implement other necessary mechanisms or to monitor issues to

assured that quality of care continues to be satisfactory under New Jersey's DRG system.

SENATOR PALLONE: Thank you, Ms. Goldschmidt. I wanted to also compliment you because I have your testimony in front of me, and I notice you summarized it. I appreciate that, as well.

Let me ask you one thing. You mentioned Senator Heinz's study, and one of the things that I brought with me today is an article that was in The New York Times last September about his Committee, a staff report that recommended that Congress change the law to allow Medicare to pay for extra days that patients spend in the hospital when there is no appropriate place to send them at the proposed time of discharge. In addition, it said that Congress should promptly revise the Medicare payment system to reflect differences in the severity of illnesses among patients classified in the same diagnostic category.

Do you feel that what is being suggested here on a Federal level, that that is not a problem in New Jersey because of our DRG system -- these recommendations that are being discussed on a Federal level? How does what you say fit into that?

MS. GOLDSCHMIDT: Okay, there are two things. First of all, the-- I'll take the severity first. The Federal government has the authority to change the DRGs themselves. We feel that if-- It gets rather complicated; I could give you a very long-winded answer. But, I'm not sure that severity is really the answer outside of New Jersey, because we had massive educational efforts before we even implemented the system for about four years. One of the areas that we concentrated on was accurate hospital records.

If the codes used for diagnoses and procedures are accurate, if they are all listed -- in other words, if the medical record is accurate and appropriate -- then much, I

think, of the severity is accounted for. I think one of the problems outside of New Jersey is that there was not this massive educational effort, and there tends to be great variation in medical record completion, coding of the diagnoses and procedures. I'm not sure how good the records are outside of the State of New Jersey. So, the severity issue may, in part, be answered by upgrading the coding and the completion of the medical records.

Remind me of what the first part of the question was.

SENATOR PALLONE: Well, the first part was suggesting that the law be changed to allow Medicare to pay for extra days that patients spend in the hospital, when there is no appropriate place to send them at the time of discharge. I guess that is what was discussed before; Senator Brown brought up where there may be no nursing home, or whatever, to place the individual in.

MS. GOLDSCHMIDT: Okay. In New Jersey, if the patient has no place to go and is, for instance, awaiting a nursing home placement, then the level of care can be downgraded to a SNF level of care. And for Medicare -- Marty, I believe -- the rate is $53 -- (Ms. Goldschmidt consults with someone in the audience, but response is inaudible.) -- for a SNF level of care. Other payers will pay the going per diem rate, but the level can be downgraded so the patient will stay, you know, with the designation "Awaiting nursing home placement."

But, you know, the other piece of that is, if they are not awaiting nursing home placement and you have a problem at home, where the place that they are going to is not really equipped to handle them because they are being discharged a little sicker than they would have been in the past, that is where you need the upgrading for the alternative health care systems, like the home health aides, the visiting nurses, etc.

SENATOR PALLONE: Okay, thank you. Senator Brown?

SENATOR BROWN: Thank you. You really gave a very

comprehensive testimony. Thank you ever so much.

What is the average cost per day in a hospital here in the State of New Jersey? Let's not get into all of the categories, but just, you know, an average figure.

MS. GOLDSCHMIDT: That's not something that we deal with a lot. Betty Lou or Craig, do you know? (Witness addresses question to persons in the audience, but response, if any, is inaudible.)

SENATOR BROWN: Are we talking about a couple hundred, 500, 400? You must have-- If you take all your categories and divide, you must be able to come up with a figure.

DR. LOMAZOW (speaking from audience): Are you including just the hospital stay, or are you including all laboratory tests, physicians' visits--

SENATOR BROWN: No, just for space in a hospital.

DR. LOMAZOW: Space?

SENATOR BROWN: Obviously, that means a lot of backup.

MS. GOLDSCHMIDT: Can I send you something?

SENATOR BROWN: Yeah. I would be curious to know what we are talking about.

MS. GOLDSCHMIDT: Okay. But you're interested in per day?

SENATOR BROWN: Yes. I gather with the way you figure it, it's different from a tonsil versus, you know, heart surgery, versus everything else. But the basic care, the attendants, the cleaning-- Somebody has-- Mr. Chairman, would it be all right to recognize-- (Senator Brown referring to someone in the audience.)

SENATOR PALLONE: Well, are you on our list?

FROM AUDIENCE: No, I'm not.

SENATOR PALLONE: Or did you want to ask a question of Ms. Goldschmidt?

FROM AUDIENCE: I wanted to answer the Senator's question.

SENATOR PALLONE: Oh, okay. Please identify yourself.

L Y D I A L I T T L E: I'm Lydia Little, Utilization Coordinator at the Muhlenberg Regional Medical Center in Plainfield, New Jersey. To answer your question, the rates are approximately $250 per day, excluding any ancillary testing. (Ms. Little speaking from audience; not near microphone. Balance of statement indiscernible to transcriber.)

SENATOR BROWN: Just simply for occupying that bed, getting fed, and getting, you know, attention -- okay.

SENATOR PALLONE: I am just going to say, for the future, that I was just notified that when someone speaks from the audience, we are not able to record it. So, we are going to have to stop that practice.

MS. LITTLE: Oh.

SENATOR PALLONE: We did not get down what you said. Okay? So, it won't be part of the record.

SENATOR BROWN: My other question deals with -- since we are the Senate Committee on Aging -- trying to focus in a little closer on how specifically we can help the needs of the elderly population -- vis-a-vis hospital stays -- as opposed to the rest of the residents in New Jersey.

Do you have any specific ideas-- Has the Department of Health received more unhappiness with this system on an age basis than on any other basis, you know, geography, certain parts of the State? Have there been complaints regardless of age, or--

MS. GOLDSCHMIDT: Well, originally, when we first implemented the system, everybody was upset; all of the patients were upset, you know, back in 1980. They came to the Department, they came to the UROs, and they talked to the hospitals, but that kind of died down. But then when Medicare's Prospective Payment System came in and you started getting the newspaper articles, and then when the Federal Review came into place, then there was an upsurge from the

elderly of problems, and questions, and confusion. And, it tends to mix -- the PPS system and the review under the Federal guidelines -- with New Jersey's system and review under Chapter 83. So, there is a lot of confusion out there about the two systems of review that are in place.

I think one positive thing that could be done would be massive educational efforts to just explain what is going on, explain the two systems of review, explain what is happening. Then, have mechanisms so that the elderly have some way to fight back, if you will, have a mechanism to appeal, have somebody to talk to.

SENATOR BROWN: See, practices change. We very much appreciate having the gentleman here to testify about the hernia operation. But, with all due respect, when I was born my mother was supposed to spend two weeks in the hospital recuperating from having me. I am about to become a grandmother, and my daughter-in-law may be in the hospital for 48 hours. Now, when she comes home, something may happen. She may have more discomfort at home. But this is a societal difference of how we're coping, not to say that two weeks is right and two days is wrong, or vice versa.

But, we are concerned, as a Committee, that there be proper care for our elderly as individuals in the State of New Jersey, whether that is at home or in the hospital, or wherever. I think that has to be the focus of the communication here, so there is an understanding of what the roles of our hospitals are today in New Jersey. Now, with an increasing number of beds, maybe it would be better for us to take care of the elderly with a longer stay in our hospitals, when they are not in competition with other needs, or maybe it is better, I mean-- Again, some people may enjoy being in the hospital longer than others, but there are some people who would rather not be there at all.

SENATOR PALLONE: Most people, I guess.

MS. GOLDSCHMIDT: Right. I think there are a number of things that can be discussed, you know, that possibly we could implement in New Jersey. We would be happy to work with the Committee, or with any other group.

SENATOR PALLONE: Thank you very much. We appreciate your testimony.

Again, I am going to call some people who have to leave. The next person is Judy Parnes, who is the director of a health planning agency, and a Monmouth County resident -- Ocean Township.

J U D I T H S. P A R N E S: Thank you. For clarity, I served as the past Chairperson of the Long-Term Care Committee--

SENATOR PALLONE: You'll have to talk louder, or if you can hold the microphone, Judy, I think it would be better.

MS. PARNES: --which is a Subcommittee of the Monmouth County Advisory Council, a part of the Central Health Planning Council, which serves as the adviser to New Jersey Region IV on Health Planning.

Over the last six months, we have been studying the impact of DRG regulations and the resultant earlier discharges to county nursing homes. Our intent was not to study the effectiveness of the DRG regulations, but to examine the issue of how elderly patients are now being discharged earlier to nursing homes, and the nursing homes' ability to handle these patients.

Our Long-Term Care Committee has met with representatives of the New Jersey Medicaid Program, New Jersey State Department of Health, and the State Ombudsman's Office. Throughout our discussions with these three State agencies, our County's concerns for the hospitalized elderly and the nursing homes' ability to care for the "sicker," or so-called recovering patient, were frequently reenforced. It was our concern, as the Health Planning Agency for the County, that greater efforts need to be taken towards assisting nursing

homes in caring for the patients who are presently being discharged from hospitals. That is to say, we worked from the premise that the DRG regulations that are presently in effect throughout this State have resultant repercussions on area nursing homes that have not been addressed. With these patients being discharged earlier from hospitals, the necessary systems that are required to care for these people need to be in place prior to hospitals discharging them.

Long-term care issues for the elderly have to address not only hospitalization, but obviously the aftermath of that hospitalization. Unless the systems that are required for caring for the elderly either at home, or in long-term care institutions, are better equipped to handle the patient, addressing the discharge of the elderly people from hospitals is only half of the problem. The resultant changes and implications for nursing home care have not been met. Nursing homes are accepting or not accepting patients based on the type of care required.

It is the Long-Term Care Committee of the Monmouth County Advisory Council on Health Planning's recommendation that a greater examination be made of the resultant impact on nursing homes of discharges under the DRG Program, and that the necessary systems be organized to provide for the ongoing long-term care needs of this State's elderly.

Thank you.

SENATOR PALLONE: Thank you, Judy. May I just ask you to elaborate a little, if you can? What possible problems and what, you know, could be done? In other words, are we talking about the fact that a nursing home doesn't have proper facilities, proper equipment? Are we talking about the fact that the nurses, or individuals taking care of the patients, would need better training because of the greater amount of service that has to be provided? And, also, if you could, is there any problem with reimbursement for those, you know, extra

services? I know that is a lot to ask, but I am just wondering.

MS. PARNES: Well, nursing homes have the final say as to who they will accept and who they will not. The so-called sicker patient, or patients with specific needs, are the ones who are the most difficult to place.

The question of reimbursement is definitely at issue here because the facilities state that they need more highly trained professionals, more RNs on staff to deal with the so-called sicker patients -- the tube feeders, the ventilator patients, the ones who are staying in hospitals longer.

The other issue, I think, is that mention was made that SNF patients -- skilled nursing patients -- could be cared for, no longer in the hospital, but in long-term care institutions. The problem then is, I don't know of any nursing home that will accept a patient based on the premise that he or she is a Medicare eligible patient. They always want a backup because Medicare does not always pay for nursing home care, as we all know. So what we then say is that the facility is requesting hospitals to then find out whether the patient is Medicaid eligible, filing all the necessary Medicaid paperwork, even though it is understood that the patient will probably get some Medicare coverage time in the nursing home, or whether the patient will pay privately if Medicare denies them.

SENATOR PALLONE: So, in other words, because-- I guess it's simplistic, but because a greater deal of care may be necessary for these sicker patients, or possibly patients who have been prematurely discharged, and Medicare doesn't cover some of those things, there is going to be more--

MS. PARNES: Medicare may cover some of the recovery period in the nursing home, but that, typically, is not enough.

SENATOR PALLONE: So we're going back to the same problem, with the nursing home wanting to either know that the person can afford to make up the difference himself, or that he is a Medicaid patient.

MS. PARNES: And the other issue is the training itself of the staffs of the nursing homes, because I think that a lot of the nursing home operators would say that their staffs aren't trained to deal with this specific problem.

SENATOR PALLONE: Okay, thank you. Senator Brown?

SENATOR BROWN: Do we not have two different problems here? One is when we use the term "premature." If I go into the hospital, for example, as a senior citizen with, let's say, appendicitis, or something that's cut -- well, not necessarily cut and dry -- but a specific thing, versus, as you are mentioning-- What do you mean by premature when you are talking about a patient who needs ongoing care? I have a little-- I can understand what the definition is if it's premature when I have had a heart attack, or when I've had lung surgery, or something like that, but premature when I am going to be ill for maybe the rest of my life? What does premature mean in that context?

MS. PARNES: Senator, I did not use the word "premature" at all in my statement, because I am not addressing the issue of premature discharge; I am addressing the problem of discharges being made to long-term care facilities, possibly not prematurely. I'm talking about facilities not being able to handle the sicker or recovering, which was the term which was used earlier. I specifically am not addressing prematurity.

SENATOR BROWN: Super. I support you in that. It's just that the emphasis here today-- I believe the definition of the hearing is on premature--

MS. PARNES: If you have a copy of my talk, my topic just says "Discharge."

SENATOR BROWN: Thank you very much.

SENATOR PALLONE: But, in other words, Judy, I don't know if it's a problem, or what we want to call it, but the point is that if people are-- I mean, if the nursing homes are going to have to handle what we call sicker people, or people

who are going to need a greater deal of care, then the whole question becomes, are they equipped to do that, and are they going to be reimbursed for it? That's your concern.

MS. PARNES: It looks like half of the system is addressed, and the other half is not. I, too, do not see so much-- I am not addressing the issue of prematurity, but more, what do we do with the patients? If we say they are no longer in need of acute care, which they may not be, where do they go and who will handle them? It's the same issue if they go back to the community.

SENATOR PALLONE: It's all part of the same -- okay. Any other questions? (negative response) Thank you very much.

Okay, our next speaker is Mr. John Sergi (phonetic spelling) from the New Jersey Federation of Senior Citizens. I'm sorry you had to wait, but we are trying to proceed here. We do have some representatives of various senior citizen organizations here today, too, and I would like all of them to have an opportunity to speak.

J O H N S E R G I: I hope all of you can bear with a little cold. It is only a couple of minutes of your time that I want to take. In fact, the reason that I came up to mention something is that the past two speakers spoke about something that I have been involved with as a 10-year Executive Board member of the New Jersey Federation of Senior Citizens and on their Tax and Health Care Task Force, primarily a Tax Task Force. But, very little has been said about home health care until the last two speakers.

The first doctor mentioned that home health care was in a dismal situation. We have been after this for a long while. If the government is interested in cost containment, and politicians are interested in cost containment, the facts and figures are there that home health care will give you the answers to that, if it is done right.

Now, I don't know why DRGs, doctors, and so on -- I

listened to this young fellow, and I'm glad that the young fellows are in here-- Why don't we all get together some way and develop a very efficient type of a home health program, because most seniors want to be in their own homes. Every Tuesday, I go into Plainfield. I land at 12 o'clock at my aunt's, who is 92 years old, to have lunch with her. "Where the hell have you been?" Excuse the Polish. This is just an example of so many. She really didn't want to have any help. She's arthritic, and so on and so on. Until a couple of months ago, we had somebody come in at least maybe once a week to talk with her, and so on. Now she has a more cheerful atmosphere about her, and so on. "Well, did you like the person?" "Yes, I liked the person," and so on and so on, but she doesn't necessarily want help with the housekeeping, and so on.

But, we have so many of our elderly who want to be in their own homes, and from the hospitals, to nursing homes, to their places. If we had efficient help in home health care, it would save an awful, awful lot. I live in the original Leisure Village here, and one of the basic reasons that my wife and I finally ended up here-- I have lived in Plainfield, New Jersey all my life. When I go out on Tuesdays, I visit four nursing homes and two hospitals to see my old friends who are there, and so on. Two of them are in Sussex County, Wayne Dumont's place. But we ended up here after looking around -- why? One of the reasons is because they have a Health Care Center there which is covered by 12 nurses who are sympathetic and who are available any hour of the day through a mobile setup, and we know that the health care problem is the number one thing that the elderly are interested in.

So, I would like to have doctors think in terms of this, getting their heads together with the hospitals, and the government, in terms of developing this. The government, through the Gramm-Rudman bill, has now-- This is a bill which says they are not going to fund home health care trainees.

That is a tragedy and a disgrace. I think you ought to look into that.

Thank you very much. (applause)

SENATOR PALLONE: I just want to say that one of the main focuses, probably, of this Committee over the next year or two, will be the question of home health care. Both Senator Brown and I were members of the Casino Revenue Fund Commission, which recommended that any increased funding that comes from the Casino Revenue Fund be used for home health care as one of the major priorities.

Did you want to add something, Senator Brown?

SENATOR BROWN: I support all of your testimony very strongly. I've got to add, though, that each case is different. Having, again, just had personal experience, if you get a certain type of individual, with a certain type of health problem, the amount of home health care needed brings the cost up to the same amount that it would be in a nursing home or in a hospital, if you need two people round the clock in shifts, and so on.

So, it's very complicated. In some situations, we can deliver services in the community cheaper, and in some cases we can't. And I think in fairness to our institutions, we have to say that for some of our people it takes a tremendous amount of backup service, and we're kidding ourselves if we think some of these people can be handled more easily in the community.

MR. SERGI: Well, you're absolutely right there, but this is an area that I notice that those who were speaking-- Not much was said except for the last two people. Thank you.

SENATOR PALLONE: I appreciate your comments, and with that, I am going to ask John Paul Marosy, Executive Director, Home Health Assembly of New Jersey, Inc., to be our next speaker. Maybe that will get right into it.

J O H N P A U L M A R O S Y: Thank you, Mr. Chairman. It is a pleasure to be here today to have the opportunity to tell the

story from the point of view of the nurses and social workers who deliver home health care in the State of New Jersey.

Last year, the 56 certified and licensed home health agencies in New Jersey provided home care assistance to over 135,000 persons of all ages. About two-thirds of these patients were over 65 years of age.

A great deal of attention has been focused on whether or not elderly patients are being prematurely discharged from the hospital. From the point of view of the nurses and social workers who help families care for the elderly coming home from the hospital, I want to make three things clear:

First, home health care providers in New Jersey have the capacity to help patients recover at home;

Second, we have seen elderly patients discharged earlier in recent years, but, in general, we have not seen patients discharged irresponsibly early; and,

Third, the real crisis in care of the elderly is being fueled by actions of the Federal Health Care Financing Administration, which has so tightened eligibility for Medicare home health care services, that thousands of elderly New Jerseyans are being thrown into a no-care zone; denied home care by the Medicare Program, but not rich enough to purchase the home care help they need on their own.

The DRG system of hospital reimbursement, which was introduced in 1980, encouraged early discharge from the hospital. The length of stay in hospitals dropped from 8.8 to 8 days, and, at the same time, between 1978 and 1983, home health agencies experienced an increase of 8% in the number of patients referred from hospitals.

This transfer was possible, in part, because recent advances in medical technology have made possible very sophisticated kinds of care in the home. Home health agencies in New Jersey were quick to gear up for the new technologies and, on the whole, this shift in the focus of care was

accomplished smoothly and without adverse impact on the elderly patient. In fact, many individuals no doubt welcomed the convenience of home care.

The problem, indeed the crisis, came later. Beginning in 1984 and increasing through 1985 and into the present year, the Health Care Financing Administration has introduced cost containment policies to limit the use of the Medicare home health care benefit. The result has been that many very ill and impaired elderly persons are being discharged from hospitals, and are also being denied use of the Medicare home health benefit.

I am going to describe some of these cases for you, but first let me give you a little background about the Medicare home health benefit.

Home health services reimbursed by Medicare are:

1. Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;

2. Physical Therapy; and,

3. Speech Therapy.

If one of these three services is needed, Medicare will also pay for:

4. Occupational Therapy;

5. Medical Social Service;

6. Part-time home health aide services; and,

7. Some medical supplies or equipment.

Medicare does not pay for full-time nursing or other home care services, such as homemaker/housekeeper services.

The law further stipulates that these services can only be provided if prescribed by a physician under a specific plan of care and if the patient meets certain eligibility conditions:

1. The patient must require "skilled care";

2. The nature of the care must be "intermittent," not continual; and,

3. The patient must be "homebound."

Now, I should make clear that the Medicare home benefit was never intended to cover long-term chronic illness, whether in a nursing home or home care setting. The underlying assumption was the benefit would provide skilled nursing care for a specific episode of illness where skilled nursing was required and where there was a potential for rehabilitation. It is the combination of the two policies, DRGs and the curtailed use of home health care, that has brought about the crisis.

Just to explain how the cutback has happened, it has happened in a behind-the-scenes kind of way. The United States Congress has voted two times since 1980 to expand home health care on Medicare, and yet, in recent years, the Health Care Financing Administration has cut it back through tightening guidelines for what is eligible to be covered under Medicare. Those guidelines are the homebound guideline, the intermittent care guideline, and the skilled care guideline. What happens is, a claim is submitted to a fiscal intermediary. In New Jersey, most of those claims are processed by the Prudential Insurance Company, which is the primary fiscal intermediary. Blue Cross/Blue Shield also processes some claims. Sometimes claims are denied retroactively, and it can cost agencies thousands of dollars for care that they have already delivered.

The fiscal impact in the last 18 months has been staggering. The loss of income from uncompensated care and the cost of documenting appeals are threatening the survival of many agencies. But that is a secondary issue. More important is the impact on elderly patients. Let me just tell you about one patient whose care was denied by Medicare recently.

Mrs. K is a 79-year-old, widowed, retired school teacher living with three elderly sisters, all over 70 years old. Mrs. K has cancer of the right eye, with lesions on her face and neck. The patient was on service for home care from

June 26, 1984 through August 27, 1984. Then she had to be rehospitalized to have the right eye removed because of spreading infection. The patient was readmitted to home care on September 11, 1984, and died on November 17, 1984.

Following her hospitalization for surgery, Mrs. K required daily irrigations and dressings to the right eye orbit. It was a very serious wound. The three sisters were unable to do this dressing. There were no friends or relatives willing to do the same. There was one occasion that required an additional nursing visit when the patient had an episode of bleeding that was difficult to stop.

Mrs. K had extensive, rapidly growing facial tumors that also required care and treatment on a daily basis. As her health deteriorated, a home health aide was placed for bathing, dressing, positioning, and feeding. The sisters assisted and provided as much care as they could, but were unable to provide all the care required. Nursing care involved irrigations, dressing changes, treatment of facial tumors -- which bled easily -- vital signs, pain control, bowel control, and continuing instruction and demonstration of care for a gradually weakening, bed-bound, immobile patient, and later, catheter insertion and instruction for care.

On March 18, 1985, several months after the patient had died, the agency was notified that nursing visits over five times per week were denied retroactive to October 1, 1984. This is just one example. I have cited other ones in my written testimony, which I will not read now. But the point is, a 1985 survey of New Jersey's home health agencies found in a one-year period, a 27% increase in the number of denials in the State. We're conducting a survey now, in early 1986, and we're finding that the trend is worsening.

We have called upon Senators Bradley and Lautenberg, as well as Congressman Rinaldo, who serves on the U.S. House Aging Committee. Also, Congressman Howard has been very

responsive to addressing this problem. These officials have pledged to investigate the problem. Senator Bradley will be conducting a hearing of the U.S. Senate Committee on Aging in Newark on April 21 -- and I brought some flyers for anyone who would like a copy -- to look into the matter, and we will appreciate your support -- the support of this Committee -- in seeking a solution, probably through Federal legislation, to protect the rights of elderly and disabled Medicare beneficiaries to the home health care services they need.

