

PUBLIC HEARING

before

ASSEMBLY INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

STATE PERINATAL PLAN DESIGNATIONS

Held:

December 8, 1980

Assembly Majority Conference Room
State House

Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman George J. Otlowski, Chairman
Assemblyman Raymond Lesniak, Vice-Chairman
Assemblyman Charles Mays, Sr.
Assemblyman Richard F. Visotcky
Assemblyman C. Louis Bassano
Assemblyman John W. Markert
Assemblyman Clifford W. Snedeker

ALSO:

John D. Kohler, Research Associate
Office of Legislative Services
Aide, Assembly Institutions, Health and Welfare Committee

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Doctor Joanne Finley Commissioner, New Jersey Department of Health	8 & 1X

ASSEMBLYMAN GEORGE J. OTLOWSKI (CHAIRMAN): The meeting will come to order. The purpose of this hearing is to give this committee a better understanding and an idea of some of the proposals on perinatal care and neonatal care and also to see whether or not any legislation is needed, whether the regulations that are being imposed are the kind of regulations that the hospitals and the people can live with and, as a matter of fact, whether they are workable. That is the nature of this hearing and, as a matter of fact, we're interested too in learning what Dr. Finley knows that we don't know, some of the things that she has been alleged to have said. We would just like to have her amplify those statements. In the meantime, we would just like to get a good grasp of this subject matter and, as a matter of fact, we've asked certain people to testify today and if we don't finish the testimony today, of course, we will continue until we feel that we have heard the people that should be heard.

So, with that, I'm going to call on Dr. Sisson, Chairman of the Committee on Child and Perinatal Health of the New Jersey Pediatric Association. Doctor, before you begin, will you just tell us who you are, where you came from, what your experiences are in this area and, then, we would just like to have your ideas on the subjects that I just covered a moment ago.

D O C T O R T. R. S I S S O N: Chairman Otlowski, I am currently the Chairman of Pediatrics at Perth Amboy General Hospital and a clinical faculty member at Rutgers Medical School, clinical professor of pediatrics. I am Chairman of the Committee on Maternal, Child and Perinatal Health of the New Jersey Chapter, American Academy of Pediatrics.

The major part of my career has been spent in neonatology and, prior to coming to New Jersey two years ago, I was Director of Newborn Research at Temple University and St. Christopher's Hospital for Children for twelve years. I held other positions previous to that.

ASSEMBLYMAN OTLOWSKI: Doctor, would you give us a definition of what is meant by the terms, perinatal and neonatal, as they are being covered by these regulations from the State Health Department?

DR. SISSON: Perinatal refers to that period of time around birth, but it actually involves from the time of conception to labor and delivery and beyond, during the first month of life. Neonatal refers to that period of time following delivery until the end of the first month of life, in its defined terms. So, there is an overlap, indeed.

ASSEMBLYMAN OTLOWSKI: Doctor, as those terms and those concepts are being applied to the present regulations, would you just elaborate on that and give us some of your own approaches to the regulations?

DR. SISSON: I think the concept of regionalization of perinatal services refers particularly to the mother as she carries the infant during her pregnancy, the management of the labor and delivery, and then the management of the infant once it is born. Since not all infants are born without some risk, since some infants are born to mothers with an inherent risk during their pregnancy and delivery, and since some infants, also, of an apparently normal pregnancy will be born at the risk of serious illness--most particularly, the prematurely born infant--then we must consider how best to achieve the proper care for both mother and child to reduce the risk and/or salvage the outcome of the pregnancy to the best degree.

ASSEMBLYMAN OTLOWSKI: Doctor, excuse me. Presently, without the implementation of the regulation, perinatal and neonatal births are treated how? Just generally