SENATOR PALLONE: Thank you very much. I just want to-- Well, a couple of points. First of all, you mentioned what may be going on -- hopefully what will be going on -- at the Federal level. As we know, there are constant efforts on the Federal level to try to save money because of budget deficits, or whatever.

To what extent, you know, if any -- I imagine there are some possibilities -- would you have the State, you know, step in and get involved in some of this home health care? I know that is a very broad question, but it is something that this Committee is concerned about.

MR. MAROSY: Well, we've given a great deal of thought to that, Senator. Early in your remarks, you pointed out how it is so important for the State and the Federal government to understand their roles in this. I think it is essential for the State of New Jersey -- for State officials -- to work with our Federal delegation to protect what Medicare, by law, is supposed to be paying for under the Medicare Program.

The separate question is the long-term home health care needs which Medicare, by statute, does not pay for. And, although there have been attempts in legislation on the Federal level to expand Medicare coverage for that, we don't think it is going to happen in the foreseeable future. For that reason, we expect a new piece of State legislation to be introduced by Senator Richard Van Wagner, which will address this growing

crisis in long-term home health care in a very creative way.

So, I think the State of New Jersey, if it is going to look at the home health care issue, should focus on that long-term home care need and how to target the services to people with the most severe needs. We are prepared to help to do that.

SENATOR PALLONE: What -- if you don't mind my asking -- kind of a price tag are we talking about for that program -- the State program that you're suggesting?

MR. MAROSY: If the State of New Jersey were to open up a program to serve people who are just above Medicaid, that is, people who have assets over $1,500 a year and whose incomes are somewhat above the Medicaid level, and if we could target it to the 2,000 or so in greatest need, we estimate that a statewide program of that kind would cost the State about $10.8 million to get it established. But that would depend on one very important factor.

We believe that this problem must be addressed through a public/private partnership, that well seniors should be invited to help sick seniors. Seniors helping seniors is an essential part of the bill that Senator Van Wagner will be submitting, so that volunteer services for the non-medical services can supplement the more intensive professionally provided services that the State would pay for.

SENATOR PALLONE: Okay, thank you. Senator Brown?

SENATOR BROWN: Thank you very much. I am a little sorry that you have used these two examples because I do think -- at least as a non-medical person reading them -- they are examples which seem to be very complicated situations, with individuals who needed a lot of care. I've got to tell you that one of the things that impressed me, from personal experience dealing with home health care officials, is, at a certain point they said, "Hey, this is beyond what we can take care of in the home. This is a patient at risk." You know,

just from reading these, certainly these individuals were in very, very bad conditions, and I am not sure that we are ever going to be effectively able to deal with these types of cases in a home. I would think that at some point, the home health care person would have said -- which they probably did in the first case -- to get the person back into the hospital, right?

MR. MAROSY: Well, you're right. Most of the cases are very complicated. That is one of the aspects of treating the elderly at home. Most of our older patients have multiple health care problems. Where is the line? Where do you draw the line? If a family is willing to do all that they can do, and if Medicare is supposed to pay for the services in the home, and if that individual wants to remain at home, shouldn't we be providing that care in the home?

Of course, there is a cost line, you're right, that is passed at a certain point, where it becomes more costly at home than it would be in a nursing home. But, in these particular cases, the individual could have been cared for at home over a reasonable period of time. When there is cancer involved, it is a terminal situation. The individual probably would have received hospice care eventually. But, if a family is willing to do its part, I think society then has to ask, "Are we willing to support that?"

SENATOR BROWN: Do you have a figure -- I asked for a ball park figure for costs in the hospital -- for treating patients who need this degree of care, which I would say is round the clock in these situations? Do you have any idea what the costs would be of providing home health care for these patients?

MR. MAROSY: This person was not receiving round-the-clock care, but I can get you those statistics. I don't have those figures in front of me. The average cost of a nursing visit is about $37, and the average visit lasts something over an hour. Now, there are different rates if you

are getting into 24-hour care. The rates are not set on a per-visit basis. I could get you that information, Senator.

SENATOR BROWN: Through the Chairman, that would be nice. Thank you.

SENATOR PALLONE: If we could have that, we could make it part of the record also. We would appreciate it.

MR. MAROSY: I will be glad to do that, sure.

SENATOR PALLONE: And, thank you again.

MR. MAROSY: Thank you. (applause)

SENATOR PALLONE: I am going to ask Bonnie Williams, President, New Jersey Society for Hospital Social Work Directors -- is she here? (affirmative response) I know that you have to leave, so please come up next.

B O N N I E W I L L I A M S: Thank you. I'll try to speak into the mike so everybody can hear me. I would also ask, if you don't mind, one of my colleagues, Mark Yarnold, Director of Social Work from Monmouth Medical Center, to come up and be with me.

SENATOR PALLONE: Sure.

MS. WILLIAMS: Mr. Chairman, Senator Brown, and others: I would like to thank you, on behalf of the New Jersey Society for Hospital Social Work Directors, for allowing us the opportunity to speak to you today.

As background, let me just say that for the past 16 years I have participated in the New Jersey Society for Hospital Social Work Directors, and similarly, in hospital social work, both as a line worker and with over 13 years in management. For the last 10 years, I have participated in different leadership capacities within our State organization, served on community agency boards, served as a consultant to nursing home social worker staffs, and lectured on home care for home health aide classes. This information is provided only as a means of indicating my years of involvement in working on behalf of patients and families through the health

care system, and in having ongoing communication with peers in this area.

On behalf of the Society, and on behalf of hospital discharge planners, let me note that we do have -- as has been mentioned by the previous speaker -- extensive involvement in the coordination of multi-disciplinary discharge planning programs within hospitals. As such, we work with patients, families, health care providers, legal counsel, and community resources, and we are mindful of the regulatory guidelines.

The members of our group agree that health care delivery has changed and that health care providers are caught in the middle. We feel, however, that we are able to provide, and are providing, quality care inside our walls. Our patients and families are of great concern to us, and we are developing and implementing a post-hospital care plan through our discharge planning efforts. When exploring the types of resources outside the walls of the hospital, we look at the family support system, number one, home care services, which would include some of the disciplines that were mentioned by the previous speaker, and long-term care, including nursing homes both for skilled and custodial care, and residential and boarding home services.

We recognize that with the decrease in the length of stay, that the discharge planning process must be completed within a shorter period of time. However, some of our patients do stay longer if the outside-of-hospital plans are inadequate or cannot be arranged within the normal length of stay time. Many of my colleagues -- and we meet on a State level several times a year-- I also went to a program, a national meeting, for the American Hospital Association Society of Hospital Social Work Directors just last week in Baltimore. At that point, we also had these same kinds of discussions among ourselves. We are aware that long staying cases in the hospitals are occurring and, for your information, all of the

staff there felt that they did have the support of their hospital administration and physicians in cases where patients did need to remain in the hospital because services were not available, and where we could not actually document on the charts that the services that people needed were out there.

Some examples of these kinds of cases were, for instance: Patients for whom there was no family and no support whatsoever, no significant resources for them in terms of people; -- Okay? -- patients requiring guardianship -- many, many times we have to locate and find people who will be willing to be guardians or go through the court process to have a guardian appointed; patients in need of financial assistance to cover post-hospital care; and patients in need of highly skilled care unable to be provided in the home and/or nursing home due to lack of coverage or inability to provide for it themselves. Such cases might be--

Though there are a lot of these services provided through the home care programs, there still needs to be some method for reimbursing the people who provide the services; otherwise, you can't have it. If you are going to have it only on maybe a two-hour basis twice a week, when we discuss those kinds of plans with families, families throw up their hands because they are very concerned about what is going to happen, you know, all those other hours. Okay? Many of them cannot afford to pay for it out of their own pockets, even though they are willing to have the person at home, and even though they would be willing to have the person at home if the appropriate home care providers could provide the staff to be there, with a live-in, 24 hours a day, eight hours a day, or whatever.

In many of these cases, these are not the kind of people who can go to medical day-care programs or social day-care programs because of a need for equipment or high-tech services; patients, for instance, who are on IV antibiotic therapy, patients who have pump tube feedings, patients on

respirators, patients with trachs, patients who are ventilator dependent. Let me also add, that procedures for specific services are available at home and in a few nursing homes, but not for long periods of time. And, if that is the case, then they are seen as maintenance programs, and for chronic care -- Medicare costs do not cover that kind of service.

In the nursing homes, many times the question is whether or not they do, in fact, have the staff, whether they are trained to provide the service, and whether or not they are going to be reimbursed at the cost that they feel is justified for providing that high-tech service. So, in these kinds of situations, including como patients, etc., the hospital is forced, if you will, or is willing, to accept the responsibility for providing for the gap in services to the community.

Also, patients in need of custodial care-- We find that we are still having, at times, and more frequently than not, long waiting lists for people, especially if they need Medicaid, especially now that we have the new programs where some of the nursing homes are opting -- choosing to opt out of Medicaid because of the levels of reimbursement where nursing homes are concerned. If we are talking about custodial care, it is also a question for some nursing homes as to what is a Level 7, a Level 8, because it has something to do with the amount they are going to be reimbursed. Many of them have said that if they are going to provide the care -- although I am not speaking for them, these are things that we hear in trying to provide the discharge planning piece -- they would prefer the easier care patients than those who require more care, since they are only going to be reimbursed at a certain level.

We are also concerned about those patients who need maintenance care and who need case management services within their homes. If you are going to have the services there, they need to be coordinated; otherwise, they end up being fragmented

or possibly nonexistent. The services can be out there. We're finding that many, many of our elderly patients do not know, oftentimes, that services are out there. And, even though I know a lot of the programs do take steps to publicize, there is still the question of how to get the information to the people who need it. If you can solve that one, that will be great.

Overall, discharge planners are concerned that the demand on transitional settings has not met the needs as quickly as hospitals have sharpened their focus on acute care. In the past, and in the present, hospitals are having to fill the void created by the gap in services for older patients, as well as for others. We need help in educating the consumers. I think this has been said, but I want to stress it again. We need help in educating the consumers, not just the elderly, but all consumers, that these changes have occurred. Especially, we need to have acknowledged that the hospitals are now for acute care, and not for chronic, convalescent, recuperative, and custodial care. This is for information. We need people to be aware of this because we have definitely been given that line, and we have tried to respond to it. Thus, it has an impact on our changing function.

As our Society has studied the impact of what is happening to our consumers -- meaning our Society of Hospital Social Work Directors, our Society itself and its members -- it is clear that the pressure is felt on all levels. It is clear, also, by you having this hearing, that it is also felt on your level. We are happy to be here to have a chance to express our equal concern about pressure and stress.

We all realize that change in itself creates stress; however, we must focus on the elimination of the stress factors and realize what needs to be addressed. So, what we have done is try to address the issues as we see them.

We are all aware that there is an increasing senior citizen population and, correspondingly, an increase in the

utilization of health care services. Additionally, there is a need for non-skilled care, such as homemaker services, chore services, friendly visitors, increased protective services, and companionship services. These are the types of services where usually it is very difficult to get reimbursed. If you happen to qualify for Medicaid, and you happen to be able to get on a community care program, and if there happens to be enough slots in your county, or what have you, so that you can have access to that program, then, depending on the match, because you have to be able to fall into a certain category and you have to have a certain percentage that you pay-- In order to be accepted in the program, you have to be old enough to go into a nursing home, already on Medicare, and this is a way of keeping you out of a nursing home. See, we try to know what the regulations are. At times it is difficult to match people with services, though the need is there. We definitely see that there is a need for more of these kinds of services.

I will not talk about the decrease in financing for skilled care and all that because that was discussed before. But that is of concern to us, as well, because we're talking about sending people home on high-tech equipment, people who are in dire need because they do have medical problems. It is a fact that people are going home sick. We are supposed to be treating them during the acute phase, and then they are supposed to be going to another level of care. If they are going to go home and can only get two hours of care, that's not enough care, especially if it is not five days a week, and in many cases it is not. Sometimes it is only for a week and you might only have it for three days out of the first week, so it gets to be a concern to all of us.

We also feel there is a need for an increase in case management services for better coordination of services and follow-up in the community. Once people leave a hospital, it is very difficult for us inside the hospital to continue to

follow up, because we still have other people coming in who we have to assess and plan and provide some kind of treatment for.

We feel that there needs to be an increase in community screening programs for access into the health care system, which also relates to, how do you get the word to the people who need it so they can get the service that is out there?

We feel that there needs to be an increase in community geriatric medical screening programs, or at least consultation available for those of us who are providing the service, including physicians and the like, so that if there are questions about whether or not what we're doing is appropriate in terms of medical care and follow-up, another layer possibly could be made available. Possibly this could be provided through nutrition programs -- looking at existing services that are already aiding the elderly and placing some of those services there where the elderly are, so they don't have to come for the service. It would also cut down on travel time for the providers of the service going to all the homes.

We feel that there needs to be increased financial assistance to families which have been and/or are still willing to care for patients. Now, I know there has been a lot of discussion about how to make sure that the money is spent in an appropriate way, or what have you, and I'll let you figure that out. All I'm telling you is what the problem is and what we feel is needed.

We also feel that there needs to be coverage of the "nursing-home-without-walls" concept, such as financial assistance for the elderly who are interested in remaining at home and who are able, with the help of home alert systems, to manage at home, so that they have the medical backup for this. I know there was a study by HEW in terms of the benefits of it. It was proven beneficial, but the money was not -- as I understand it -- afforded to help to pay for that service. So

we do have people who are paying for that out of their pockets -- $30, $40, $50, a month -- depending on the cost of the program. There are more people who could use it, but the ones who can't afford it-- It gets down to the question again of how to supply the need. Most of the programs that are in existence at hospitals do have certain numbers of patients that they do provide the service to without payment.

We also feel that there needs to be a review of the Medicaid application process. This, I know, is on the State level, but if you have any input in that, we would appreciate it because we are aware that the processing procedure, based on some of the studies we are looking at in our Society, can take anywhere from seven days to six weeks or more in different counties for approval of Medicaid. That, of course, makes it difficult for the hospitals, because if there is no payment source, nursing homes aren't going to touch the person until they know how they are going to get paid. So the hospital ends up having to, of necessity -- not because we don't want to, okay? -- but of necessity, keep people in the hospital until we can get them moved to the appropriate level of care.

We would also like to have a look at the reimbursement to nursing homes for high-care patients, with emphasis on capital expenses, staff training, and our development of special programs. We don't have enough como treatment programs. I am aware, for instance, in Camden County, that there is a program in one of the nursing homes, but they do not accept New Jersey Medicaid patients. They will accept New York Medicaid patients. I don't know how many of those we have in New Jersey, but we can't get our como patients into that program because of New Jersey Medicaid.

We would also like to have increased emphasis on hospital services, especially in terms of assistance to families, not only while the person is still at home and being cared for, but we are also seeing some stress-related problems

with family members who are responding -- who have needs identified during the bereavement period, but in terms of hospice, those services are not reimbursable.

We also feel that there needs to be an increase in Medicare coverage for social work services through the home care programs. Serving on some of the utilization review committees of home care programs, sometimes this becomes an issue in terms of the fact that possibly more services should have been provided, could have been provided, but there needs to be more of an increased team effort and inclusion of the social worker services made more available, to help in this kind of assessment and treatment.

Lastly, we would like to have recognition and support of the need for professionally trained, qualified staff within hospitals to continue to provide appropriate discharge planning. If the staff is not there to do the assessment on admission -- or what is prior to admission in some cases -- then, on the back end, the services are not going to be there.

Thank you.

SENATOR PALLONE: I want to thank you. That was a very comprehensive and caring analysis of everything. Did you want the other gentleman to say something before we ask questions?

M A R K Y A R N O L D: I was going to say that hospitals are certainly not perfect systems, but they are caring institutions. Hospitals will simply not discharge patients until there is a viable post-discharge program. Might I also say that in addition to the DRG Program as a recommendation, the second tier of the DRG Program can be the upgrading of post-hospital care programs, such as home care programs, nursing home programs, and RHCF, which is "residential home care facilities." If more attention were paid to those programs which would be natural follow-ups to hospital care, I think the DRG Program could effectively be enhanced.

SENATOR PALLONE: Your name again -- what was it?

MR. YARNOLD: Mark Yarnold, Director of Social Work at Monmouth Medical Center -- Y-A-R-N-O-L-D.

SENATOR PALLONE: Okay. I just want to ask a quick question about the personal care you mentioned. As opposed to home health care, I use the term personal care. In general, that is not covered by Medicare? I mean, that's pretty much out of the question, right? (no response) That is another thing, of course, that this Committee has been concerned about and has talked about. We have even had some legislation.

Again, would you have any suggestions there with regard to State programs or State financing? I know I kept seeing dollars. The longer you talked, Ms. Williams, the more I kept seeing the account going up and up, and finally said, "Oh, it's hopeless." But, I mean--

MS. WILLIAMS: That's why I said, "It's your problem to solve, but I'm telling you the following."

SENATOR PALLONE: Okay. (laughter) No, just in terms of the personal care issue, though, have you, you know, any suggestions in terms of legislation for a program?

MS. WILLIAMS: Well, in terms of the kind of access I have, the development of those kinds of formulas is limited. Okay? But let me just say that based on the amount of care and the cost of care that is attached to nursing home care, and the fact that I know that many, many people -- I heard one of the gentlemen speak today -- would prefer being in their own homes-- It seems to be a known fact that when you are paying for care within someone's home or within the community it's cheaper. I would go on record as saying it has to be cheaper than what we are already spending.

I do know that in many cases there are people who, because of a need for custodial care even, have to go into a nursing home because we can't get that amount of care provided in their homes. And, if you're talking about somebody being

home at night, or even for six or eight hours a day alone, many of them can't do that. So, even if you are spending, say, the same amount of money, or a little bit less, it has to be more cost-effective than some of what we are already doing.

SENATOR PALLONE: Thank you. Senator Brown?

SENATOR BROWN: Thank you for a most comprehensive testimony. My solution, as far as some of the personal requirements that we all need if we are in an infirm situation at home, is-- Mr. Chairman, we've got to strengthen the neighborhood, and we've got to strengthen the family. With a lot of people working, you don't have the volunteers that maybe you used to have years ago, but there is no reason why I could not come home from being here in Monmouth County and provide a casserole for my senior citizen next-door neighbor. I don't think we are ever going to be able to pay for all these services, and if we don't encourage a sense of neighborhood, a sense of family for caring, we're out to lunch, period.

Okay, back to the services that all of you are providing. As an elected official, let me just say a heartfelt thanks. I can't tell you the number of good things we have heard in our office about the type of planning that goes on for all ages out of hospitals, whether it is a constituent in Ringwood or a constituent in Parsippany who has had a very good experience with hospital planning.

Let me ask you, though, do you find that there-- First of all, do you make a plan-- You don't make a plan for everybody who is in the hospital. What is the definition? How am I sure that I will benefit from your services if I am in Monmouth Medical Center?

MS. WILLIAMS: Since it is his hospital, I'll let him answer that.

MR. YARNOLD: If you came to Monmouth Medical Center, the Social Work Department, or other departments within the hospital, have automatic screening for certain categories of

individuals, such as those people over 70 years of age, those people with high-risk diagnoses that are, for example, cancer related, heart disease related, stroke related, etc. You can also make yourself a recipient of social work or discharge planning services by simply calling the Department, having your doctor refer it, having a nurse refer it, or having the family refer it. It is as simple as that.

SENATOR BROWN: Okay. So, by definition, anybody over 70 who comes into the hospital is supposed to be checked through? Is this just for Monmouth, or is this statewide?

MR. YARNOLD: It varies from hospital to hospital, but most hospitals have their own similar screening procedures. I'm not saying that anyone under 70 cannot receive those services, but these are the automatic high risk. We also screen, just as a slight deviation, child abuse cases and children who are also considered high risk for their particular admitting diagnoses.

SENATOR BROWN: All right, but let me say again, Mr. Chairman, we've heard from a lot of people. I think all of you are in key positions to really be able to make a difference. I can't believe that having discussions and planning with some of the elderly does not have different complications than if you are dealing with other age groups. Each age has its particular situation, but-- For example, my father -- whom you have heard me speak about -- at 83, had the guts to, you know, in his unstable condition, get up and almost walk out of the hospital, which I am not sure that anybody age 30 would have the guts to do. We all want to walk out of a hospital, but it takes a certain independence that comes with age to actually -- with my mother's help -- get dressed and be on his way out.

However, as a result of this, we never got the discharge planning from the hospital. I think they were so glad to get rid of my father that-- I think, again, that with the elderly, there is the different responsibility of dealing

with other members of the family. I mean, with all due respect, telling something to my mother as far as actual follow-through was no help whatsoever. I guess what I'm saying, and pleading for as a legislator, is that we consider how we can be assured that hospitals in the State of New Jersey are given appropriate backup and financial resources -- the job that all of you are doing, which was your last point, I believe?

MS. WILLIAMS: We're concerned about-- Although we're speaking about New Jersey here, we are also concerned about what is happening throughout the United States with people who are in similar capacities to ours. Specifically, though, on the State level, we are seeing, and are concerned, that as hospitals are looking at reimbursement, and also looking at decreasing lengths of stay, that also affects how all deployments within hospitals are viewed. We have found that because of the new system, as well as PRO and some of the other things that preceded what is going on here, that in most hospitals the discharge planning piece has gained new acceptance and new support.

SENATOR BROWN: In terms of money and staff?

MS. WILLIAMS: In terms of image and, in some cases, in terms of money and staff.

SENATOR BROWN: In other words, you have more people working for you that you did five years ago?

MS. WILLIAMS: Some hospitals do; some hospitals don't. This is one of the things-- This is one of the reasons why we included that as one of the issues that we would like to have support on. We're not just here asking for -- out of context -- help for our particular areas, but on behalf of patients who need the service. We are asking that more emphasis be placed, both on your level as well as on other levels, on the importance of these kinds of services, because they are vital.

We need to be able to do even better, if you will, in

assessments of people, not just always paper reviews or talking to the nursing staff, or whatever. I don't know if we will ever get to the point where we will be able to go in and, eyeball-to-eyeball, look at every particular patient, but that might be one of the ways of preventing the kind of problem that you possibly experienced.

On the other hand, I think, too, if we can educate the consumers to let them know that these services are there, then there is nothing wrong with people also saying, "Well, I might have been okay when I came in and might not have needed these services, but my situation has changed, so I now need the services before I leave." It is not always true that we pick up cases on daily admissions. Sometimes it happens that we pick them up just prior to their discharge or somewhere during their length of stay.

SENATOR BROWN: Mr. Chairman, I think it would be interesting, through the Hospital Association, or whatever, if this Committee could get some sort of figures about the number of people in these units, maybe in various hospitals throughout the State, to just find out a little bit more about who is out there. Again, thank you for just a vital job that you're doing.

SENATOR PALLONE: If you could provide that to us, we will make it part of the record. I want to thank you again.

MS. WILLIAMS: Thank you very much. (applause)

SENATOR PALLONE: We are going to try to get some representatives of senior organizations again now. We have Mr. William Feirstein, from Lakewood. I believe you represent one of the organizations.

W I L L I A M F E I R S T E I N: Good afternoon, Senator and members of the Committee. It's no longer morning, so I might just as well say "Good afternoon."

Up until now, we have been hearing from directors and people from various organizations who represent, let's say, the office people. Right now, I would like to speak as a person

who has had the experience of being under DRG.

I am Vice President of a B-nai B-rith lodge which goes to the Catskill Mountains every year; it's been eight years now. As the group leader of 200 people, we went to the Catskills to a hotel. The evening before we were to leave -- we were leaving via the -- near the bar -- the floor was wet. My wife fell; she fell on the back of her head. She had a concussion, a deep concussion.

She was rushed to the hospital, and the hospital there refused to let her go, or discharge her, until a hospital here in New Jersey would accept her. I called Kimball Hospital. They refused to accept her because it was not a prior case where they had had anything to do with the head. They refused to accept her as a patient.

I called Point Pleasant Hospital, and they finally accepted her. I had the doctor there call the doctor up in the Catskills. The two of them got together, an ambulance was obtained, and she was brought here to Point Pleasant Hospital.

She remained there for three days, and they discharged her. I gave them an argument because it was three days and she was still in pain, and yet she was discharged. I brought her home and she was in terrible condition. I took her to a neurologist and he, in turn, said that she must be in a hospital immediately because something was definitely wrong with her head. The head is nothing that you can just look into to determine just what is wrong.

The result was that he ordered her to another hospital, and there they kept her for three weeks. In the interim, while there, they did not have the necessary equipment, and they sent her to Red Bank, to the Riverview Hospital, where they found that her head was still bleeding. All the veins and all the arteries were bleeding in her head. She was unable to walk any distance at all without falling. She completely lost her equilibrium.

Today, it is now three months later -- since October, I should say -- I have to lead her. She walks with a cane. She walks on one side -- the right side -- with a cane. On the left hand she has to walk under my arm.

Now, I, myself, have been a heart patient for many, many years. I had six by-passes placed in my chest with veins from my leg. As a result, I had a stroke. Even today, I can barely lift my left leg. Yet, I have to be her nurse. I had someone at the house, and it cost quite a bit of money to have a homemaker -- someone at the house. If you get someone in the house, even a homemaker-- It cost $1,200 to have a homemaker come to the house, which Medicare refuses to pay.

The doctor ordered an electric bed to vary positions. Medicare refused to pay. I had to get her a walker; Medicare refused to pay. I can imagine an ordinary couple, just about making it, or depending merely upon Social Security -- what position would those people be in?

I believe that we in America here today, ourselves -- and I have papers to prove it-- We in America, along with South Africa, are the only nations in the world-- Remember, America is supposed to be the richest nation in the world -- supposed to be. Yet, right now, we, along with South Africa, are the only industrialized nations in the world which do not have home care, or health care, or any sort of a health committee or a health system whereby they will take care of their citizens. Why do we have to have such a situation?

I just outlined what has happened to my wife. I, too, as a matter of fact-- Two weeks ago Monday, I was discharged from the hospital. They discovered that I have cancer. Despite all that, I was called to come to Washington to appear before a Senate Committee, such as you are here. I called my doctor, and he said, "You're crazy. You'll never make it." Yet, I am determined that before I go, I must see that my fellow senior citizens have something upon which they can

depend to have the government take care of them so that they can live in dignity, so that they can live with an idea that should anything happen to them, someone will take care of them. If other nations can have it, what is wrong with America? Are we such a backward nation? We say that the savages in Africa are backward, yet are we not a backward nation, a nation that will not take care of its own citizens in situations such as I have just described? Why? What is wrong? What is going on?

This is only two cases. What about the hundreds of thousands of other cases of senior citizens who are in the same position, and perhaps do not have a reserve fund? What are we supposed to do, take a gun and go out and shoot ourselves, and say, "Well, that is the end of it"? Sometimes, with what I have, I feel like doing that. I might just as well end it all, but I will not do it because I am fighting to help my fellow senior citizens until that Fellow upstairs calls my number, and I am ready to go. Then I will know that I fought until the end. I know I have to go shortly, but I will not go down without fighting because I want to see others -- at least let them have some something upon which they can depend, and not have to appear before a Committee and beg or ask or "Please won't you do this?" or "Please won't you do that?"

I have told my fellow citizens at meetings, "America has prosperity today, but it is an arsenal of death because we are all working on those things that make arms, and eventually -- eventually -- God help us, it should not come to that." I may not see the day, but eventually those arms will be used for what, for killing our children or our grandchildren? We have a big huge deficit, a deficit that we never had for many, many years, and yet, here we are faced with that situation, while our grandchildren are already mortgaged.

We senior citizens today are begging you people, are begging everywhere throughout the entire nation, "Help us,

because we need it, we want it, we must have it." We've done our share. In the '30s, we suffered because of the Depression. In the '40s, we fought for our nation to defend our flag. In the '50s, we fought in Korea. In the '60s, we fought in other nations. My own son was shot down three times. But, I still keep going because I feel I want to see my fellow senior citizens -- at least that they can depend upon their own American government to help them when they need it, whether they have thousands in the bank, or whether they have a thousand pennies in the bank. I want to see them with something to help, so that when they are ready to go, at least they will go and say, "Thank you, God, thank you, Mr. President, thank you, American people, for helping us when we needed you."

I have some papers here that I would like to pass out to you people. I have since joined the Coalition on Health so that I can help other people with their dilemmas, the same dilemmas that I have, which I am trying to do. I sometimes attend two or three meetings a night. I know that when I get home I'm pooped, but I'm ready and willing to continue doing it until I go. It won't be long, but I'll continue going on.

Thank you very much. (applause)

SENATOR PALLONE: Thank you very much. We will make those papers part of the record. I want to thank you for coming. I know I have seen you before, and I know you have long been an advocate of senior citizen issues and issues for the elderly, not only in your own area, but throughout the State. So, thanks for coming.

MR. FEIRSTEIN: Yes. Our own area is full of senior citizens.

SENATOR PALLONE: I know; I know.

MR. FEIRSTEIN: As a matter of fact, if I may add-- I have gone to the Governor, and I spoke to him. I have books in my car which show that we have but two doctors who took

assignments in Toms River. If you are acquainted with our neighborhood, north to Lakewood, there are approximately 60,000 to 70,000 seniors, and we have two doctors who took assignments. From Howell Township, in the southern part of Monmouth County, north in Monmouth County, there are 110 such doctors who take assignments. Below Toms River, there are 55 doctors who took assignments. I sent a letter to the Governor and asked if I might see him on a very important matter. His secretary sent me a letter back, "Come," and I went.

I went to see him in Trenton, and I had a little talk with him. He lives in Livingston; I originally came from West Orange, and we were more or less buddy-buddies. I told him then that it was a shame, two doctors in a town, or in an area where there are approximately 60,000 to 70,000 senior citizens. He was amazed himself. He said, "Send a letter." At that time, it was Commissioner Renna. He has since resigned, and we now have Commissioner Coleman, but he did say that he would send a very, very strong letter to all the doctors.

I went to Deborah Hospital, and I said, "Look, we need a doctor in our area, a cardiologist, who will take assignment," and they said, "Yes, we have just the man. He wants to go into business for himself and he will open an office in Lakewood." He did. I go to him. I spent 10 days in the hospital last June, and the entire bill, to me, was $4.13. I asked no questions. I immediately made out a check for $4.13. I said, "Grace, well, what is my bill now?" "You're all paid up." Well, if I'm paid up, wonderful -- $4.13 -- whereas -- and I repeat this -- a friend of mine, whose wife just died a month ago-- She was in a comatose condition, dying of cancer. There was no hope. At Kimball Hospital, a doctor came in and saw her 13 times in one day. He charged $16 each time he came in. He went out one door and came in another door. Thirteen times in one day. He sent the bill to

Medicare, and it was paid. How long will Medicare continue with situations like that?

The papers are now writing up that Medicare may go broke again, as they have warned time and time again. Certainly, with situations like that. Thirteen trips in one day, at $16 a trip, and he was paid in full. No questions asked, no query as to how, why, and which, and yet he was paid all that money. For what purpose? What reasoning? That is the reason why we, with DRG, are now being kicked around as if we were second-class citizens. Therefore, I ask you folks -- I ask the government, I ask the State, and I will ask everyone in Washington when I'm there-- I received a phone call on Tuesday to come back in three weeks. "Get all of your bills." I received a bill of $18,000. I didn't pay a dime; Medicare paid it. Another one was $11,000; another one was $14,000. Medicare paid them, true, but on the other hand, where is all this money coming from? From our taxes, the taxes that the people are paying. But, how long can Medicare exist with such situations?

I will appear, even if I have to go on one leg and be carried. I will go to Washington. I will confer with the people there. And, I will give my story the same as I am giving it to you, because I do wish to see something done for the senior citizens who are now in those situations where they cannot go on any longer.

Thank you very much.

SENATOR PALLONE: Thank you. I think Senator Brown has a comment.

SENATOR BROWN: I just wanted to personally thank you for coming here today. I think you underscored the importance -- in a nation like this -- of providing adequate health care coverage. You know, financial planning is very popular out there today, and certainly we are all told to put away nest-eggs for our children going to college, and so on. I

wonder how many of those financial planners are saying to people in their '20s and '30s, "You know, you've got to be ready to pay some big bills in your later years, for which we are getting no help from the government at this moment."

MR. FEIRSTEIN: But, when you are in your '20s, you don't think of those things. You're out for a good time. I know it; I did it myself. I was 20 at one time.

SENATOR BROWN: Thank you so much for coming.

MR. FEIRSTEIN: Weren't we all?

SENATOR PALLONE: Thanks again. (applause)

Could I just see, by a show of hands, how many more speakers we have? We want to accommodate everybody. I was thinking of maybe taking a break. About six or seven. Senator Brown, do you want to go right through?

SENATOR BROWN: Sure.

SENATOR PALLONE: I guess we'll continue then. There aren't that many.

May I have Mr. Walter Soltysik?

W A L T E R S O L T Y S I K: Senators, ladies and gentlemen: I come here for the benefit of my wife. She passed on the 10th of last month. She went to the hospital, she got operated on--

First, let me start off. She had a stroke on October 21st of last year. She stood in one hospital for 10 days. From there, she went to Kessler to be rebuilt. She stood there until January 14th. In the meantime, she developed a condition of the rectum; her by-pass was oozing out like lava. She had a restriction somewhere. So, I took her to the doctor the 30th of January, and he advised an operation on her rectum to make the opening wider.

She was only in the hospital about five or six days. They were giving her enemas of all kinds to relieve her. In the meantime, her stomach blew up to about 46 inches in circumference. They released her on the fifth day.

I begged them to keep her there to let her

convalesce. She was not a young person; she was 79 years old. She had had a stroke and was paralyzed on her left side. They wouldn't listen to me. Even the social worker there-- I told her, I said, "Are you working for the people or against the people?" I even spoke to the doctor, her doctor. I said, "Are you looking out for the welfare of your patient or the welfare of the hospital?" They started talking about the Rudman bill, whatever it is. I said, "I want to pay for her to stay here to convalesce, whether it's five days, ten days, two weeks." I wasn't looking for charity.

So, I brought her back to the hospital about 10 days after they released her. I brought her back in there. The second day she was there, on the 21st of February-- I brought her back the 22nd. She had a stroke, and she became dormant. She lingered until the 10th of the month, and she passed on on Monday, about 4:48. In the meantime, her body was deteriorating. They were drawing blood out of her practically every day for different tests.

See, I believe in miracles, but this miracle didn't happen to me. So, I hold the hospital responsible for refusing her right to be in there. She was not looking for charity. I was going to pay the bill. So, I'm looking for answers. I had her body -- an autopsy performed, and I am waiting for the report. When it does come, I may have to go somewhere and get that whole report gone over, or have her body exhumed to find out exactly.

In the meantime, I was down at my daughter's house the Monday that she died. The undertaker called me at my daughter's house in Sayreville, and said, "What happened to the rest of her internal parts? They kept them at the hospital?" I called the-- The undertaker called me down at my daughter's house, and I called the hospital. I talked to the doctor up there, I said, "If I was there, I would rip your eyes out for sending out an empty body."

I authorized an autopsy, but told them to leave the remaining parts inside of her. Here, the undertaker had to go up there, and in a cellophane bag they had her internal organs liquified, as if she had leprosy or something. See, that is what I want to find out about, because they had it down that she was supposed to have -- what do you call it again? -- hepatitis, which was a lie. She never had that. Being married 53 years to her, and I kept company with her for three years, that's 56 years we were together. That's like losing your right and left arms.

So, I would like to find out answers, what she died from, because these doctors here, I mean, they simply write anything they want to. We all have hypertension -- most of us. They put down hypertension, so they can't miss. See, I was an auto mechanic. When we made a mistake, the customer let us know, but when they make a mistake, they bury their mistakes.

I'm getting bills now -- they're piling up -- from different doctors I never hired, and all. See, I want to pay my way through, because I'm not looking for charity, but I want to get answers. Why did she die, and why were her rights denied?

SENATOR PALLONE: Let me just ask you, if you don't mind my interrupting-- When these decisions were being made about, you know, saying that she had to leave the hospital, which you felt should not have been made, were you, at any time, informed of what your rights might be, or that you had a right to appeal that decision?

MR. SOLTYSIK: Not at all. Even her doctor-- In other words, she had a doctor for nine years. When I asked the doctor to come to the hospital when she got the stroke the first time, he said, "I have patients in the office." What the heck was she?

SENATOR PALLONE: There was nobody -- not just a doctor -- but no one, for example, no provision made or

anything, as far as the hospital was concerned, to tell you what your rights were, or that you could appeal a decision?

MR. SOLTYSIK: No. I just left it up to the doctor. I don't want to mention his name at all, but if it comes to a point where I have to mention it, I'll mention it.

SENATOR PALLONE: I think one of the most important things is that people be informed, you know, of what their rights are, and then if you think that the decision being made--

MR. SOLTYSIK: Well, now I heard that today, about our rights and all.

SENATOR PALLONE: That you should appeal, but you were never made aware of that in any way?

MR. SOLTYSIK: I never was, and this is not a small hospital either. It is one of the biggest in the State. As far as the personnel in there, the nurses and all, they are like angels. They took good care of my wife.

SENATOR PALLONE: All right. Did you want to ask anything, Senator Brown? (negative response) I really sympathize with what you're saying.

MR. SOLTYSIK: But, I want an answer, see?

SENATOR PALLONE: Let me say one thing--

MR. SOLTYSIK: I want advice from somebody who can turn around and-- I don't want to hurt anybody by making remarks -- slurry remarks about them, but I was hurt.

SENATOR PALLONE: I'm very glad you came today because, you know, I know it takes a lot of courage to even come down here and tell the story, and also to give the details you gave. Hopefully, you know, this is the type of situation that we are concerned about and that we would like to do something about. I don't know if the answer is maybe just to better inform the public so that they have, you know, so that they know what their rights are, they know that they have a right of appeal of some of these decisions about discharging individuals. But certainly, I appreciate your coming down and

telling us the story because this is exactly what we are interested in knowing, whether or not this is taking place.

I don't know what you are going to have to pursue personally in terms of, you know, any kind of action, but--

MR. SOLTYSIK: Well, I'm looking for someone to lead. I don't want to be led astray, by no means. I don't want to hurt anybody. But, I want results.

SENATOR PALLONE: You had a question, Leanna?

SENATOR BROWN: No, I was just going to say that obviously our ability to get into the specifics of any one situation is difficult. But I'm sure that if you speak to somebody on the Committee afterward, at least we could just write the hospital general questions, and make sure that you get some sort of an answer.

MR. SOLTYSIK: I spoke to the Director -- the Vice President of one hospital. He was very good and all. He listened, he was compassionate and all that, but he still didn't want to go against-- Everybody has pets. At the other hospital, the same thing. I spoke to them. I'm waiting for answers from them. I said, "You tell me why my wife died."

SENATOR PALLONE: Well, Mr. Soltysik, I have some information here about the particular case. Even now that I have your name and address and everything, I would like to get back to you afterward about this. Okay? And thanks for--

MR. SOLTYSIK: I can leave that with you.

SENATOR PALLONE: Can I keep this?

MR. SOLTYSIK: Yeah.

SENATOR PALLONE: All right, fine.

MR. SOLTYSIK: I just want the phone number on the back of that.

SENATOR PALLONE: All right, fine. If you want to give it to us now, or you can give it to us before you leave.

MR. SOLTYSIK: You can have it now.

SENATOR PALLONE: You came all the way from Essex

County?

MR. SOLTYSIK: East Orange.

SENATOR PALLONE: East Orange.

MR. SOLTYSIK: I was born and raised in Newark. My wife was born in Connecticut. She lived there all her life. She was very religious and all.

SENATOR PALLONE: Okay. Well, thanks again, and we will get back to you.

MR. SOLTYSIK: Okay.

SENATOR PALLONE: Take care.

MR. SOLTYSIK: Thanks for listening to me.

SENATOR PALLONE: Okay. I am just going to go through the list, and if you are here, please come up. We have-- Well, David Keiserman, did you want to say something?

D A V I D K E I S E R M A N: Yes, please, because I have to get to work by two o'clock.

SENATOR PALLONE: Okay, please come up.

MR. KEISERMAN: Senator Pallone, Senator Brown, hello.

As an Executive Member of the New Jersey Council of Senior Citizens, past President of the Monmouth County Senior Citizens Council, and a member of the State Legislative Task Force, I am here to express the concerns of the people I represent regarding The PRO, the Diagnostic Related Groups, and the Health Care Financing Administration, HCFA.

I have had no dealings with The PRO since I challenged their original guidelines regarding the prescribed criteria for certain ailments. This criteria has since been changed after Mr. Marty Margolies, The PRO Executive Vice President, admitted that the criteria, and these are his quotes, "Was ill-advised and done in haste." My concerns now are based on what I read in the newspaper. For example:

1. The newly elected President -- and we heard from him this morning -- of the New Jersey Medical Society has stated -- in a newspaper article when he was installed -- that

doctors are being pressured by their hospitals to discharge patients early, and are threatened the loss of hospital privileges if the doctors do not comply;

2. Congressman Claude Pepper stated that early discharge has increased the number of patients needing medical home care by 40%. Despite this tremendous increase, HCFA is disallowing Medicare coverage for thousands of cases that were approved in the past;

3. The ever-changing HCFA rules have the providers of transportation, home care, and nursing homes afraid to provide proper service for fear that they won't be paid;

4. Two-thirds of the doctors who responded to a survey by the American Medical Association stated that Medicare recipients are getting poorer care in hospitals because of DRG and PRO. Many physicians reported administrative pressure to limit laboratory tests, discharge patients early, and to treat more people as outpatients without regard to their age or mobility; and,

5. Senator John Heinz, Chairman of the United States Senate Special Committee on Aging, reported that a Congressional study showed that thousands of, and I quote again, "Seriously ill Medicare patients are being denied admission to hospitals or catapulted out of hospital doors prematurely." Also according to the Senate Committee on Aging, at least 4,200 cases of inappropriate treatment or discharge were flagged by The PRO for further investigation.

These are just a few of the reports that prove there is a serious problem. To add to the problem, the over-65 age group is the fastest growing segment of our population. With this expanding population, the cutting of the Medicare budget is unconscionable. It is little wonder that over 25% of all senior citizen deaths is caused by suicide.

There is no doubt that many doctors, hospitals, and patients have abused the health care system, and some action is

needed. I strongly believe that a PRO with proper objectives could be very valuable. If The PRO would concentrate on proper care and the prevention of abuses in our health systems, both the young and the old would benefit. It is unfortunate that The PRO, at present, concentrates only on the saving of money at the expense of the sick and aged. It is interesting to note that hospitals had a very profitable year in 1984 under DRG. Profits rose to a 14.12% return on investments and a net profit of 24.17% over costs.

In closing, I would like to point out that all of the major senior citizens' organizations in New Jersey have pressed for a comprehensive home health care program, the aim being to maintain seniors in their own homes, rather than in the more expensive nursing homes and hospitals. Until such a program is in effect, not just for the poor but for the middle income as well-- I would like to stress that, the middle income as well, on a sliding scale, because that is something that is not being addressed by any of the bills that have been coming up. Even Richie Van Wagner's new bill does not address it. We have the Medical Needy bill for all around the poverty level or below the poverty level, but the real need, and I understand they call that now -- I made a note of it -- the "no-care zone," affects the majority of seniors, which is the middle-income group. Until such a program is in effect, we will not see cost savings in either Medicare or Medicaid.

I know that both of you -- and this is not part of my testimony, I am running away from that now -- have been on the Casino Revenue Fund Study Commission. I have read your report, and we are delighted with that report, needless to say. We all took turns testifying from the Task Force, throughout the State. My turn was in Burlington County at the time. We are delighted. We would like to see all of this implemented.

I want to thank you very much for this opportunity to address you.

SENATOR PALLONE: Thank you for coming. I just want to say that you have been very helpful, not only to senior citizens in general in the County, but also to me in particular in terms of legislative initiatives. I don't even know if you mentioned that you are the Legislative Chairman of the County Senior Citizens Council, but in that capacity, I know that you have been extremely helpful in terms of getting input about what is needed and how we can frame legislation to deal with the problems.

MR. KEISERMAN; We've worked together, and I want to thank you for your previous, and current, and future cooperation, which has been extensive. I am delighted to be working with you, Frank.

SENATOR PALLONE: All right, David.

MR. KEISERMAN: And Senator Brown as well. I have met Senator Brown before and discussed matters with her. I gave testimony in Trenton. Thank you very much.

SENATOR PALLONE: Thanks again. Is Dr. Alexander Rodi here, Present-Elect of The Peer Review Organization of New Jersey? (affirmative response)

D R. A L E X A N D E R E. R O D I: May I bring my chief administrator with me?

SENATOR PALLONE: Fine.

DR. RODI: With me is Marty Margolies, our Chief Executive Officer. In case you should ask me any numbers, he might be able to help you rather than me.

SENATOR PALLONE: Okay, thank you.

DR. RODI: Thank you for this opportunity to be here today to represent The Peer Review Organization of New Jersey. I am Alexander E. Rodi, Sr., D.O., a family practitioner from Hammonton, New Jersey, who has among his patients many older Americans.

I would first like to tell you that The Peer Review Organization of New Jersey is a utilization review agency

certified by the Federal government and the State of New Jersey. The PRO covers the entire State. We have an all-payer system, which means that all third-party payers pay a similar DRG rate to the hospitals. Initially, our Organization was mandated to monitor the utilization of resources for the Federal programs; however, our initiative some years ago was to place more emphasis on the type and quality of care the patients were receiving, rather than pure utilization of resources. Recently, HCFA has emphasized, through recommendations of the Heinz Committee, the importance of evaluating the delivery of quality care.

In my practice, as well as in my duties as President-Elect of The Peer Review Organization of New Jersey, I am very much aware of the concerns of the older Americans in our society and their fears concerning our health care system. Amongst these concerns are:

1. Will I be able to get into a hospital if I need to?
2. Will medical care be rationed?
3. Will I be discharged from the hospital prematurely because I will have exceeded some monetary allotments?
4. Is some other force coming between or interfering with the care between my physician and me?
5. Am I going to be able to afford medical care?

I am not here to answer all of those questions today because I cannot answer those which relate to fiscal responsibility. However, I can tell you that The PRO of New Jersey is sensitive to these questions and seeks to find solutions and answers to the many problems which present themselves to our older Americans. We are concerned that the health dollar is used wisely, without any funds wasted or used foolishly which might limit resources to others in greater need. Therefore, we do not wish to see patients placed into the hospital environment for acute care if they do not need to be there for treatment. Also, a hospital very often is not the

best place for anyone to be, particularly fragile persons who succumb easily to infections or other hospital-related problems. When a patient is admitted to a hospital, a cost of several thousand dollars is triggered which will be paid. If significant numbers of unjustified admissions occur, thousands of dollars will not be available for other needs.

At this time, I would like to address some of your concerns specifically.

First, any patient who is ill, that needs to be evaluated and treated will not be denied admission.

Second, will medical care be rationed? I hope not. There are many factors why medical care has increased in cost. One is the escalation in technology which, in most cases, improves the diagnosis and treatment of many of our Americans. However, many technological advances carry exorbitant costs. The American public must make a determination whether or not they are willing to allocate limited resources to these areas.

Third, the question raised as to whether or not a patient will be discharged early, or, quote, "thrown out into the street", unquote, is a cogent one. Our organization has been looking for premature discharges or discharges of patients who believe they were sent home before they were stabilized. We have limited resources, and, therefore, cannot evaluate every medical record upon discharge. We do, however, have certain clues we utilize in order to look at a hospital discharge. Any patient who is readmitted within seven days for the same diagnosis results an immediate review of both stays.

To date, we have reviewed 74,183 Medicare records, and have identified 11 cases -- .014% -- where we felt the patient was discharged early. However, in review of these 11 cases, we did not find any intent to discharge for financial gain, but rather professional judgment deemed that the patient was stable at the time of discharge.

Finally, is some other force coming between or

interfering with the care between my physician and me? The relationship between a physician and his patient has always been a special one. We at the PRO are practicing physicians who deal on a daily basis with patients of all ages, especially the older American. We are very jealous of the special rapport that we develop with our patients, and are not anxious to have other forces intercede. In these times, we encourage the enhancement of the physician/patient relationship so that there's only a minimal damaging effect by other forces on this relationship.

The PRO of New Jersey places great emphasis upon the documentation that a physician places in his chart. This is the primary source to determine what is happening to that patient. We continue to depend upon this documentation in order to help make fair decisions, and we insist on its credibility.

The reason that the statistics that you heard earlier may have relevance -- and that is reversal of denials done initially -- is based upon the fact that the attending physician did not document appropriately when the patient was admitted. Therefore, essential information to make an appropriate decision other than the one that was made was not there. When the physician presents his case before the Committee, suddenly all other information is presented. Therefore, it's not a weakness of the PRO that creates a reversal of decisions, but the strength of the PRO which can recognize that the extenuating factors that should have been there in the first place were not there, and we have not upheld the denial in those cases.

Incidentally, it was also said someone believed that these were political appointments on the Board of the PRO. They are not political appointments; we are all practicing physicians.

All of you must know that no one can discharge a

patient except his attending physician. The hospital administrator cannot do it, the nurse coordinator cannot do it, the PRO cannot do it, the medical society cannot do it, nor can anyone else discharge a patient except in extremely extenuating circumstances. Some providers misunderstand this. Because certain guidelines have been established, they may believe that they must follow a, quote, "cookbook", unquote, type of plan for that patient.

We in the PRO are interested, primarily, that the patient is discharged stabile. If that patient needs to stay a day or two more, or stabilized a day or two early, that is not-- We repeat, however, that the patient should be sent home stabilized. We also want the patient to be discharged to a stabile environment which will not compromise his medical status.

If you know of any situations where you believe a patient has been prematurely discharged, please contact the PRO office first so that we can determine whether or not it is factual. We have two phone numbers where we can be reached: Centrally, area code 201-238-5570, in East Brunswick, and, in the South, area code 609, 424-7433, in Cherry Hill.

We will address these issues when they are presented to us. I can assure you appropriate evaluation and determination will be made.

Thank you very much for allowing us to come before you today. We have seen this as an opportunity to reaffirm our policy which we are hopeful will be disseminated to all.

Finally, this system operates in a political environment. Each and every American, in one way or another, has input into the type of medical programs which exist.

Thank you, again. There are a couple of items I wanted to address: I wanted to reemphasize the documentation factor, and how important it is for the PRO to have appropriate documentation up front to make a decision; we would like to

reemphasize the importance of the attending physician as being the all important cog in what makes this thing go; we at one time felt that the -- and we, I think we disagree with Faith Goldschmidt a little bit on this on intensity of service -- we think that in reference to the information that was disseminated about two weeks ago, intensity of service is a factor.

And I'd like to reiterate that the criteria that are developed are not taken out of the air. They are criteria developed by true peers of that specialty, and therefore, they are not taken without any due concern about what that specialist thinks about that particular case. We do not discharge patients on criteria, we do not admit them on criteria alone. A nurse coordinator, by nature of the cost of resources, reviews and uses criteria and if she feels that there is an element which is not present she refers it to a physician. So, therefore, it's not a nurse who makes the determination based on criteria, it's not based upon criteria alone, a physician will help make that decision.

As far as continued stay in the hospital is concerned, I am a practicing physician; I have an acute hospital practice. No one -- that includes the PRO, that includes the hospital, that includes anybody -- is going to force me to send home my patient before they are stabilized. So, therefore, I tell you the responsibility lies with me, that patient's attending physician, to see to it that when they go home they are stabile.

Thank you very much.

SENATOR PALLONE: Thank you, Dr. Rodi. I noticed some people were taking down the numbers when you were giving them to us, so that's productive too. I just wanted to ask you a few things that, I guess, came up around my mind. What about the cost of administering the PRO? Who pays for that, or how is it administered?

DR. RODI: Well, this is administered through a grant from HCVA, which was put up for a bid process about two years ago -- one and a half/two years ago -- and it's coming up again. And HCVA pays for the performance of the implementation of the program, and for a two year period it was $8 million.

SENATOR PALLONE: You mentioned that the members of the State PRO are strictly physicians.

DR. RODI: The members of our Board are all physicians, and the people who make the final decisions are physicians, yes, sir.

SENATOR PALLONE: All right. And, what about-- How are they chosen? I mean, what is the appointing process?

DR. RODI: Well, the present Board is composed of two prior PSROs, one in Central and one in Southern, which really included geographically about two-thirds of the State, and about 48% of the Medicare discharges, and possibly a little bit less of the physicians. This was a process which started back in the '70s, at which time each county had representation elected into the PSRO Board. When the contract went into a bid basis before that, we had merged with the PSRO from Central to form the PRO of New Jersey, and we have retained basically the same people who were placed on the PSRO some years ago.

SENATOR PALLONE: And how were they chosen, again?

DR. RODI: Election.

SENATOR PALLONE: I'm not sure -- by--

DR. RODI: By the medical community.

SENATOR PALLONE: By the doctors themselves.

DR. RODI: Yes, sir.

SENATOR PALLONE: Senator Brown?

SENATOR BROWN: Okay. So let me follow through a little bit more. Most impressed with your testimony. You come from a magnificent community -- the blueberry capital of the world -- and certainly it's good of you to take your time to come.

What are we doing now here in the State of New Jersey to sensitize physicians to the needs of the elderly? Which I do think-- You know, you've got pediatric medicine -- and we all know it's terribly-- Well, you know, traditionally, the pediatrician has played a real role in delivery of medical service. There are ongoing courses, obviously, for physicians. Are enough of them being offered in the area of geriatrics? Do we have enough attention to geriatrics in our hospitals?

DR. RODI: Well, I believe your concern is a valid one. There are courses, on an annual basis which are increasing in number, for geriantology, and I believe those of us who do a significant amount of geriantology in our practices always seem to want to go there, feel it's the appropriate thing to do. Somehow, I believe we do need more emphasis and initiative.

We do read. We have periodicals that can be read on medicine for older people -- elderly Americans -- but I agree that there probably ought to be a little more emphasis on education and developing a more formalized participation in a course on geriantology. Your comment is well taken.

SENATOR BROWN: I would say, Mr. Chairman, I think there needs to be more than a little. You know, if we took a cross-section of physicians here today in the State of New Jersey -- and here again, we have many people in the audience with more wisdom than I do-- But I am appalled at the basic overall lack of understanding on the part of some people in the medical profession on the needs of the elderly. Now I understand-- This is another thing I have to ask you. It's finally get out of a hospital situation. Before we develop alternatives, how can we be assured that there's going to be medical coverage by the physician in the community? You know, it's $80 that I am paying for one physician to come every two months into a nursing home. And, you know, if I'm the

physician, and I've got crises -- you know, a kid that's chopped off an arm, and all these other acute care -- my first priority, understandably, is not going to be to a chronic patient out in the community. But there must be some area of the medical profession that could concentrate on delivery of services to the chronically ill elderly in the community, whether they're at home or in a nursing facility.

DR. RODI: Well, as I say, I agree with you, and I think it's a developing specialty. Since we do not have a growing group of family practitioners -- or at least we were down very low for a while, and maybe we're coming back again -- that was the one source at one time which provided the care that you're talking about, and I believe they still represent the nidus, hopefully in greater numbers in the future, providing the care of which you're speaking.

We, however, as a PRO -- you're speaking to me now as an individual physician, I believe -- as a PRO we are concerned about these kinds of problems, and we can give it some initiative. But we don't have the force of empowerment of any type in which we can get physicians to take this particular education unless we see a pattern of care which we believe is either potentially or actually impairing the treatment of the patient. Under those circumstances, we can, and will direct that the physician take further training, if we believe he falls into that category.

But, we do not have a positive program of which you are speaking that I-- It's a very appropriate comment.

SENATOR BROWN: Well, with the second largest number of elderly population in the whole State, I think this is legislators' -- is an area where we have a legitimate concern. And we put all sorts of requirements on our teachers, and all sorts of requirements on everybody else, but this business of how we are going to take care of the medically needy of our people in the community, as well as in the hospital-- I happen

to think, and be most supportive of the work that you're doing with PRO, but I'm worried about the people-- You know, I do think that just because you're in the nursing home doesn't mean that you don't need to see a doctor on occasion. On the other hand, there must be ways that we can deliver that service in a caring fashion, and yet in a cost effective fashion. And I'm not sure any of us have the answers yet.

DR. RODI: Well, I think you're correct. And we, however, feel that we have an accountability to the population of New Jersey, particularly the older American, and we welcome queries, and questions, and even recommendations. If there's anything that we can do in order to make this system work better, we would do it.

If you were to ask me the question about the DRG system, whether we'd be better with it or without it, I'll tell you that we're much better with it. It certainly needs to be refined, it needs to be tuned-up, but I don't think anything we've ever had before was anywhere even remotely close to doing what we're doing with DRGs. Physicians are very independent, and they have never liked the idea that somebody was looking over their shoulder when they were treating a patient. It's only happening in the hospital now, as you know. I probably had the same feelings. But when we understand the great accountability that we have today to our people, we have to accept the fact that there are going to be people looking over our shoulders and looking at our records, and that that is a greater challenge of staying up to date, and being accountable, and most of all, being humane.

I don't know that we can't educate people to do this, possibly, but we certainly can let them know we're watching, and bring them along with an educational process and with counseling and so forth. And, hopefully, they'll understand that the whole idea here is there are only so many funds and resources available. Let's use them wisely for the people who

really need them, and not put people in a hospital strictly for a test anymore, if it can be done on the outside.

SENATOR PALLONE: Thank you, Dr. Rodi. Appreciate it. Is Rosemary Bryne here? I meant to call you earlier, I apologize.

R O S E M A R Y B R Y N E: You are very lucky, because I've been shrinking my speech the way Medicare shrinks its covered services while I've been sitting there.

Thank you for inviting me to the hearing. I speak to you today as a private citizen who happens to be a registered nurse. It's the purpose of my presentation to suggest that the present DRG reimbursement system to hospitals is incompatable with the safety and well-being of the Medicare population in this country.

I originally meant to go over the origins of Medicare and how this started out extremely idealistically. It wasn't a total comprehensive health care program, but I think it has an honest goal of helping senior citizens, and probably, indirectly, improving the technology that was available to a population that had before been previously ignored.

I'd like to speak right now on the DRGs, and the premature discharge. As a result of circulating rumors across the nation on premature discharges, the federal government has recently begun requiring hospitals to give Medicare patients written notification of their rights to appeal if they feel they are being discharged prematurely. A federally mandated statement in this notification is, and I quote, "Your discharge date should be determined solely by your medical needs, not by DRGs or by Medicare payments." This is the disclaimer to absolve Medicare in any complicity of premature discharge. However, look at "...determined solely by your medical needs..." Medicare has defined what the medical needs are, based on the singular diagnosis of the DRG code. Medicare has already dictated to the hospitals and physicians, by way of

reimbursement, what the medical needs are, not of the patient, but of the diagnosis.

A representative from a California PRO organization, which is supposed to be the first line of defense in an appeal situation for Medicare patients, has stated, and I quote, "That many of the appeals forthcoming as a result of this mandate will be based on discharges that some patients may perceive as inappropriate, but in fact, are medically appropriate. Such perceptions may arise because in the past patients were allowed to remain in hospitals until they experience psychological and comfort satisfaction." It sounds like the verdict is already in on the forthcoming appeals, why bother with the paperwork. "...patients were allowed..." to stay in the hospital. I ask you, where does the mentality of "allowed to" stay come from?

There is an implication here that all patients are malingerers, and if given the choice will elect to permanently settle into a resort like atmosphere of a hospital. Has anyone in this audience ever been in a hospital? It's not a pleasant experience. The first question most patients ask when they enter a hospital is when can I get out? In most cases, if an individual perceives that he or she is not ready to go home, I tend to believe them, not anyone else.

Just to take this one point further, in the literature going back 10/15 years, there had been a lot of studies done specifically on elderly people, and it was found that if they were forced to move against their will -- this could be apartment to apartment, apartment to nursing home, whatever -- but if there was a move -- they were made to do, physically go somewhere, against their will -- there were definitely significant increased morbidity/mortality rates. I think we should stop the conversation on premature discharge -- everyone has their own opinion -- and start to ask the patients; the people that perceive that they're not ready to go home yet. These are the people we should be looking at. This is probably

the first group that should be studied, and followed-up on this problem.

It's at the section of human beings and to medical statistics where the illness and or surgical procedure is separate and unique from the psychological and so called "comfort satisfiers" that have great difficulty in accepting. This type of rhetoric is designed to lead taxpayers into believing that patients are being waited on hand and foot in a luxurious environment.

In actuality, Medicare patients have become victims of their own insurance plan, which is quickly being reduced to mere tokenism. I wouldn't even call it rationing health care. Mature physiologies are extremely complex. There may exist one of several chronic illnesses which have a bearing on the acute episode of disfunction necessitating a hospitalization. Length of recuperation from one acute illness or primary diagnosis is directly influenced by the pre-existing health status of an individual. Individuals have different health histories, and do not respond to one or more therapeutic interventions at the same rate. The Medicare population is the most vulnerable to this type of typecasting approach to an illness where the script is unwritten. Studies are now just beginning to show how complex the aging process really is. Competitive forces from the chronic illnesses individuals acquire as they age are contributing factors to delayed healing responses. It is extraordinary that just at the moment in history research is demonstrating a need with particular attention to detail and diagnosing and treating the illnesses of older adults that their primary insurer, the federal government, has charted an opposite course.

The effects of forcing complex physiologies into compartmental categories are unknown. The potential for harm exists in this puzzle because the pieces will not fit. I believe the vulnerable situation senior citizens have been

placed in by Medicare's attempt to obtain fiscal solvency on the backs of its own subscribers is unfair. Of course, fiscal responsibility is necessary on all levels of health care, but let's be humane.

That's it. The end.

SENATOR PALLONE: Thank you. I just-- Obviously you feel that premature discharge is a problem -- a widespread problem?

MS. BRYNE: Well, initially, I did. But, I didn't mean premature discharge in the sense that hospitals were arbitrarily throwing people out.

SENATOR PALLONE: Okay.

MS. BRYNE: I think they were taught, very carefully, by Medicare how to respond, and when to discharge people. They're just following the DRG system.

SENATOR PALLONE: Well, what-- I mean, I know you've listened to most of the testimony today, because you've been here most of the day. What do you feel should be done? I mean, obviously, you feel the DRG system needs to be--

MS. BRYNE: Something-- Something should be done as far as significant studies. Everyone here today has referred to studies, but they've been done by biased parties. It's been the federal government, the Health Department -- now the Health Department has advised interest in this -- PROs-- We need independent groups studying and looking at these statistics. There's many ways to finagle statistics and come out looking good.

Secondly, I would really like to take a good look at that group in the hospitals that goes for the appeals, and do a longitudinal study on them as far as increases in morbidity and mortality after they've been denied or whatever the outcome of the appeal. This is the group to look at, because they felt that they weren't ready to go home.

SENATOR PALLONE: Well, this is the thing, I've-- I

mean, we've had people here today -- I guess at least two, maybe three -- that felt very strongly that they were victims or their friends or relatives were victims of premature discharge. I know I've had the same thing in my office, with people calling periodically. And yet, at the same time, we've had statements from the different agencies in effect saying that that just doesn't occur at all, or practically at all. And there seems to be a big discrepancy.

MS. BRYNE: Well, obviously-- So, you can play the rhetoric game -- you know, people use different words -- and that way make a problem disappear. But I truly believe if a senior citizen feels, or the family which is going to be caring for this person, if they're truly frightened about the fact of going home, then that makes it valid, and we should look at that. Why are they frightened? If they are frightened, then they could have all kinds of home health care and services, nothing good is going to happen. They'll be frightened; they'll be in a high anxiety state; nothing good is going to happen.

So, we have to start to look at them, talk with them, and find out what their concerns are. And then, maybe, arrive at some solutions. But we're not even -- we haven't even isolated the problem yet, where there is argument of semantics over premature discharges and statistics.

SENATOR PALLONE: But basically, you feel that we need the DRG system, it's just that we need to perhaps look at the whole system and see what could be done with improving.

MS. BRYNE: I'm not as sure about that as the rest of these speakers today. I think we might do just as well without it. Maybe better.

SENATOR PALLONE: Okay, thank you.

MS. BRYNE: You're welcome.

SENATOR PALLONE: Senator Brown? (negative indication) No? Thanks a lot, and thank you for coming down.

Mr. Hoyden? George Hoyden, from the New Jersey Federation of Seniors.

G E O R G E H O Y D E N: Good afternoon, ladies and gentlemen. I will reverse a little time and go back to 1981, '82, and '83. At that time Senator Bradley was trying very hard to get home care on the books and to have it put into New Jersey. Well, on that hearing, it all wound up that four states out of the United States were picked for an experiment, and home care was started here in New Jersey.

Well, at the present time, it seems there are many lobbies trying to beat us down, and take it out of the State of New Jersey. There will be a hearing April 21st, at the Essex County College, 303 University Place, Newark, New Jersey, and that hearing will be on the attempt to save our home care service.

But when you look at the prospects of home care service, it has been stimulated and harmed by the DRG and the PRO system. We cannot say each person in a hospital must be dedicated to time and sent home, regardless of the condition of that patient. As I go through hospitals and nursing homes, it is a shame what the American public must take. I was in a hospital the other day, and I checked a room where two men both had the same problem -- heart problem -- both were severe cases. One had died since that time, but the other fellow, he received the wrong medicine from a nurse at 9 p.m. at night. After she handed him the pill and the glass of water, and he swallowed it, she says, what's your name. Now, what kind of medical system do we have to protect human life? All right, this was a new nurse maybe, as I heard, but regardless of that, the name of the doctor, the name of the patient is on the bottom of the bed, plain, right across the back of the bed.

Well, however, he was due to go to Deborah Hospital for a heart operation on a certain day. Due to this incidence, he lost his bed at Deborah, and stayed 17 days in the hospital,

which I don't want to mention the name at this time. On the 17th day, after all kinds of liquids removed from his body were tested in the lab, they finally decided he could go home and take a rest with the medical doctors and the Board of Health nurse visiting every day.

Now, if we look forward to who's going to pay the bill for those extra days that he was in the hospital which he shouldn't have been there. However, this is one case. If you go to a nursing home today, you will find that the DRG is pushing people into nursing homes, and they don't have the facilities or the nursing clientele to handle that type of patient.

Well, here we go again. If we're going to force nursing homes to take care of patients that should stay at the hospital an extra day, or two, or three, and get them in good shape so they can go home-- But, then, when you look at it the other way, the nursing home lobby doesn't want their business attended to by a group. They want to run it their way, and they are.

At the basis of $85 a day, you have to sign a contract for 12 months before they will think of taking you in. Now this is a ridiculous way of doing business with the sick, but they're doing it. Now they come up with the present gimmick, we don't want Medicaid patients. If you stay there twelve months and your money runs out, go. That's ridiculous. As it come out in the press the other day, Medicaid patients are to be handled after their money runs out by Medicaid, and no qualms about it. At the present time, our nursing homes should have, according to the rules, 45% Medicaid patients. Well it got to the point, since DRG is active, their 45% Medicaid have got to go. They've got to make room for the DRG patient.

However, it all is a problem. But we heard testimony today, and we are just up against it. What is $85 a day going to do to a patient? They must sell their home, pawn

everything, or do anything to get money to fill a contract. It is wrong.

Now, let's look at a way of solving something on the DRG system. I say we should have six rooms in every hospital -- that would mean six rooms, two in a room -- 12 people -- when the hospital says, your time is up, you've got to go home, put them into this special unit, and work from that unit with the social worker of the hospital, the social worker of the county, and get a proper means of putting that person to where he should be. Maybe we can take him home. But if we do take him home, we don't have the money appropriated for home care service. It would cost, according to statistics, $900 a month to take care of a home care patient, where it would cost in a nursing home $2400 a month. There alone the government doesn't look at statistics.

Let's take the statistics as they are. Where do we save money? Pushing people out of a hospital into a nursing home? No. The home cannot handle a DRG patient who just left a hospital. They're not ready, and they must be put into some other system.

So, I say, put the "XYZ" unit up, and keep them there out of the DRG, but into another program of Medicare or home care. Get the money and fund it until they are strong enough.

Now, when we say home care, it may be for a few hours a day, it may be for 24 hours a day, depending on that patient. But the DRG patients I see leaving the hospital are 24 hour patients, and therefore we must have two or three shifts to take care of them -- either eight hour shifts or twelve hour shifts.

But it has come to the point where if we're going to put money before people, our whole health system is no good. And I hope that we can work it out with a hospital; get this "XYZ" unit, let's see what we can do. But, in all means, the Medicaid system has gone bad. And when that goes bad, what are

we going to do with all them people?

The nursing home industry is not losing money. They are bleeding the system. I come across a case the other day where a doctor put in a bill for $80 surgery on top of his usual call to that patient in the nursing home for $30. Well the bill was sent to me by mistake because I monitor this person who is very sick. I went to the bedside, and I said, Theresa, how about this bill I got -- $80 for an operation? What did you have done to you? "I didn't even see a doctor." I checked out with the nursing home -- but first I let the bill hold. I held the bill for five or six days. I got a call from the doctor's office: "I understand you received a check for "X" number of dollars from Medicare." I said, yes, I have the check, but I'm not going to give it to you because I don't know what $80 surgery means. Now, they don't go to the patient in the nursing homes. But Medicare and Medicaid are paying for it. They sit down at the main desk with a nurse, and go through the book and page it, initial it, change the medicine, or do some little thing. They are supposed to go to the bedside of every patient and check their heart, lungs, and etc. That's what we are paying them for. But we don't get it. Anybody can sit at a desk and go page after page and do a hundred patients in a couple of hours.

So our system is sour. And here we're adding to it by telling them we can't get home care. I urgently hope that this panel can get some results some way, and when a patient is told to leave that hospital, put them in the XYZ unit and let the social worker from the county and the hospital find out where we're going to put that patient.

On home care, it's wonderful. But they won't put up the money. There's your answer. Is it better to give it to the nursing home, who hasn't the facilities to take care of a patient out of a hospital? I know of one case, as I said. I monitored another case: That patient went to the hospital four

times in eight months, and I got fed up. I went to the hospital at eight o'clock that night, and I happened to meet a nurse that had a heart. So I walked into the room and I said to the nurse, why is this person coming back and forth just like bouncing a ball? She says, well, I'll tell you, but don't use my -- what I say. I says, that's confidential between you and me. That patient had been cemented from the stomach to the vent, and could not have a bowel movement even with the hospital trying to get an enema in that person. Now what does that mean? That means the home was so neglectful; the food, the diet, and so forth was not permissible to that patient, and the patient almost crawled up with pain.

So I said to the nurse-- She says, yeah, I took care of this patient when she came in last night. She says, we almost had to cut it out; we couldn't do any enema work on her. What kind of a home does she come from? Well, that person went to and from. That person went as far as St. Francis Hospital in Newark, from local area, to have tests made. The tests had nothing to do, it was the care in the nursing home that clogged her up and caused all the pain and trouble.

Well, they made a finester (sic) out of it, and the doctors-- I happened to go another day, and I met the doctor from the operating room. So I says, well doctor, you going to operate today? He says, no, I don't think the patient can take it. I says, it's just what I was going to tell you, doctor. This patient is cerebral palsy, and mixed up for all their life, and you want to operate. I says the pain in the stomach is due to the fact of a lack of diet and watching her expiring from her rectum.

I went back to the nursing home and I told the director, if you charge this patient -- and they wanted to take away the bed because she was in the hospital for two weeks -- I says, if you charge this patient for any extra expense to

Medicaid, I says, I'm going to bring you on charges. It was your fault.

Now, some nursing homes do it right. They have a wagon, all the linens, all the diapers, anything they want -- soap and so forth -- and they go in each room on a rotation basis and check the person, if they have wet the bed or what. And then they keep them and check a record. This is health care. But, we're not on health care with some of these institutions.

So, therefore, I told this doctor, I'm going to take the check and put it back in the nursing home. If you want it, you go to the nursing home and get it. I talked to the director that day and he flew off his chair and he went in the office, and he checked it. He says, well, I'll take care of it. I let it go at that. Well, the patient died since, and no way of burial or nothing. We had to do it through public assistance. But a home care would be the best feasible way. It would be cheaper.

Now we're going to have -- I'll leave these circulars with you -- we're going to have a hearing on that. Bradley worked on it; Heinz worked on it; and we have it. But where's the money?

So, in conclusion I say, we have to get home care and keep the people out of nursing homes.

SENATOR PALLONE: Okay. I appreciate your testimony. It's very thorough and informative. (audience applauds) I understand, too, that there has been some discussion about the concept that you talked about, with the separate unit. It's something that we-- And certainly, with regard to the home health care issue, that's a top priority for us. And of course, the funding mechanism is always the problem, and how, exactly, you're going to go about it.

I should point out, too, that both Senator Brown and myself are both on the Senate Revenue, Finance and

Appropriations Committee, so we're constantly dealing with budgetary matters and trying to -- have to deal with the funding mechanisms, so we don't act in a vacuum. We know what the consequences are going to be in terms of the budget.

MR. HOYDEN: Well, you see, it was wrong to say, "Four states will have this plan, and Jersey is one." But, when we put this plan in, the money wasn't there. Now, the guideline is too low -- definitely too low.

I suggest that if your panel wants to work on it, make this suggestion when you can. If you go into a nursing home, they take your Social Security check and give you $35 for necessities through the month. Now, why can't we take the check away from a home care patient and give them $35 back for their necessities, and use it for their care? It wouldn't even be a little bit to pay, but it would help keep our budget lower. I mean, there must be a way that we can get into this. We have money for everything else, let's take care of the sick on their last days of their life.

SENATOR PALLONE: Senator?

SENATOR BROWN: Mr. Chairman. Thank you very much for your testimony, and you hit on a very important thing. I'm very impressed that you go to visit some of your friends and colleagues in nursing home facilities, because I think, whether we are at home or whether we're in a hospital, or whether we're in a nursing home, it's the visiting with our friends and relatives who care that are the contact. I happen to have had an uncle who died in unbelievable conditions at home.

So, I think as a Committee, we're concerned that our senior citizens get the best possible care no matter where they are. And I'm sorry, Mr. Chairman, there is a Commission on Hunger meeting -- which, again, some of our elderly are in institutions today because they didn't get the proper nutrition -- so if you would excuse me, I would appreciate it. It's no reflection on those of you that have waited so long to testify,

but I am overdue as it is.

SENATOR PALLONE: I appreciate your coming down, I really do, because I know you had a long distance and it's really appreciated.

SENATOR BROWN: Thank you. Important day.

MR. HOYDEN: I was trained by a CETA program many years ago, just to do that. I had an 18-month contract, but the money was cut out, the Department was closed up, and I still get calls from people. And I take care of everything on a senior basis -- whatever they need, whether it be rent assistance, medical assistance. And I get the calls. I'm more busy now that I'm retired than I was when I was working.

SENATOR PALLONE: Thanks again.

MR. HOYDEN: Okay. I'll leave these with you.

SENATOR PALLONE: Is Mary Stickle here? (no response) Can I see who else is here who would like to speak? Your name?

J O H N M A L V E Y: John Malvey (phonetic spelling).

SENATOR PALLONE: Could you come up please? This is John Malvey from Spring Lake, my legislative district.

MR. MALVEY: Senator, I want to thank you for the opportunity to speak. I only heard about the hearing--

SENATOR PALLONE: Could we just hold one second? We still have some speakers, so those of you who are talking in the back, I'd appreciate it if you would either sit down and listen or go out of the room. Excuse me? Mr. Feirstein? I don't know if he hears me.

Okay, go ahead.

MR. MALVEY: I just want to thank you very much for the opportunity to speak, because I only heard about the hearing yesterday on the radio, and I guess that's one of the problems -- people are not informed.

I guess I represent the confused and frustrated public. I'm not Medicare age; I just recently retired. And

just so you know the context of my remarks, my son-in-law is a doctor in Canada, where they have socialized medicine. My daughter is a nurse, and I was in benefits for one of the public agencies in New Jersey, so I have dealt with many, many health care problems.

I think what I want to say is, the general public finds it very, very difficult to believe that DRGs and PROs are not an overreaction to the 90-day stays of the 70s. My father-in-law was in a hospital for 89 days in 1978, and that's when the hospitals kept people in right up to the time that Medicare was willing to pay. My specific problem now is -- and I think that-- It's been a very, very informative afternoon, and I think that I've got enough information today to solve the problem, but I've waited so long and I'm probably the last speaker.

My mother visited me when I first moved to Monmouth County. I didn't realize how sick she was at the time, and she got out of the house -- I believe she had Alzheimer's -- and the police tried to get her back in, and ended up taking her to a hospital. And if it's all right to say one hospital, I will--

SENATOR PALLONE: Oh, sure.

MR. MALVEY: Okay. They took her to Jersey Shore Hospital. I had to go down to the hospital. My mother was violent; she was irrational -- it was a very, very sad scene. The hospital said that I would have to sign her in, because she was incapable of making decisions. I did. She was in the hospital about a week when they told me that she was going to come home. I went to that hospital to take her home; they had her in a padded room that day, and she almost attacked me. And I went out and I said, "Well, I don't know what's wrong with who, but my mother is in no condition to go home." And I left her there.

What happened then was, they told me that her Medicare would be cut off and I would be responsible for the bill.

Well, whether that was true or not, I couldn't take her home because we were minding my first grandson, who was three months old at the time, and a patient -- my mother, who was totally incapable of -- she had to be watched constantly. My mother was eventually transferred to a hospital in Jersey City -- never left the hospital from the day she went in, and subsequently died about 10 months after.

What I'm saying when we're talking about premature discharge, I can't help but believe that if they had not gotten me to sign a financial statement and duped me into signing that statement, that the decision of the Peer Review Organization would have been different had they known that they didn't have somebody on the hook for the money, so while they did not discharge her, it was their intent to discharge her. Purely, someone who never left the hospital again, and the only contact - the only information that I ever got from that hospital was that I owed them money, and I am now indebted to that hospital for $6800.

And what I can't understand is, I hear about appeals. No appeal procedure was explained to me. The hospital completely stonewalled me. They gave me no information when I visited my mother. Once they found that I wasn't taking her out, I was almost totally ignored when I walked in and out of the hospital. I don't know who had input, because my mother did not have a personal physician; and I don't know where the peer review committee got the information to make their evaluation. And basically, now that I've heard Dr. Rodi today, I hope I'm going to be able to clear up my problem. I'm not here looking for solutions, but when people say that there are not abuses of this DRG and PRO, they're wrong. And it's-- The problem is, the public is not aware. This hospital -- not once did they tell me that I had the right to appeal. The only thing they said was, "Get your mother out. If you don't, we're going to hold you responsible." And right now, as I said, I

probably owe them about $6800, and for a woman who never left the hospital, it's going to be pretty hard to convince me that she wasn't being discharged early. Thank you very much.

SENATOR PALLONE: Thank you. Let me just ask you again -- you said that once you signed the statement, that you would be responsible for her. Was she taken out of the hospital, or was she just transferred to another hospital?

MR. MALVEY: She never left the hospital from the day the police took her into Jersey Shore. She was then transferred up to a hospital in Hudson County, where she lived.

SENATOR PALLONE: Oh, I see. So, at no time did she ever leave the hospital.

MR. MALVEY: Never. And the only bill I got was for the period that Jersey Shore disallowed by saying that she didn't need care. But, obviously -- I mean, I would think she did. And now that I have heard Dr. Rodi and know where to contact him, I'll be able to find out just who was on that peer review-- See, I've been stonewalled up until today. Who was on that--

SENATOR PALLONE: Well, people are not aware. As I said, people come to my office and they're completely unaware. And that's what we're trying to get to the bottom of here. So, I appreciate your coming.

MR. MALVEY: Well, I know that no system is perfect. And, I didn't come here asking this Committee to solve my problem, but I thought I wanted to at least have my input in that people who believe there are not abuses had better take their head out of the sand.

SENATOR PALLONE: I'll be glad to help you on an individual basis as well, especially since you're in Spring Lake, which is in my district.

MR. MALVEY: Thank you very much.

SENATOR PALLONE: Thanks again.

MR. MALVEY: Okay.

SENATOR PALLONE: Thanks again for coming. (confers with aide) Okay, you've got a copy there, Mr. Malvey, of that Patient Bill of Rights that I was talking about, and we're going to try to have that distributed to everyone through legislation.

MR. MALVEY: Thank you.

SENATOR PALLONE: Thanks.

And Dr. Primich? I apologize again. I don't know if I called you earlier, or what.

D R . F R A N K J. P R I M I C H: I've been sitting patiently, listening while I heard you ask some very intelligent questions. Faith Goldschmidt from the Department of Health couldn't answer some of your very reasonable questions. The duo from the Hospital Association wasn't able to answer a lot of questions. Our good friend, Dr. Rodi, from the PRO couldn't answer some of your questions. The questions he did answer, some of them he answered totally erroneously.

Your very good question -- and a very important question -- was, where do the doctors in the PRO come from? How are they arrived at? There is no election process by the medical community. That's a total farce. Where they come from are doctors who are willing to shuffle papers for $40-50 an hour. I'm tempted to go on, to describe what kind of doctors I feel-- I'm not very inclined to do this, but I will let you draw your own conclusions as far as that's concerned.

Secondly, we've repeatedly heard from all three of those people about this marvelous study that was done which proved that there was no premature discharge, or that the level of readmission was normal. That study was the biggest farce that ever came down the pike. I and the -- several of the upper echelon of the Medical Society were sitting in Dr. Goldstein's office the day the press release went out. It took two days before I could refute that thing in the press, and it appeared in most of the papers on the page with the

obituaries. That study did nothing more than look at the face sheets. If you know what a hospital chart looks like, it's a humongous thing nowadays, which is something else we complain about; however, the face sheet simply says the patient was admitted on such and such a day, any previous admission to the hospital, etcetera.

Now, in looking at that, if the patient was not readmitted within seven days, that was it. They didn't look at another thing, about that chart or about that patient, for that matter. Subsequent to this, they counted up these things, and they came up with the customary readmission rate. What they didn't include was the people that died before they could be readmitted, the people who are so dissatisfied with being discharged ahead of time that they wouldn't be caught dead in that hospital again, went elsewhere; or got so turned off by the whole health care system that they chose not to go to any hospital, and suffered at home in silence. So, that study was the biggest fake that ever came down the road.

At that point in time, I was the Chairman of the DRG Committee of the Medical Society, and I was going around -- not making any accusations, mind you -- simply saying there is no allowance in this system for quality control. In other words, we -- I project that if you spend a lot of money on regulation, the only place the hospital can get it back is by cutting care to the patient, and therefore, we are going to lose on quality of care and availability of care. And this is all now come to pass. So, that that is one of the things that is very important, that you understand.

Now, if you would-- It's sort of disheartening to see so few of these folks, and I've testified at a number of these Committees. I've been told, on occasion, that I was the only one there who was entertaining; I hope I can hold up on that. And my other thing is, since I give of my time, I have someone else watching my prac-- I'm an actual, real doctor. I

practice medicine. I have somebody else watching the store for me so that I could come down here. And my point is not to jump in and jump out, as so many of these witnesses do. I want to hear what everybody has to say; and, to the extent that I can, to refute what is gross misinformation, when it occurs. So, I always come down, and they say that they save the best until last. I hope that you might think that there's some possibility of truth in that.

Now, if I may. It is a shame that this hearing was not held five years ago. Concerns regarding the impact of DRGs on the quality and availability of health care, particularly for the aged and the infirm, were raised by me, on behalf of the Medical Society of New Jersey, before then.

At this point, with the impending loss of our Medicare waiver, those predicted problems will be addressed primarily from the Federal level. Senator John Heinz' United States Senate Committee on Aging has already conducted an extensive, if superficial, inquiry. What was uncovered represents, in my mind, merely the tip of the iceberg.

Six months ago, I wrote a critique of that Committee's findings and recommendations, which was published in Medical Tribune, a weekly tabloid circulated primarily to physicians. For a variety of reasons, practicing physicians -- those with the closest and clearest understanding of the problems involved, have had little opportunity for input regarding this entire issue.

To whatever extent the New Jersey policies may affect the overall situation, I trust that whatever I have to say will give you a broader and perhaps a different perspective.

Now, this thing, when I submitted it, I called it "Good News and Bad News." The newspaper changed the title, and I forget what it is right now, but it's even better than mine.

"Approximately two years after the institution of a national Medicare prospective payment system, the first

significant study of its impact on the quality of care has become available.

"The staff report of the U.S. Senate Special Committee on Aging was published September 26, 1985. Chairman Senator John Heinz has been widely quoted regarding the impression that patients were being discharged 'sicker and quicker'."

"Those of us who warned unsuccessfully regarding the predictable shortcomings of DRGs, and the lack of feasible quality control, had been dismissed from consideration because of insufficient provable documentation of our charges. DRG incentives to withhold or limit quality care, and PROs' initial disinterest and later inability to address these larger issues, provided the major basis for our objections.

"The 'Heinz Report' gave promises of supplying the long-sought confirmation of our criticism, and to a large extent, did exactly that:

1. Stressed the inflexibility of DRGs -- made no allowance for severity of illness, nor for sociological or socioeconomic factors.

2. Diagnosis-based reimbursement invited 'creative' diagnosis and 'fictional' chartkeeping.

3. Bureaucratic ineptitude was illustrated by their characterization of HCFA as a source of 'vague, confusing, and conflicting information.'

4. Hospitals with limited reimbursement must balance costs of compliance with regulations and appeals processes by cutting patient-related expenditures, and pressuring the physicians to let cost considerations overrule good medical judgment.

5. The PROs' stress on utilization review for cost control has been at the expense of quality assurance.

6. 'Peer review' by non-peers (nurses, G.P.s, etc.) leads to a high percentage of appeals. At a great cost to all involved in time, paper and money, reversals of appealed

rulings are in the range of 50%. Such inaccuracy is unjustifiable.

7. The PROs lack the funding, personnel, or capability needed to give more than lip service to the quality of care issues.

8. Unawareness or inability to register complaints on the part of patients is a major factor in the under-reporting of 'horror stories' and the failure of appropriate relief.

9. Inadequate or unavailable intermediate non-acute care continues to be an unresolved problem.

10. Hasty implementation of the program without adequate resolution of the obvious gaps and predictable shortcomings has created a real and present danger to the aged and infirm.

"So much for the good news. Now, for the bad news. The report is accompanied by a list of 10 recommendations which leave much to be desired. They range from the redundant to the ridiculous. The most alarming aspect of the recommendations is that implementation would require large amounts of additional funding, little of which would relate directly to providing adequate health care.

"Highlights of the recommendations, and my analysis follow:

1. 'Adjust DRGs to better reflect the differences in severity of illness between patients in the same DRG category.' Correction of this major original shortcoming should make the program less bad, but -- multiplying present DRGs by a factor of three, four or five would further complicate an already overly-complex system.

2. 'Remind Medicare-certified hospitals of the illegality of discrimination on the basis of disability, and prosecute via the HHS office of Civil Rights.' Gross violations already qualify as malpractice. Adding Civil Rights considerations would merely add Constitutional litigation as a

non-productive cost increase.

3. 'Revise PRO's scope of work to require comprehensive quality assurance monitoring and enforcement activities.' This is akin to legislating morality, with a comparable chance of success.

4. 'Pass S-1623, which would authorize PROs to deny payment for substandard care, and help PRO financial viability.' PROs, like their predecessor PSROs, share the customary track record of governmental bureaucracies for cost inefficiency. This attempt to make bounty hunters out of the PROs would only focus attention upon the already disturbing conflict of interest issue.

5. 'Authorize and appropriately fund large scale quality review.' Logistically impractical, and fiscally exhorbitant. The issues involved in determining the quality of health care are too involved and too individual to permit abstract evaluation via computers and marginally knowledgeable reviewers.

6. 'HHS should require a clearly defined appeals procedure for grievance, and inclusion of rights and responsibilities under DRGs in Medicare patients' informed consent forms.' Grievance mechanisms already exist. Additions to consent forms would not ensure patients' understanding, nor their ability to respond.

7. 'Expand existing laws to allow payment to hospitals when no appropriate post-hospital placement can be found.' This sounds reasonable, but if the requirements for approval are as demanding as current criteria when nursing home beds are lacking, we will reap little more than snarled red tape from the process.

8. 'PROs should extend quality assurance to a percentage of hospital discharged patients through the continuum of care in nursing homes, home health, and other programs.' Prior expensive studies have been all but

invalidated by failure to do such follow-up. This proposal would either be confined to an inadequate number of cases, or require massive funding which could be far better applied to the holes in the safety net.

9. 'Congress should create within each state a Consumer Advisory Board (CAB) to conduct oversight of the PROs.' Any such Board must have a minimum of 51% of members who qualify as consumers. By definition, anyone involved in the provision of health care (and therefore knowledgeable on the subject) is excluded from the category. With little more than an insatiable appetite as qualifications, such groups have wrought havoc in many areas of the economy. Most of the individuals involved represent self-interest lobbying groups, capable of presenting their complaints as well as their suggestions and demands. To formally recognize them in an overseeing capacity simply adds another layer of bureaucracy.

10. 'Congress should authorize the creation of an interagency panel to seek out quality problems, and develop criteria for a uniform quality of care review system.' This is still another redundant committee concept approach to problem solving. Most are nothing more than a selective forum for rhetoric. Any output is far more apt to be political, rather than practical.

In summary, the Report lends credibility to the concerns of those of us who honor our responsibility to be the ultimate patient advocate. Regardless of the seemingly good intentions, third party intervention between the doctor and patient substitutes someone else's criteria of acceptable health care for that of the person involved.

Many reputable authorities evade the issue by claiming that we have yet to define quality of care. Conceding it to be a relative term has not prevented me from, in any given instance, being able to characterize it as good, bad, or mediocre.

Since bureaucratic programs are at best mediocre, we should do everything in our power to prevent them from establishing standards. Prevailing egalitarian concepts of equality would make mediocrity the intermediate goal, while they strive for the only absolute degree of equality at point zero."

Thank you.

SENATOR PALLONE: Well, thank you for that statement. (audience applauds) It's very thought-provoking.

I just wanted to ask you. In the beginning, when you were talking about the way the PRO board was chosen -- now, just a little more detail about that. What exactly is the process? How do they go about it?

DR. PRIMICH: Literally, this thing -- as Dr. Rodi told you -- stemmed from the PSROs, which were basically community things. Again, there was a big hassle within the medical profession as to whether we should be part of this. Some of the doctors had the idea, it's better that we do it to ourselves than somebody else does it to us. Those of us who are more activistic definitely objected to this idea.

As a result, the people who staffed the PSROs by and large, had sort of a cross-section. There were some well-meaning doctors who went on the basis of, "It's better that I'm there and have some input." As that sort of faded away, and it became obvious, number one, PSROs were proven by the government to be not cost-effective, there was a big to-do by Reagan. Among his many promises was, he was going to do away with the PSROs. He did. He replaced them with something more expensive and more onerous.

Now, the people involved had gotten down to a cadre of bounty hunters, as I call them. These people got 8.3 -- forgot the .2; what's $200,000 -- $8.2 million for their two-year contract.

SENATOR PALLONE: They don't practice medicine?

DR. PRIMICH: Pardon?

SENATOR PALLONE: They don't practice medicine?

DR. PRIMICH: Well, they practice-- He says he practices medicine. He says he's got a lot of compassion for his patients, that he does all sorts of wonderful things. But meanwhile--

SENATOR PALLONE: No, but I mean--

DR. PRIMICH: --he, as a general practitioner, and an assortment of characters like him are entering judgments on whether a neurosurgeon should or should not have done a CAT scan on a lady that bounced her head off the floor, or some of these other horror stories that I've heard. This is not-- Peer review is supposed to be review by your equals. Now, it's absolutely ridiculous, whether somebody's got a doctor's degree or not, to say that just because he has this piece of paper, this makes him an adequate judge of someone else who has infinitely more knowledge than he does.

Let me make one thing perfectly clear. I have been equally adamant in my criticism of a lot of my, quote, "colleagues" that I wouldn't let practice on my dog. There are doctors who are money-hungry; there are doctors who overcharge. But where is the rationale? Some place here, Big Brother has decided he's going to take care of the people. And as I say, if these people aren't bright enough to figure out how to find a decent doctor who cares about them, then they're damn well too dumb to vote.

SENATOR PALLONE: Well, then, let me just ask you-- In other words, when they go about the process, you know, reviewing these various categories, is there a problem in that the people who are making the review, then, are not specialists in that area? Is that what you're kind of getting at, too?

DR. PRIMICH: Among other things. Classically, the way these things are reviewed is that nurse reviewers, or in some cases, some of the doctors will do the preliminary,

retrospective review. They'll look at a chart which -- oh heavens, I'd have to give you a stack of paper like this. That's the chart. They look at it; they fumble through, they look someplace they'd like to find an explanation. If they don't find it there, regardless of what the reason was, the patient was sick. The doctor came, he saw the patient, he ordered something for the patient -- he didn't write a progress note, because somebody else was sick down the end of the hall. And I'm talking about good doctors -- there's doctors who don't write any notes. That's another crime of another sort, where you have-- That's our problem, to deal with them.

However, I'm talking about the legitimate doctor, and the nurse says, "Well, I don't see any reason why this patient should have been here." After all, the lady who had concrete in her bowel, all he did was give her an enema. My goodness, you could have done that at home, right?" Now, somebody has to start digging into this thing. And, unless the physician is an avid writer and gave this whole long dissertation about the sorry, pitiful condition of this patient when they were admitted-- There are these various, different degrees of problems. Every patient is an individual. I have never seen an average case of any disease, in all the years that I've practiced medicine. I have never seen an average patient.

The averaging, in my mind-- We were questioning before; somebody said most people, the day they come into the hospital, the first question they ask is, when can I go home? Now, in my experience, I would say that the vast majority of people fit that category. I have seen other patients who, from the time they come in, before there were DRGs, said, "You're not going to send me home again." Now ordinarily, you balance these things out. But the old system, it was easy enough. The patient who wants to go home -- and I misjudged this so many times that it shatters my faith in how well I know human beings. I will see a person and think, well, this person, they

really want to go home. All they talk about is their kids, and so on, and I'll say, "Well, I'm going to send you home." "What do you mean, you're going to send me home tomorrow -- go home, with those screaming brats? The way I feel?" Oops, I didn't get the whole story.

On the other hand, you have the individual who is very docile, very formal, and -- "When can I go home, Doctor?" "You can go home tomorrow." "What do you mean, tomorrow?" Now this person -- "You mean, with the pain I have and all the rest of this--" Well, this sort of stuff balances out. And in my experience, left to their own judgments -- and, God forbid, if they're paying for it, now the balance swings way further. But typically, I would say that four out of five patients want to go home as soon as is medically feasible. If they're paying for it, nine out of ten of them want to go home because they don't want to spend the money, and they'll take their chances with the fact that they weren't totally cured. But, it's going to cost them a little less. If somebody else is paying for it, now you get a whole different ball game. And this is where the real crux of this whole thing comes in.

I was down last week with the Assembly Committee on Health and Human Services, and I "racked" them to the point where Otlowski and one of the other men who was there refused to ask me any questions. They were quizzing everybody, and when it got to be me, they threw up their hands and said, "We wouldn't ask him a question." Because I was laying the blame all on them. It was the government that promised this. They don't have the wherewithal to give it-- Be honest. Say, "We can't do it." Indigent care -- care for the elderly -- is going to cost "x" number of dollars, all right? This is a reasonable estimate. We don't have the funds to do it -- we are going to have to ration care. We don't want to ration care-- Put it to a vote. Ask your constituents, "Are you willing to pay taxes so that these nice old folks don't have to

go without care?" And if the people say yes, you raise the money and you pay for the care. If they say no, my suggestion is, we go to a true two-class system.

And in that system, the way I project it-- I use a baseball analogy. I call it the American League and the National League. The American League is fee for service medicine. The people either buy insurance with reasonable deductibles, pay their own way, choose who they want to go to, and so on. The National one -- the nationalized league -- the government pays for -- pays for out of taxes; they use the facilities we already have -- city, county hospitals, the VA hospitals, all the rest of these facilities. They set up clinics. The doctors and the personnel who are willing to work for them for whatever they are willing to pay, on a salary -- or on a fee for service basis -- contract with them. They're all in one nice little group over here. They're responsible, and they screw it up and they get blamed. What's happening here, and what is most upsetting to me of anything-- I try to practice decent medicine, for my whole career, and I find people coming in from the outside who know nothing about medicine, screwing up my system and then trying to lay the blame on me. And I refuse to accept it. That's why I'm willing to go with all the time and the rest of the stuff that I've put into this thing.

But I've put in an awful lot of time, an awful lot of effort; I've written on this, I've lectured on this all over the country. I testified in Washington before -- representing the Medical Society of New Jersey, when they contemplated federalizing Medicare. I told them, "Don't do it." I told them New Jersey's system is terrible. What they did, they did-- But of course, the Department of Health said it was wonderful, it was saving money, it was improving the quality of care -- all sorts of unsubstantiated claims.

On this basis, they went off. And they learned a few

things from us. Part of what screwed up New Jersey's DRG system was, they had an elaborate appeals mechanism. They would lay ridiculous rates on the hospitals, and the hospitals would appeal. The appeals got so snarled that nobody knew what the hell they were getting. Three years after the fact, you still didn't know what your rates were from three years before. They were still doing reconciliations -- it was absolutely pitiful. The feds learned from that. They said, "There will be no appeals process with our rate setting." Now, that's a pretty good thing.

The second thing -- the whole purpose of DRGs, how they got introduced in New Jersey-- It was a stupid system, it's still a stupid system. If you question what to do about it, we should have thrown it out before we started. We should have limited it, as I suggested over and over again, before it was expanded, and right now it still would be the best thing that we could do, to throw it out, start over again, go back to the old share system -- which was the last funding system that we used -- which could be monitored. Granted, there was some question, there was a need for monitoring, because there were a lot of people that were ripping off the system -- inadvertently, consciously, however, they were doing it. But all you needed was to have somebody reasonable -- not a bunch of clowns who are getting paid $40-50 an hour in order to screw up the practice patterns of the hard-working doctors.

But with this whole business of the DRGs-- Public Law 1978, Chapter 83, was designed to do two things: presumably, to equalize payments, because prior to that, everybody was getting charged different rates, depending on what kind of an insurance company you were or whether you were paying your own bill, whether you were Medicare, Medicaid -- they sort of brought that into balance. That was part of the-- The other thing was to find a way to pay for uncompensated costs. This was primarily indigent care; it also includes the costs of

people who just chose not to pay their hospital bills. That, at the time, was $100 million a year. Five years later, that figure was $250 million a year; currently, it should be about $300 million. And we're now in hot water because the Feds, when they had their system, they said, "We're not going to pay for indigent care." So, the rest of the states had to cost-shift their indigent costs.

Now, they say we're costing them money under their system -- not paying their share, incidentally, in the current thing -- what would run to some place about $100 million a year. They're going to pull the rug, and it's just a question of when they do it, whether it's July or October, and everybody who's connected with this whole business understands this fact, that that was this hearing at HHS, with what are we going to do? How are we going to fund this? And they're coming up with the cockamamie ideas -- tax tobacco, all the people with bad lifestyles. I've got a whole story for that, if you had the time. That's where my real entertainment comes in. Among the suggestions I make is that they tax people who are judged to be overweight $1 a pound per year.

SENATOR PALLONE: Let me ask you one other thing. When you mentioned about the survey that was done, that showed that there wasn't -- supposedly, I guess, came to the conclusion that there wasn't a problem with the premature discharge. I just wanted you to elaborate a little bit on that. You said that they used-- In other words, the only thing they were looking at is whether a patient who was released came back and was readmitted to the hospital--

DR. PRIMICH: They weren't even looking at that. They were looking at a patient who was admitted to see whether they had been previously admitted, and if so, when. And their criteria was, had that patient been in that hospital within seven days of the readmission--

SENATOR PALLONE: Of the readmission.

DR. PRIMICH: --all right? That was it. If the patient was in the hospital and was readmitted eight days later, it did not count on their statistics.

SENATOR PALLONE: And, of course, anybody who went into the community or nursing home or whatever, and had problems, we'd never--

DR. PRIMICH: Was lost. No one knew what happened. We were raising the question of premature discharges, patients dying on their way home from the hospital in an ambulance -- all sorts of cases were surfacing. They keep saying, all these people-- The Hospital Association, you have to understand, they've got to protect themselves. No, they can't very well say, "Yeah, it's a lousy system; we've been screwing it up." It's a lousy system. They've been doing the best they can with it, but they're still screwing it up. And they sit there, and they-- Right now, we are now coming at loggerheads between these two co-existent health care providers, the Hospital Association and the Medical Association.

SENATOR PALLONE: Well--

DR. PRIMICH: They're trying to lay the blame on us. And they're the ones, right now, with this new thing that's coming up -- where they're going to get the $100 million a year for the indigents. The Hospital Association is in bed with the Department of Health. You know what they want to do? They want to put a 10% surcharge on everybody's bill -- make a central fund, and then siphon that money back to the places that have-- That's cruel and unusual punishment. If it has to be paid, it should be through taxes, not taking it out of the hide of the people who are sick and infirm. You don't put a tax on food to pay for food stamps. You don't put a tax on homeowners to pay for housing for the homeless. Why the hell should you put a tax on sick people to pay for welfare costs of health care? It's utterly irrational.

SENATOR PALLONE: Well, let me ask you this. That

survey-- All the statements, then, in your opinion, and all the statements that have been made today about how there is no problem with premature discharge in New Jersey are based on that survey. Is that it?

DR. PRIMICH: Well, what happened with that survey, which was designed to do one thing, check on the number of patients who were readmitted within seven days-- The whole substance of this-- And this cost a potful of money, for them to do. All the PSRO did this, all right?

Because of how they structured that, and said, "Well, within seven days was within the normal parameters of what one might expect for readmissions, therefore, this proves that there is absolutely no basis to the questions being raised by Dr. Primich and the Medical Society, saying that, how do we know that this thing isn't going to ultimately affect costs." My simple-- Again, it was all common sense. They kept saying, "Show me proof;" well, hell, we haven't even started. How can I show you the documented proof? But just think. If you're going to take a given cost, in proposing care -- now on top of this you're going to lay the costs of conversion and compliance with regulations to hire the -- buying of computers, the hiring of highly-skilled clerical personnel. You run up the cost, how are you even going to get back to even, forget about cutting it?

SENATOR PALLONE: It also--

DR. PRIMICH: By taking it away from the patients. You're going to give them second-hand equipment, you're going to give them poor quality -- you're going to give the doctors poor quality tools to operate with, you're going to buy your rubber gloves from a purveyor who's going to give them to you for $2 a gross less, and the damn things break when you go to put them on -- these sort of chintzy things. And one of the biggest ones -- directly related to quality of care -- is, in certain infectious diseases, we know that the medically --

statistically, Drug A has an 80% cure rate. Drug B is half the price, and has a 60% cure rate. What happens is, they take -- "We don't have any Drug A in the pharmacy." The way hospitals screw things up, most doctors figure, "Oh, well, it's a logistical problem. They just didn't get the shipment," or it was this or that. But the patient's sick. Better you give him the stuff that's 60% good than nothing, so somebody's saved a few lousy bucks, which are being taken out of quality.

SENATOR PALLONE: Well, the other thing, too, is that Mr. Malvey's case -- is it Malvey? Your case wouldn't come under their survey, where you were actually told, "Look, you either pay privately or" -- you know -- "she's out of the hospital."

DR. PRIMICH: That's another rather-- I don't know how that--

SENATOR PALLONE: I mean, that's another twist on it, because in that case, the patient stayed in the hospital but they went off Medicare.

DR. PRIMICH: Yeah. But one of the biggest problems with this whole thing, in a so-called all-payer system, everybody's bills are geared to DRGs. Now, you can be Mr. Astorbilt (phonetic spelling), and you can come in and say, "I want to pay God knows what," you can't. It's illegal for the hospital to collect from you--

SENATOR PALLONE: Oh, okay.

DR. PRIMICH: --outside of-- This is-- The law says, what they will be paid. They will be paid "x" number of dollars for the DRGs.

SENATOR PALLONE: Well, how does it happen in his case, then?

DR. PRIMICH: When you get into the outliers, with-- Faith was trying to--

SENATOR PALLONE: Did you listen to what Mr.-- Did you listen to his testimony - Mr. Malvey?

DR. PRIMICH: I'm-- That may have been one of the times when I had withdrawal symptoms and had to go out and have a cigarette.

SENATOR PALLONE: He was saying that in his case, the patient was -- they were told that Medicare -- you know, Medicare isn't going to cover this anymore, and that you have to pay on your own. He signed a statement that he would be responsible, and then it was your mother, I guess? Your mother that stayed--

MR. MALVEY: (speaks from audience) They had that statement first, Senator, and then they decided that she (inaudible) needed care. They conned me into signing that.

SENATOR PALLONE: Oh, I see. All right, well, thank you very much. I appreciate your coming down. Sorry you had to wait so long.

DR. PRIMICH: I'm sorry I (indiscernible) Senator Brown. (audience applauds)

SENATOR PALLONE: Yeah, well, keep in mind that this is all going to be transcribed, and then every member of the of the Committee is going to get a copy of it.

Mr. O'Brian, did you want to speak?

R O B E R T A. O' B R I A N, SR.: I complement you, Senator Pallone, and your aide, on your absolutely inexhaustable patience. For five hours now we've been hearing and listening to what amounts to aging and dying. It's part of the seed that's going on--

SENATOR PALLONE: Can you take down his-- I didn't want to stop you, Bob, but I just wanted to make sure-- Can you take down what he's saying? Does he have to get closer to the mike? (speaking to hearing reporter, who gives positive response) Okay, go ahead, I'm sorry.

MR. O'BRIAN: I was just saying that this business of aging and dying is so prevalent today in America, it's beginning to sew the seeds, in my humble opinion, to a form of

euthanasia in this country. There are too many old people, so one governor said -- I can't recall his name -- but he did distinctly say that there were too many elderly, and something had to be done about them. I don't know whether he had in mind putting us on board a ship and sinking us or what.

But, I came here this morning specifically to talk about one case, and unfortunately I am not permitted to say publicly who the individuals were in this particular instance. I'll be glad to give the Committee, for their information, the name of the doctor. I don't mind mentioning the institution, because I talked with the doctor at the institution this morning who is at the head of the PRO, and he told me that he had absolutely-- Not even did he, nor the attending physician, have any control over the discharge of someone in my family from that hospital, who entered that hospital as a critically ill patient, and was discharged from that hospital as a critical patient. If I didn't see him every day, I talked with the hospital every day. And every report was that his condition was critical. This man was discharged in a critical condition from the hospital -- and I don't mind mentioning its name: the Jersey Shore Medical Center -- to his home where my sister, an 80-year-old woman, ill of health herself, was supposed to care for him with the help, I might say, of the visiting nurses. But how long do the visiting nurses stay? Do they stay an hour? Do they stay two hours? In this particular case, they came every day. His buttocks, from radium treatments, was a mass of red flesh which had to be treated by a special nurse skilled in taking care of such cases. He was discharged to die at home, and that's exactly what happened.

I think it is a disgraceful condition that exists in this country; in this community, where people are so treated. That's about all I have to say.

SENATOR PALLONE: I appreciate your comments, and it's another case that we have to look into as a basis for this

whole analysis.

MR. O'BRIAN: Well, I'll be very glad to give you the name of the doctor in charge.

SENATOR PALLONE: Okay.

MR. O'BRIAN: Very glad to give you full details.

SENATOR PALLONE: All right, thanks a lot, Mr. O'Brian.

MR. O'BRIAN: The patient, and everything else--

SENATOR PALLONE: Okay. Do we have anyone else that wants to address the Committee?

Well, I was going to-- I can't thank Senator Brown, because she already left. I do want to thank all of you, Rosemary, Norma, Diane, and Barbara for helping us with the public hearing, and also the two gentleman over there who have been transcribing all of this, David Inverso, and Don Gephart. Thanks a lot for transcribing that and staying here all this time.

I just want to point out, lastly, that as far as the financing of health care for senior citizens, it continues to be a very serious issue. We -- or I should say I -- set this up, and requested that we have this hearing today, because I felt that there was a problem, and that we should look into the problems of premature discharge. Not only possible premature discharge, but also what happens when people are discharged, and what type of programs are available for their care in the community, at home, in nursing homes, and whether or not that is being reimbursed and the financing of that.

What we're basically going to do is analyze what came out of this hearing today, and then probably have another hearing in Trenton at a later date of this month or sometime later in the year. And at that time we're going to ask members of the Executive Branch to come in before the Committee and ask some questions, and also have another opportunity for other individuals who might be interested in the whole issue.

I think one of the most important things is, perhaps,

that we just covered a tremendous scope, really, of activity and problems here, and raised a number of questions, I think, and also there were some suggestions about how to deal with the whole problem.

So, I thought it was a very informative meeting, and just want to thank those of you who are still here for coming, and assure you that we do plan to look into this in a very -- in a total way, get to the bottom of it, and see what can be done legislatively, not only on a State level, but also, possibly, make some suggestions to the federal government and federal officials as well.

Thanks again.

(HEARING CONCLUDED)

APPENDIX

The Senate Committee on Aging
Testimony on the Premature
Discharge of Senior Citizens
From Hospitals Under the
State DRG Program

Wednesday, April 2, 1986

Long Branch, N.J.

Bonnie Williams, MSW, ACSW, MHA

President, N.J. Chapter

Society for Hospital Social Work Directors

and

Manager, Patient Affairs & Counseling Services

Memorial Hospital of Burlington County

175 Madison Avenue

Mount Holly, N.J.

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Mr. Chairman, Senator Frank Pallone, Jr., Senator Leanne Brown and others - thank you for the opportunity to speak today. As background, let me say that for the past 16 years, I have participated in the New Jersey Society for hospital social work directors and similarly in hospital social work both as a line worker and for over 13 years in management. For the last 10 years I have participated in different leadership capacities within our state organization; with community agency Boards, consultant to nursing home social work staff and lecturer with several home care programs. This information is provided merely to indicate my years of involvement in working on behalf of patients/families through the health care system and ongoing communication with peers in this area.

On behalf of the Society and Hospital Discharge Planners,let me note our extensive involvement in the coordination of a multidisciplinary discharge planning program. As such, we work with patients/families, health care providers, legal counsel, community resources and are mindful of the regulatory guidelines. The members of our group agree that health care delivery has changed and that health care providers are caught in the middle. We feel that we are able to provide and are providing quality care inside our walls. Our concern for all our patients/families is of great concern for us as we develop and impliment post-hospital care plans through our discharge planning efforts. When exploring the type of resources outside the walls of the hospital,we look at the family support system, home care services, such as,Nursing, Physical Therapy, Occupational Therapy, Home Health Aide, Hospice, etc. and long term care in nursing homes such as skilled and custodial and Residential and Boarding Home services. We recognize that with the decrease in length of stay the discharge planning process must be completed within a shorter period of time.

2x

However, some patients do stay longer if the outside hospital plans are inadequate, or cannot be arranged within the normal length of stay time. Many of my collegues have discussed their long stay cases within their facilities (with the support of their hospital administration and physicians, I might add). Some of these cases include:

-patients for whom no families exist

-patients requiring guardianship

-patients in need of financial assistance to cover cost - hospital care

-patients in need of high skilled care unable to be provided in the home and/or nursing home due to lack of coverage or inability to provide -

-IV Antibiotic Therapy

-enteral and pump tube feedings

-patients on respirators

-tracheostomies

-ventilator dependent care

Let me add - procedure specific services are available at home and in a few nursing homes - but not for long periods of time or they will be seen as maintenance care and disallowed under Medicare.

-patients in need of custodial care (long waiting lists, level of reimbursement, etc.) and/or maintenance care and need for care management services within the home.

Overall, discharge planners are concerned that the demands on "transitional" settings have not been met as quickly as hospitals have sharpened their focus on acute care. In the past and in the present, hospitals are having to fill the void created by the gap in service for older patients as well as others. We need help in educating the consumer of these changes especially the acknowledgement that hospitals are now for acute care and not for chronic, convalescent, recupera-

tion and custodial care services (for this is the information that we have received regarding our changing function .

As our Society has studied the impact of what is happening to our consumers, the society, health care facilities and our membership. It is clear that the pressure is felt on all levels. Change creates stress. However, we must focus on the elimination of the stress factors and realization of what needs to be addressed.

1. We are all aware that there is an increasing senior citizens population and correspondingly an increasing utilization of health care services. Additionally, there is the need for non-skilled care
   - -such as, homemakers services, chore services, friendly visitor, increase protective services, companion services, etc.
   - -people are discharged sicker and finances are tighter; there are decreasing finances to cover skilled care and shrinking of allowed time coverage.
   - -live-in services are needed and desired by many instead of nursing home care, but no coverage and shortage of providers.
2. Increase case management services for better coordination of services and follow up within the community.
3. Increase community screening programs for access into the health care system.
4. Increase in community geriatric medical screening programs and medical consultation services to physicians also to seniors through the nutrition programs.
5. Increase financial assistance to families who have been and are still willing to care for patients.
6. Coverage of the "Nursing Home without walls concept" such

as financial assistance with home alert programs with appropriate medical backup - to help patients who are elderly and/or disabled to remain at home.

7. Review of the Medicaid application processing procedure which can vary from 7 days to 6 weeks in different counties.
8. Look at reimbursement to nursing homes for high care patients with emphasis on capital expenses, staff trainings and/or development of special programs.
9. Increased emphasis on hospice services assistance to families including through the bereavement period.
10. Increased Medicare care coverage of social work services through home care services.
11. Recognition and support of the need for professionally trained qualified staff within hospitals to continue to provide appropriate discharge planning and counseling services.

Thank you for allowing me the opportunity to speak to the issue of not only the problem identification but additionally to recommend some solutations. Hopefully, your committee will help to find ways to support these solutions, to fund these suggestions and/or to turn these into reality.

BW/hh

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TESTIMONY PRESENTED

to the

NEW JERSEY STATE SENATE'S

COMMITTEE ON AGING

SENATOR FRANK PALLONE, JR., CHAIRMAN

APRIL 2, 1986

Public Hearing on the Effect of New Jersey's Diagnosis Related Group (DRG) System on Discharge of Elderly Patients from Hospitals

BY: Faith K. Goldschmidt, Director
Reimbursement Systems Development,
Evaluation and Research
New Jersey State Department of Health

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Good morning, Mr. Chairman and members of the Committee. I am Faith Goldschmidt, Director of Reimbursement Systems Development, Evaluation and Research of the New Jersey State Department of Health. I am one of the two directors who administer New Jersey's Diagnosis Related Group (DRG) system, and within my program is housed a team responsible for quality of care assurance under New Jersey's DRG system.

I would like to thank you for calling this hearing. Quality of care assurance is a primary concern of the Department of Health. Certainly any system of containment of hospital costs cannot function at the expense of quality of care.

I will describe New Jersey's overall DRG system and the quality of care assurances built into the system. Because concerns about Medicare's system have spilled into New Jersey, I will discuss Medicare's Prospective Payment System (PPS) and its quality of care assurances. I will also discuss public expectations, the need for interaction and involvement of all health care industry groups and the health care consumer.

I. Background

Diagnosis related groups (DRGs) are a means of grouping hospital patients into 468 groups based upon diagnoses and other clinical attributes. Patients within each DRG are expected to consume similar amounts of resources, so an average amount of resource consumption can be calculated for each DRG (the DRG rate).

In New Jersey, each DRG can be related to hospital resources used to treat patients within a DRG through the data collected by the Department of Health. Each patient's bill and medical abstract information, and the hospital cost reports are collected and used to calculate an average rate for each DRG for each hospital. Each patient whose length of stay falls within a range of days typical for each DRG is billed the DRG rate. I will discuss exceptions in a few minutes. Hospitals assign the DRG and bill payers.

DRGs were developed at Yale University and brought to New Jersey as a means of possibly containing rapidly excalating hospital costs. New Jersey implemented its DRG system (also known as Chapter 83) over a three year period, 1980 - 1982. By the end of 1982, all 90 New Jersey acute care general hospitals were utilizing New Jersey's DRG system to bill patients and collect management information.

Prior per diem systems encouraged retention of inpatients because each patient paid the same amount per day, and the more days of stay, the more money paid to the hospital. Insurance

companies usually paid the bill without too many questions. With an average rate hospital payment system, the incentive becomes to decrease resource consumption by discharging patients as soon as they are medically able to leave, so that another patient can be admitted, and reducing unnecessary services. Strong quality of care assurances were implemented in New Jersey to prevent abuse of the system.

In October 1983, Medicare implemented its Prospective Payment System for Medicare patients across the country. New Jersey has retained its own system of payment through a Medicare waiver. However, Medicare's utilization review mechanism has been functioning in New Jersey, for Medicare patients, in place of New Jersey's Chapter 83 review mechanism since October 1984.

II. Quality of Care Assurances under Chapter 83 and PPS

There are several unique features of New Jersey's system which help ensure that cost containment issues do not override quality of care concerns. I will focus upon those which affect length of stay and care in the hospital.

A. Rates

First, hospital rates in New Jersey are set up using every hospitals' total historical experience in resource consumption and are hospital specific. This "individualization" ensures that each hospital's rates are more reflective of that hospital's experience than are rates under Medicare's PPS. Under PPS, there are 18 rates for each DRG across the nation. In addition, New Jersey hospitals can appeal their rates to the Department. If the Department finds that a hospital is suffering significant financial shortfall because of a change in generic

medical practice, in the scope of teaching, in physician compensation arrangements, in certificate of need items, and other items as defined in regulation, hearings are held and the rates changed. These rate adjusting mechanisms help ensure that a hospital has sufficient revenue to treat its particular types of patients.

B. Outliers

Second, New Jersey has several categories of atypical hospital patients (outliers). The outlier categories are high length of stay, low length of stay, clinical DRGs, same day stays, transfers out and low volume DRGs. Patients in these categories are considered atypical in terms of length of stay or resource consumption in an acute care general hospital setting. They are billed amounts other than the average DRG rate. The outlier payment mechanism decreases hospital and payer concern over resource consumption for atypical patients.

I would like to focus on the high length of stay outliers. In New Jersey, once a patient's length of stay exceeds the range of days that is considered typical for a DRG, that patient becomes a high length of stay "outlier". The last day of the range of days is called a "high trim point". If the patient has to stay in the acute care hospital for valid medical reasons, the patient stays, whether or not the stay exceeds the high trim point. In New Jersey, the type of payment simply changes.

Under Medicare's PPS, there are two outlier categories -

high length of stay and extremely expensive cases. Both types of cases must be thoroughly justified to the fiscal intermediary, and the total dollar amount collected by a hospital for these cases is capped.

C. Utilization Review

Third, New Jersey implemented a strong system of quality of care and utilization review under its DRG system. As mentioned, in an average rate system incentives are present to discharge patients as soon as they are medically able to leave the acute care setting and to reduce unnecessary services. In 1980-1981, the Department certified the existing independent Professional Standards Review Organizations (PSROs) to review all patients under New Jersey's DRG system. The PSROs became known generically as Utilization Review Organizations (UROs). There are now 5 UROs in New Jersey. Under Chapter 83, UROs review all hospital patients on a concurrent and retrospective basis either themselves or through delegation of review to a hospital. For purposes of discussion, I will use the term "URO" to apply to both the independent URO and a delegated hospital.

1. Concurrent Review

Concurrent review includes certification that the acute care admission is appropriate, and that treatment rendered throughout the stay is appropriate. Admission certification occurs within 24 hours of admission, and continued stay certification occurs every few days throughout the hospital stay. Ideally, hospital discharge planning begins early in

the stay, so that by the time a patient is ready for discharge any necessary arrangements have been made.

It is the attending physician who admits the patients, orders hospital services, and discharges the patient. If there are valid medical reasons why a patient must stay in the acute care setting or at an acute care level of care, the patient stays. Neither the average length of stay of a DRG or the high trim point determines when the patient is discharged. There has been much confusion generated on this issue among patients, payers and non-New Jersey hospitals.

If a patient does not require an acute level of care, but cannot leave the hospital for various reasons, such as lack of a place in a nursing home, the level of care is considered to be skilled nursing (SNF) or intermediate (ICF). The URO will designate that the patient is at a SNF or ICF level of care.

2. Retrospective Review

Under Chapter 83, UROs also review cases on a retrospective basis. Samples of medical records bills and any other information required are reviewed. The purpose of retrospective review in New Jersey is to focus in depth upon practice patterns, trends, and areas of concern. Retrospective review is only one part of New Jersey's review system. In conjunction with the concurrent review portion, utilization review and quality of care assurance is very powerful within New Jersey's DRG system.

The Department of Health has the authority to direct the UROs to investigate any area of hospital quality of care concern. In 1983, during federal hearings on New Jersey's experience under DRGs, concern over quality of care was discussed. The Commissioner of Health directed the UROs to study alleged early discharges to determine if inappropriate early discharges were occurring because of New Jersey's DRG system.

The study was completed and the results distributed in the summer of 1984. A copy of the study is attached. The study, which included full review of cases of possible early discharges as determined by readmissions, showed that any problems that occurred were not caused by the DRG system. The problems included poor discharge planning, unnecessary tests, etc., which occur regardless of the payment system. In these cases, educational efforts were undertaken by the UROs.

As an update, the Department keeps in contact with the UROs on this specific issue. The UROs, as typified by the attached letter from Martin Margolies, Executive Director of the Peer Review Organization of New Jersey, have indicated that there still do not appear to be inappropriate early discharges of patients caused by New Jersey's DRG system. At a meeting on Saturday, March 29, I also heard that, under Chapter 83, hospital administrators in New Jersey are not forcing physicians to inappropriately discharge patients.

We have heard anecdotal stories, and have received some cases to review. On full review by the UROs, treatment of the cases was found to be appropriate and quality of care of the cases was not adversely affected by the DRG system.

3. Chapter 83 - PPS Differences in Review

Under Medicare's PPS, utilization review differs from Chapter 83 review. In New Jersey, Medicare and Medicaid patients had been reviewed under Chapter 83 guidelines until October 1984 (Medicare), and February 1986 (Medicaid).

In October 1984, Medicare designated one utilization review organization in each state to do review for Medicare patients under PPS. In New Jersey, the organization is Peer Review Organization of New Jersey (PRO of N.J.). In February 1986, Medicaid signed a similar contract with PRO of N.J.

There are two major areas of concern with the federal review guidelines. First, the review itself and, second, mechanisms to affect positive change.

a. Review

First, under the current federal guidelines for PRO review, only retrospective review is done and only a sampling of cases is reviewed. There is no concurrent review. New Jersey's concern is that two segments of its hospital inpatient population, Medicare and Medicaid, are not subject to the same quality of care review as are non-federal patients.

PRO of N.J. has indicated that small pieces of Chapter 83 review have been retained because of its own desire to provide more thorough review than that required by PPS. But, there is a double standard now in place in New Jersey for quality of care review - one for Medicare and Medicaid patients, and one for all other patients.

b. Mechanism

Second, in addition to differences in review, there are mechanisms to affect positive change in hospital, physician and payer behavior which differ between Chapter 83 and PPS. In New Jersey there is, and has been, direct interaction, education and cooperative efforts between UROs, hospital administration, payers, physicians, associations, patients and the Department of Health. The Department has made a concerted effort to ensure open communication in Chapter 83's review process. The Department has an "open line" policy for the health care industry and for patients. UROs carry out educational and feedback sessions with hospitals. Associations have education sessions for members. Education and positive interaction are extremely important to all concerned parties, and direct "hands-on" involvement by the regulatory agency is vital to the success of any system.

In New Jersey, there is a patient appeal mechanism by which a patient can appeal a hospital bill on excessive charges, DRG assignment or medical necessity. The appeal is screened by the Department and then referred to the local URO, which administers the first level. A second level committee

is also available to adjudicate issues that were not settled at the first level patient appeal.

In New Jersey, there are mechanisms at the Department of Health to rapidly screen and handle complaints, referrals and clinical or quality problems. These issues are handled by the Department or referred to the appropriate group - the Board of Medical Examiners for complaints about physician practice, to the UROs for quality of care, to Health Facilities Evaluation for standards issues, or to other appropriate groups. The PPS does not have a state level group that rapidly can respond to system problems.

In summary, New Jersey's DRG system includes mechanisms to ensure that patients are not inappropriately discharged and that quality of care does not deteriorate. However, with the concern over what is happening outside of New Jersey, under PPS, it is appropriate to remind everyone of these mechanisms, to hear comments, to make any necessary improvements and to continue to encourage open communication.

III. Other Issues

There are several other issues that should be discussed in a hearing on quality of care.

A. Public Perception

First, health care consumers have been used to past patterns of medical practice, and it is difficult to change public perception. Patients have been used to staying in acute care hospitals probably longer than really medically necessary, simply because an incentive existed to retain patients, and because costs were paid by third-party payers without much question.

Any change in familiar routines takes time to affect and is cause for concern. A discharge earlier than in the past is not necessarily a bad thing. If a patient is medically able to leave an acute care hospital, it is to his or her advantage to leave provided appropriate post-discharge plans have been made. Patients tend to have fewer hospital acquired problems the earlier they are discharged. However, patients also have a right to be informed of changes in practice patterns, the reasons for the changes, and the name of a contact person or group for more information or help. Hospitals are required to inform patients about the DRG system. Pamphlets are distributed about the overall DRG system, by hospitals, and hospitals should have a contact person. Perhaps massive educational sessions and "gripe" sessions should be held to help health care consumers focus on the changes occurring in health care. Often, talking is

more satisfying than reading.

B. Alternative Care

Second, nursing homes, long-term care facilities, rehabilitation facilities, and home health care have been used to dealing with patients almost ready to walk home. Sicker patients can be appropriately cared for by these organizations, provided that the organizations can obtain the money and staff to do so, patients can access the necessary services, and insurers adequately cover those services.

Acute care hospitals should be for acutely ill patients. Alternative health care systems must be fully developed to complement changes in health care that have already started to affect the health care consumer.

C. Inappropriate Early Discharges

Third, the other type of early discharge is the type where the patient is not medically ready to leave the acute care setting. It is these inappropriate early discharges that are of concern. As discussed, New Jersey has not seen a problem supported by hard data. The Department feels that its dual system of utilization review and close interaction has prevented such abuses in New Jersey. However, there is a question of such instances outside of New Jersey in PPS and the question has spilled into New Jersey. Education of consumers and relatives can play a key role in this area of concern.

Senator Heinz of Pennsylvania had done a study on early discharges. The study itself is open to criticism, but the question remains - is quality of care suffering under Medicare's PPS and are there mechanisms in place to look at and answer the question for PPS?

Health and Human Services released mortality rates to the public on March 13, 1986. That release had some faults and created considerable controversy, but the question again is, is there really a quality of care problem as evidenced by inappropriate mortality? Can this question be investigated?

The New Jersey Department of Health already has used and continues to use the UROs to study premature discharges. We have already started an aggressive, in-depth analysis of mortality rates in all New Jersey hospitals. We plan to investigate this issue through the UROs, as a special study. We had not specifically investigated mortality because there did not appear to be a problem in New Jersey. Since the HHS numbers were released, it is appropriate to move into such a New Jersey study and get detailed information.

IV. Conclusion

In conclusion, the Department feels that quality of care has been protected in New Jersey for Chapter 83 patients through a variety of mechanisms. We would be very happy to work with the Committee, attendees and interested parties to provide education, implement other necessary mechanisms or monitor issues to assure that quality of care continues to be satisfactory under New Jersey's DRG system.

ATTACHMENT

The Peer Review Organization of New Jersey, Inc.

Central Division
Brier Hill Court
Building J
East Brunswick, NJ 08816
(201) 238-5570

Southern Division
1940 Route 70
Cherry Hill,
New Jersey 08003
(609) 424-7433

March 25, 1986

Ms. Bernice Ferguson
HERS I, Case-Mix Project
State of New Jersey
Department of Health
John Fitch Plaza
CN-360
Trenton, New Jersey 08625

Dear Ms. Ferguson:

In response to your inquiry on behalf of the New Jersey Department of Health regarding premature discharges in the Medicare population, I can only respond as follows:

> The PRO of New Jersey has not had any direct evidence that the DRG system has precipitated premature discharges.
>
> While we too have heard anecdotal stories, we have not found this to be the case.

I hope this addresses your concerns. If you have any further questions, please do not hesitate to contact me.

Sincerely,

Martin P. Margolies
Executive Vice President

MPM:rr

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State of New Jersey
DEPARTMENT OF HEALTH
JOHN FITCH PLAZA
CN 360, TRENTON, N.J. 08625

J. RICHARD GOLDSTEIN, M.D.
COMMISSIONER

TO: All Interested Parties

FROM: Faith Goldschmidt, Director Designate, FG
Systems Analysis, Development and Data Systems Support

SUBJECT: Full Professional Standard Review Organization (PSRO) Study

DATE: July 12, 1984

Enclosed is the full PSRO study on which the October news release on preliminary assessment of re-admissions in New Jersey was based. Also enclosed are the results of the chart review of selected DRGs, which is referenced in the full study. Hospital names have been removed.

After review of the charts, it does not appear that the Diagnosis Related Group (DRG) System in New Jersey had any effect on discharge, death or re-admission in the cases studied.

Any problems that occurred were due to problems that occur in many hospitals regardless of what payment system is in use. Such problems included unnecessary admissions, unnecessary tests and therapies, and poor discharge planning.

The increased focus on quality of care brought about by implementation of a system of average hospital payment rates based on DRGs has served to heighten the awareness of health care practices by physicians, insurance companies, regulators, hospitals and health care consumers. Consumers and others are more willing to question medical practice and hospital performance. Such awareness can lead to improvements in health care in New Jersey and the nation.

FG:ms

Enclosures

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Part 1

Part 1 contains the methodology upon which the preliminary assessment of a re-admission/early discharge study was conducted in three Professional Standard Review Organization (PSRO) areas in New Jersey.

An October 1983 news release was based upon this part of the full study.

Methodology for Readmission Project

I. Topic of Investigation

Are readmissions related to the early discharge of patients at acute care institutions in the three PSRO areas of Essex (EPRO) Hudson (HCPSRO) and Union (SMRA) counties?

II. Definitions and Procedures

Readmission: An inpatient stay which is preceded by another inpatient stay, and where the interval between the first stay's discharge date and the second stay's admission date is four or seven days. The stays are matched by insurance claim number and birthdate. Utilization of the claim number as a unique identifier captures readmissions across hospitals in a PSRO area. In the event of a chain of inpatient stays meeting the above criterion, all but the first stay is defined as a readmission.

Reports were produced for the 1982 data base for each PSRO. Separate reports were run for Medicare, Medicaid, and Blue-Cross of New Jersey.

Several DRGs were eliminated from the analysis because they were discounted as suspect readmissions since they would have readmissions as a normal pattern:

382 - False Labor

409 - Radiation Therapy, Medical

410 - Chemotherapy, Medical

317 - Dialysis, Medical

385 - Newborn and/or other Neonate Transferred or Died

For the same reason, records with a patient disposition of 'transfer to another short term general hospital' were eliminated. Records with a disposition of 'left against medical advice' were also discounted because a subsequent readmission would not be related to the DRG reimbursement system.

III. Data Quality and Management

The data source was the NJUP (New Jersey Utilization Program) abstract. Data quality was assured by several edits performed by HUP (Hospital Utilization Project), NJUP's data processor, and by Medical Building, Inc., the PSROs' data processor. The reabstracting of random samples of abstracts during on-site hospital visits which are routinely performed by PSRO quality assurance staff further contributed to the accuracy of the data.

Finally, the identification of readmissions through a process of matching the unique identifiers of claim number and birthdate is more

reliable than a readmission flag coded on the abstract by the hospital's staff -- a procedure which relies on the physician to note a readmission and/or the use of a single unit medical record number. The data were analyzed using SAS, Statistical Analysis System, which offers superior data management and manipulation capabilities, as well as a wide range of statistical procedures to facilitate data analysis.

IV. Reports

1. Admissions and Readmissions by Provider
2. Admissions and Readmissions, by Provider over all Providers
3. Readmissions by Provider
4. Matched Admissions - Readmissions by DRG
5. Readmissions with a Patient Disposition of Died

Reports 1 and 2 are overviews displaying the extent of readmissions in each area. Report 1 indicates the number and percent of admissions and readmissions by provider, while Report 2 shows each provider's percent of total area admissions and readmissions.

Report 3 is a DRG - specific table displaying readmissions for each provider by DRG. Report 4 focuses on the sequence of the admission and readmission by DRGs. For each DRG the frequency of admissions which are followed by a readmission is displayed. The total number of readmissions occurring in each DRG is disaggregated into readmissions which have the same DRG as the first admission, matched readmissions, and readmissions

which have a DRG different from that of the first admission, non-matched DRGs.

Report 5 displays the number of deaths by DRG.

V. Data Analysis

Analysis was performed on the 7 Day Interval Reports.

1. Extent of Readmission

The areawide readmission rate for each payor, the three PSRO merged rate for each payor, and the area rate are displayed below.

	EPRO	HCPSRO	SMRA	MERGED RATE
Medicare	3.52%	2.44%	2.71%	3.00%
Medicaid	2.13	1.36	1.64	1.87
BC/NJ	1.74	1.28	1.18	1.44
Area Rate	2.48	1.83	1.80	2.14

In 1982, 5,061, or 2.14%, of 236,802 discharges were readmissions in the three areas. The rankings of the three payor categories were the same in the three areas: The Medicare population experienced the highest readmission rate, Medicaid followed, and the Blue Cross, NJ category had the lowest rate.

2. Pattern of Readmissions

The three areas were similar in the pattern of the high volume DRG readmissions for Medicare, with less similarities for Medicaid and

Blue Cross NJ. Frequently occurring readmission DRGs for the Medicare population were:

DRG 14 - Specific Cerebrovascular Disorder, WO principal Diagnosis of Transient Ischemic Attack, Medical

DRG 88 - Chronic obstructive Pulmonary Disease, Medical

DRG 127 - Heart failure and/or shock, Medical

DRG 138 - Arrhythmia and/or Conductive Disorders, W age 70cc, Medical

DRG 140 - Angina, Medical

DRG 182 - Gastro-Intestinal disorder, Age 18+ W age 70cc, Medical

DRG 468 - Unrelated Surgery

These DRGs were also amont the high volume DRGs for the entire Medicare population.

The Medicaid and Blue Cross, NJ readmission DRGs were not as comparable across areas. HCPSRO and EPRO had two DRGs in common and Medicaid, 98 Bronchitis and/or Asthma, Age 0 - 17, Medical and 184 Gastro-Intestinal Disorder, Age 0 - 17, Medical.

For Blue Cross NJ the high volume readmission DRGs occurring in at least two DRGs were:

DRG 183 - Gastro-Intestinal disorder, Age 18+, WO Age 70cc Medical

DRG 184 - Gastro-Intestinal disorder, Age 0 - 17, Medical

DRG 125 - Circulatory disorder WO acute Myocardial Infarction, W Cardiac Catheterization, WO complex Diagnosis, Medical

82 - Neoplasm of Respiratory System, Medical

DRGs related to childbirth occurred with some frequency in all areas; these were most likely preceded by a stay due to false labor. Most of the DRGs for newborns were found to be multiple births, which, because of matching claim number and birthdate, were captured as readmissions.

3. Sequence of Admission-Readmission DRGs

Report 4 was used to select DRGs for more intensive investigation. It was reasoned that readmissions with the same DRG as the initial admission would be the readmissions most likely to be implicated in the early discharge phenomenon, since an early discharge would lead to a readmission to treat the same or similar medical condition. The table below recalulates readmission rates based on the "matching" readmissions, producing a considerably lower rate of potentially suspect readmissions ranging from 0.4% to 0.6% for the three area merged rate.

Number of Matches for DRGs for the First Admission and the Readmission

	HCPSRO		EPRO		SMRA	
	No.	%	No.	%	No.	%
Medicare	122	0.5	296	0.7	128	0.5
Medicaid	63	0.4	256	0.7	35	0.5
BCNJ*	35	0.3	156	0.4	80	0.2
Merged Rate	220	0.4	708	0.6	243	0.4

*Excluding DRG 391 which had as a principal diagnosis multiple births.

The next phase of the readmission project is on-site visits to hospitals for chart review. Those DRGs which had five or more matched readmissions were selected for review. The list for each area and payor is attached. The review staff will review the initial admission and readmission to make a determination about the relationship between the initial stay and readmission, and whether early discharge was a factor in precipitating a readmission.

VI. Deaths

A comparison of Medicare readmission death rates for those DRGs where at least five deaths occurred was made with a standard consisting of data from four N.J. PSROs for the 1981 Medicare population. Inspection of the table below did not yield for the most part death rates substantially aberrant from the standard death rate.

Readmission Death Rates for Medicare DRGs by Area

	EPRO		HCPSRO		SMRA		STANDARD*
+DRG	No.	%	No.	%	No.	%	%
14	8	13.8	8	26.7	6	21.4	26.4
82	16	27.1	5	18.5	5	17.9	29.1
121 122 123	10	20.0	6	20.0	10	25.6	20.8
127	13	9.0	11	11.3	13	13.7	11.6
203	10	37.0	-	-	-	-	42.1
316	8	7.5	-	-	-	-	20.0
416	5	38.5	-	-	-	-	25.0
468	5	5.9	-	-	-	-	9.5

*The standard was derived from 1981 data for EPRO, HCPSRO, SMRA and AREA 1 acute care institutions.

+DRG descriptions are attached.

PSRO Area Readmission Death Rate=

(No. of deaths/No. of initial admission + readmission) x 100

Standard Death Rate=

(No. of deaths/No. of 1981 Medicare discharges) x 100

VII. Conclusions

The extent of readmissions in the three PSRO areas was quite similar for each payor. The Medicare population had the highest readmission rate of the three payors. The high volume readmission DRGs were drawn from the high volume DRGs for the entire Medicare population. This pattern was in line with expectations that the elderly Medicare patient population would experience more readmissions than the younger age categories. The aged are more likely to be afflicted with multiple chronic diseases which often warrent medical management at an acute care facility periodically. Therefore, the higher Medicare readmission rate and the DRG distribution do not present a deviant pattern of hospital utilization.

When attention is focused on matched readmissions, readmission DRGs which match the initial admission DRGs, the readmission rate dropped considerably to less than 1% for each area and for all payors. These results indicate that the potential for the early discharge phenomenon is minimal in each area and for each payor. Again, these matched readmissions do not necessarily point to early discharge on the first admission, but are the most suspect readmissions. The high volume matched readmission DRGs which are to be investigated further involve medical conditions which are likely to warrant readmissions because of the natural course of the disease. Readmissions for these DRGs are just as likely to have occurred under a per diem system of payment as under a prospective system. Nevertheless, an on-site chart review of these high volume matched readmission DRGs will

be conducted to provide clinical assessment of the factors involved in readmission.

Finally, the Medicare death rates for those DRGs with five or more deaths were found to be lower than, or did not deviate substantially from, the death rates for the entire Medicare population of the four PSRO areas. The finding that no substantial difference existed between the Medicare readmission population and the entire Medicare population strongly suggests that early discharge was not a factor leading to death, but that deaths resulted from the natural course of the disease.

It is anticipated that the completion of the project will provide evidence to dispel the notion that the DRG system per se comprises the quality of care provided at acute care institutions in the three areas.

DRGs TO BE FOLLOWED-UP BY CHART REVIEW

Medicare:

82 Neoplasm of respiratory system, medical

88 Chronic obstructive pulmonary disease, medical

127 Heart failure and/or shock, medical

Medicaid:

EPRO & HCPSRO only (SMRA did not have 5 "matched" DRGs)

98 Bronchitis and/or asthma, age 0 - 17, medical

184 Gastro-intestinal disorder, age 0 - 17, medical

Blue Cross, New Jersey

395 Red blood cell disorder, age 18+ medical (SMRA, EPRO)

426 Neuroses, w principal diagnosis of depressive nueroses, medical (SMRA)

DRGs IN MEDICARE READMISSION DEATH RATE TABLE

14. Specific Cerebrovascular Disorder, WO Principal Diagnosis of Transient Ischemic Attack, Medical

82. Neoplasm of Respiratory System, Medical

121. Circulatory Disorder With Acute Myocardial Infarction, Discharged Alive, With Cardiovascular Complications, Medical

122. Circulatory Disorder With Acute Myocardial Infarction, Discharged Alive, WO Cardiovascular Complications, Medical

123. Circulatory Disorder With Acute Myocardial Infarction, Discharged Dead, Medical

127. Heart Failure and/or Shock, Medical

203. Malignancy of Hepatobiliary System and/or Pancreas, Medical

316. Renal Failure, Medical

416. Septicemia, Age 18+, Medical

468. Unrelated Surgery

Part 2

Part 2 contains the final step of the re-admission/early discharge study in three Professional Standard Review Organization (PSRO) areas in New Jersey, now combined into one Peer Review Organization, MetPRO.

Part 2 contains results from review of medical charts of patients in selected Diagnosis Related Groups (DRGs).

MetPRO METROPOLITAN PEER REVIEW ORGANIZATION
OF NEW JERSEY, INC.

READMISSION PROJECT
ESSEX, HUDSON AND UNION COUNTIES
CHART REVIEW OF SELECTED DRGS

The final stage of the readmission project, chart review of selected DRGs, has been completed. The attachments provide a detailed description of the results by county, while the following is a summation of the key findings.

Readmissions identified as having the same DRG on the first admission were reviewed for the following DRGs:

82 Neoplasm of Respiratory System, Medical

88 Chronic Obstructive Pulmonary Disease, Medical

127 Heart Failure and/or Shock, Medical

98 Bronchitis and/or Asthma, Age 0-17, Medical

184 Gastro-intestinal Disorder, Age 0-17, Medical

395 Red Blood Cell Disorder, Age 18+, Medical

The work sheets used by the reviewers addressed six questions:

1. Was the admission necessary?
2. Was the physician aware of the last admission?
3. Was care rendered appropriately?
4. Was there any unnecessary testing?
5. Was there documentation indicating appropriate discharge planning?
6. Was the discharge diagnosis valid?

Whereas some of the questions, deal most directly with the medical necessity of the hospital stay, two primarily relate to the issue of premature discharge, questions number three and five.

Was care rendered appropriately?

According to the reviewers, a total of ten patients in the three counties may not have received appropriate care. However, three of these questioned cases were readmissions and therefore unrelated to the premature discharge issue. In the remaining eight cases the suspected quality of care rendered on the initial stay did not involve the issue of early discharge in the judgment of the reviewers.

Was there documentation indicating appropriate discharge planning?

The lack of discharge planning may be related to premature discharge if the timing of the discharge precluded adequate preparation for post-discharge arrangements. There were a total of twenty-eight instances cited where discharge planning was not documented. Discharge planning may in fact have been provided but was not documented on the chart. Thirteen of the patients not receiving discharge planning were readmissions and therefore the lack of planning was not associated with the discharge date. In the opinion of the reviewers, the length of stay for the remaining fifteen cases was sufficiently long to dispel any suspicion that premature discharge occurred.

In the final assessment of the nurse and physician reviewers in each county, the readmissions examined were not caused by the premature discharge of the patient on the previous stay.

READMISSION STUDY

January, 1984

Essex County 1982 Discharges
Total Readmissions Reviewed.....52
Total Records Reviewed.....117

CHART REVIEW ANALYSIS

The following narrative summarizes the findings as related to the major areas of review.

1. Was the admission necessary?

   In all but 4 cases the admission or readmission or both was medically necessary.

   - Two cases represented diagnostic admissions both on the first admission and again on readmission. Both cases represented patients with chronic vague complaints which could have been worked-up on an outpatient basis. Both were being followed on the outside by their own physicians. Both cases represented utilization problems.
   - One case represented a legitimate admission for a left pneumo thorax in a known lung cancer patient. The patient was discharged and readmitted for personal reasons and represented a utilization problem.
   - One case represented a two year old inappropriately admitted after several episodes of nausea and vomiting and treated with less that acute care services with good response to treatment. Although it appeared that outpatient treatment would have accomplished the same results, the child required readmission for more severe symptoms and received appropriate acute care treatment.

2. Was the physician aware of the last admission?

   In all cases, the physician was aware of the last admission. Most of the charts were either patients with chronic conditions admitted via the E.R. and known to the hospital, or admitted by physicians following them as outpatients.

3. Was the care rendered appropriate?

   There were four patients for whom the care rendered may have contributed to readmission which on the surface was necessary, but caused by the type of treatment rendered.

   - One case represented a ten month old admitted with positive stool cultures for Salmonella. There were

no antibiotics administered and the child was discharged. The readmission was occasioned by continued diarrhea and blood tinged stools, treated with ampicillin until cultures negative and discharged.

- Two cases representing a 12 year old and 14 year old with recurrent bronchial asthma were admitted on several occasions within seven days. The physician reviewer felt that failure to obtain the ophylline levels to determine that a therapeutic dose of medication was being administered may have contributed to the exacerbations and recurrent admissions.

- One case represented a 26 year old patient readmitted five times via the E.R. with Sickle Cell crisis and severe pain. During each admission the patient received demeral every three to four hours around the clock and a prescription for percodan upon discharge. This appeared to be a severe medical problem complicated by possible addiction to pain medication with no documented plan for appropriate intervention.

4. Was there any unnecessary testing?

   Only one case of unnecessary utilization of services was cited. The one case involved excessive use of consultants.

5. Was discharge planning appropriate?

   In general, where indicated, discharge planning was carried out in a timely manner. There were five cases in which there was no documentation during the first admission of plans for follow-up care.

6. Was discharge diagnosis valid?

   Discharge diagnoses appeared to be valid in all cases reviewed.

SUMMARY

Of the 52 readmission patients reviewed nine patients expired during the first or second readmission. Early discharge was not determined to be a factor for any of these patients. The deaths resulted from the natural course of disease. Four cases of death were due to Lung Cancer in its terminal stages, one from Colon Cancer, three from Congestive Heart Failure and multiple chronic conditions and one Myocardial Infarction.

Readmission Study
January 1984

After review of the charts, it does not appear that the DRG reimbursement system interfered in the untimely discharge or death of any of the cases, nor the readmission of such cases.

READMISSION STUDY

OCTOBER 1983

Hudson County 1982 Discharges

Total Records Reviewed - 114

	1st Adm.		2nd Adm.		3rd. Adm.		4th Adm.	
	Yes	No	Yes	No	Yes	No	Yes	No
Was the admission necessary?	49	4	47	6	6	0	2	0
Was the physician aware of the last admission?	N/A	N/A	53	0	6	0	2	0
Was care rendered appropriate?	52	1	50	3	6	0	2	0
Was there any unnecessary testing?	N/A	N/A	4	49	6	0	2	0
Was there documentation indicating appropriate discharge planning?	47	6	45	8	5	1	1	1
Was the discharge diagnosis valid?	53	0	48	5	6	0	2	0

READMISSION STUDY

HUDSON COUNTY

Hospital	Med. Rec.#	Adm.	Disch.	Comments
		12/3/82	12/6/82	Unnecessary second admission. Diarrhea at home x 1 month - well hydrated - Electrolytes OK - IVs.
		10/25/82	10/31/82	Unnecessary first admission. Bronchiolit No I.S. - P.O. antibiotics
		9/27/82	10/1/82	Unnecessary second admission. Gastroenter hydrated - IVs - Progressive diet.
		9/28/82	9/29/82	Unnecessary second admission. No I.S. Question discharge diagnosis
		5/31/82 5/21/82 9/7/82 9/17/82	6/4/82 6/26/82 9/12/82 9/22/82	Unable to locate record. Eight admission for gastroenteritis. No where are plans home care documented.
		5/3/82 5/13/82	5/3/82 5/20/82	Question appropriate use of antibiotics in both cases.
		10/6/82	10/19/82	Second admission. Repeat urinalysis Dx. COPD.
		5/14/82	5/28/82	Second admission. Repeat urinalysis. Dx. COPD.
		2/14/82	2/28/82	Discharge planning should have had O_2 for home care.
		3/22/82	4/3/82	Discnarge planning - No patient/family plan for home care.
		2/2/82	2/3/82	Discharge plan not documented.
	1	9/11/82	9/13/82	Discnarge planning. No documentation of follow-up on O_2 at home.

eadmission Study

udson County

Hospital	Med. Rec.#	Adm.	Disch.	Comments
		1/21/82	1/26/82	Question appropriate use of Decadron.
		9/30/82	10/12/82	Unable to locate record.
		9/15/82	9/21/82	First admission unnecessary. No patient teaching prior to second admission. Seen in ER two times.
		1/19/82	1/29/82	Discharge planning - patient lives alone. No follow-up for both admissions.
		2/6/82	2/24/82	Question discharge diagnosis - second admission.
		9/14/82	9/25/82	Unnecessary first admission. No I.S.
		11/16/83	11/18/82	Unnecessary second admission. Question discharge diagnosis.
		6/14/82	6/19/82	Unnecessary second admission. No I.S.
		7/28/82	8/18/82	Unnecessary second admission. Question discharge diagnosis.
		10/31/82	11/18/82	Question discharge diagnosis.

SUBURBAN MEDICAL REVIEW ASSOCIATION

READMISSION STUDY

JANUARY, 1984

OBJECTIVE:

To determine if Union County area acute care hospitals readmissions are related to the premature discharge of patients.

TIME FRAME:

Using 1982 data for all Federal and Blue Cross patients, all those cases readmitted within 7 days of their last discharge were collected for data review.

CHART REVIEWS:

Chart reviews were limited to those DRGs which had 5 or more matched readmissions. The initial chart review was carried out by the Review Coordinators. Physician Advisors were available for chart review as needed. The chart review study design focused on 6 major questions:

1. Was the admission necessary?
2. Was the physician aware of the last admission?
3. Was care rendered appropriately?
4. Was there any unnecessary testing?
5. Was there documentation indicating appropriate discharge planning?
6. Was the discharge diagnosis valid?

Chart Review Analysis:

The following analysis is an attempt to summarize the findings as related to the major areas of review.

1. Was the admission necessary?

   In all but 2 cases the admission was medically necessary.

   - one chart related that the patient was readmitted because there was no one at home to accept the patient from the ambulance

   - one chart documented that the patient was admitted for terminal care because his wife could no longer care for the patient at home

2. Was the physician aware of the last admission?

In all cases, the physician was aware of the last admission. Most of the reviewed charts were chronic cases well known to both hospital and physician.

3. Was the care rendered appropriate?

It was the opinion of the reviewing staff that in general the care rendered was appropriate and indicated.

4. Was there any unnecessary testing?

Of all the cases reviewed, it seemed that there was only 1 case that may have had excessive testing.

- Total LOS of 27 days with diagnosis of CHF - 8/14-9/10. During that time, 29 chemistry I blood samples for serum electrolytes were done.

5. Was discharge planning appropriate?

In general discharge planning was both timely and appropriate. Most "N/A's" documented on the summary sheet (Attachment I) represent patients that expired. Others were rather well know patients that did not want discharge planning or those who repeatedly had refused help. There were a few instances where discharge planning was ordered and not done or never referred to Social Services when indicated.

6. Was discharge diagnosis valid?

Of the cases reviewed, the discharge diagnosis appeared to be valid for the principal diagnosis. However the DRG validation was not included in this study.

SUMMARY

A. Forty-nine patient cases were reviewed. This represented 112 chart reviews. The analysis of chart reviews as related to the 6 major questions can be seen on Attachment I. The breakdown of the number of cases/charts reviewed for each hospital showed no significant pattern and seemed to be somewhat proportionate to the size of the hospital and type of medical services provided.

Hospital No.	No. of cases	No. of charts
601	9	18
602	2	4
603	7	13
604	12	30
605	5	11
606	7	14
607	1	2
Continued stay in more than 1 hospital	6	20
Total	49	112

B. Of the 112 charts reviewed, only 2 were referred to the Physician Advisor for possible premature discharge. In both instances the physician reviewer felt the patient's discharge was not premature.

C. Of the 49 patient cases reviewed, 9 represented deaths on either the first of second readmission. However, it must be noted that early discharge was not a factor. The deaths resulted from the natural course of the disease. (Most of the DRG's, subject to review, related to chronic long term illnesses).

D. Although the study design did not address whether or not the length of stay was appropriate, the nurse reviewers felt many of the length of stays were excessive. As a double check on our present review system, a data analysis was done to summarize the number of cases referred to a Physician Advisor for denial. The data summary showed 4 denials. It must be noted that there may also have been some carved-out days. However, our analysis was not able to account for these.

In conclusion, after review of the indicated charts, it does not seem that the DRG system has interferred in the quality of care provided to Union County patients. Premature discharge was not the cause of related deaths or the number of readmissions.

READMISSION STUDY

Union County 1982 Discharges
Total Cases Reviewed: 49
Total Records Reviewed: 112

	1st Adm.		2nd Adm.		3rd Adm.		4th Adm.		5th Adm.		6th Adm.		7th Adm.		8th Adm.	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Was the admission necessary:	47	1	44	2	8	-	6	-	2	-	1	-				
Was the physician aware of the last admission?	-	-	46	-	8	-	6	-	2	-	1	-				
Was care rendered appropriate?	47	-	46	-	8	-	6	-	2	-	1	-				
Was there any unnecessary testing?	1	46	-	46	-	8	-	6	-	2	-	1				
Was there documentation indicating appropriate discharge planning?	36 (8 NA)	3	31 (12 NA)	3	6 (2 NA)	-	4 (1 NA)	1	- (2 NA)	-	- (2 NA)	-				
Was the discharge diagnosis valid?	*48	-	46	-	8	-	6	-	2	-	1	-				

* 1 case on microfilm

NOTE: DATA SET WORK.REVIEW HAS 5 OBSERVATIONS AND 33 VARIABLES.
NOTE: THE DATA STATEMENT USED 2.02 SECONDS AND 1032K.

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122 PROC PRINT;BY PROVIDER;
123 VAR BDATE ABSTRACT ADATE DDATE DSTATUS DX1 PROC1 LOS MD DRG
124 PAREVS ADENIAL CDENIAL;ID MEDREC;
125 FORMAT BDATE ADATE DDATE DATE7.;
126 TITLE SARA (INTERVAL, 7 DAYS MEDICARE, 1982);
127 TITLE2 RECORDS FOR READMISSION MATCHES IN DRG32, 88, 127;
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NOTE: THE PROCEDURE PRINT USED 1.99 SECONDS AND 1032K AND PRINTED PAGE 1.

NOTE: SAS INSTITUTE INC.
SAS CIRCLE
PO BOX 8000
CARY, N.C. 27511-8000

SARA (INTERVAL, 7 DAYS MEDICARE, 1982)
RECORDS FOR READMISSION MATCHES IN DRG32, 88, 127

--- PROVIDER 201 ---

MEDREC	BDATE	ABSTRACT	ADATE	DDATE	DSTATUS	DX1	PROC1	LOS	MD	DRG	PAREVS	ADENIAL	CDENIAL
[illegible]	[illegible]	00112378R	05SEP82	21SEP82	5	40291	8954	16	01403	127	3	0	1
~~[illegible]~~	~~[illegible]~~	~~00107150R~~	~~25FEB82~~	~~17MAR82~~	~~5~~	~~[illegible]~~	~~9374~~	~~[illegible]~~	~~16451~~	~~96~~	~~3~~	~~0~~	~~1~~
[illegible]	13DEC04	00107150R	13APR82	22APR82	5	[illegible]	[illegible]	9	39113	88	3	0	1
[illegible]	[illegible]	00107150R	23APR82	04MAY82	5	496	9394	11	39113	88	3	0	1

--- PROVIDER 303 ---

MEDREC	BDATE	ABSTRACT	ADATE	DDATE	DSTATUS	DX1	PROC1	LOS	MD	DRG	PAREVS	ADENIAL	CDENIAL
[illegible]	[illegible]	[illegible]	02NOV82	29NOV82	5	4280		27	00186	127	7	0	1

R; T=5.91/13.32 08:37:10

PA Pros ... of PA ... admission + CSR

X874

SENATE COMMITTEE HEARING ON AGING

LONG BRANCH, NEW JERSEY

APRIL 2, 1986

PRESENTED BY: ALEXANDER E. RODI, SR., D.O.
PRESIDENT-ELECT
THE PRO OF NEW JERSEY, INC.

LADIES AND GENTLEMEN:

I thank you for this opportunity to be here today to represent The Peer Review Organization of New Jersey. I am Alexander E. Rodi, Sr., D.O., a family practitioner in Hammonton, New Jersey who has among his treating patients a significant number of older Americans. I would first like to tell you that The Peer Review Organization of New Jersey is a utilization review agency certified by the Federal Government and the State of New Jersey. The PRO covers the entire State of New Jersey. We have an all-payor system which means that all third party payors pay a similar DRG rate to the hospitals. Initially our Organization was mandated to monitor the utilization of resources for the Federal programs; however, our initiative some years ago was to place more emphasis on the type and quality of care the patients were receiving rather than pure utilization of resources. Recently HCFA has emphasized, through recommendations of the Heinz Committee, the importance of evaluating the delivery of quality care.

In my practice, as well as in my duties as President-Elect of The Peer Review Organization of New Jersey, I am very much aware of the concerns of the older Americans in our society and their fears concerning our health care system. Amongst these concerns are:

1. Will I be able to get into a hospital if I need to?
2. Will medical care be rationed?
3. Will I be discharged from the hospital prematurely because I will have exceeded some monetary allotments?
4. Is some other force coming between or interfering with the care between my physician and me?

and finally,

5. Am I going to be able to afford medical care?

I am not here to answer all of those questions today because I cannot answer those which relate to fiscal responsibility. However, I can tell you that The PRO of New Jersey is sensitive to these questions and seeks to find solutions and answers to the many problems which present themselves to our older Americans. We are concerned that the health dollar is used wisely, without any funds wasted or used foolishly which might limit resources to others in need. Therefore, we do not wish to see patients placed into the hospital environment for acute care if they do not need to be there for treatment. Also, a hospital very often is not the best place for anyone to be, particularly fragile persons who succumb easily to infections or other hospital-related problems. When a patient is admitted to a hospital a cost of several thousand dollars is triggered which will be paid. If significant numbers of unjustified admissions occur thousands of dollars will not be available for other needs.

At this time, I would like to address some of your concerns specifically.

First, any patient who is ill and needs to be evaluated and treated will not be denied admission.

Second, will medical care be rationed? I hope not. There are many factors why medical care has increased in cost. One is the escalation in technology which in most cases improves the diagnosis and treatment of many of our Americans. However, many technological advances carry exorbitant costs. The American public must make a determination whether or not they are willing to allocate limited resources to these areas.

Third, the question raised as to whether or not a patient will be discharged early or "thrown out into the street" is a cogent one. Our Organization has been looking for premature discharges or discharges of patients who believe they were sent home before they were stabilized. We have limited resources and therefore cannot evaluate every medical record upon discharge. We do however, have certain clues we utilize in order to look at a hospital discharge. Any patient who is readmitted within seven (7) days for the same diagnosis results in immediate review of both stays.

To date, we have reviewed 74,183 Medicare records and have identified eleven (11) cases (0.014%) where we felt the patient was discharged early. However, in review of these eleven (11) cases, we did not find any intent to discharge for financial gain, but rather professional judgement deemed that the patient was stable at the time of discharge.

Finally, is some other force coming between or interfering with the care between my physician and me? The relationship between a physician and his patient has always been a special one. We at the PRO are practicing physicians who deal on a daily basis with patients of all ages, especially the older American. We are very jealous of the special rapport that we develop with our patients and are not anxious to have other forces intercede. In these times, we encourage the enhancement of the physician/patient relationship so that there is only a minimal damaging effect by other forces on this relationship.

The PRO of New Jersey places great emphasis upon the documentation that a physician places in his chart. This is the primary source to determine what is happening to that patient. We continue to depend upon this documentation in order to help make fair decisions and we insist on its credibility.

All of you must know that no one can discharge a patient except his attending physician. The hospital administrator cannot do it, the nurse coordinator cannot do it, the PRO cannot do it, the Medical Society cannot do it nor can anyone else discharge a patient except in extremely extenuating circumstances. Some providers misunderstand this. Because certain guidelines have been established they may believe that they must follow a "cookbook" type of plan for that patient. We in the PRO are interested primari that the patient is discharged stable. If the patient needs to stay a day or two (2) more, or is stabilized a day or two (2) early, it matters not. We repeat however, that the patient should be sent home stabilized. We also want the patient to be discharged to a stable environment which will not compromise his medical status.

If you know of any situations where you believe a patient has been prematurely discharged, please contact the PRO first so that we can determine whether or not it is factual. We have two (2) phone numbers where we can be reached (201) 238-5570 in East Brunswick and (609) 424-7433 in Cherry Hill. We will address these issues when they are presented to us. I can assure you appropriate evaluation and determination will be made.

Thank you very much for allowing us to come before you today. We have seen this as an opportunity to reaffirm our policy which we are hopeful will be disseminated to all. Finally, this system operates in a political environment. Each and every American in one way or another has input into the type of medical programs which exist. Thank you again.

OCTOBER 1984 - JANUARY 1986 (25%) of

NUMBER MEDICARE REVIEWS	74,183	293,007 DISCHARGES
NUMBER READMISSIONS WITHIN 7 DAYS	9,003	
NUMBER PREMATURE DISCHARGES	11	
NUMBER ADMISSION DENIALS	2,432	
TOTAL NUMBER OF DEATHS	5,536	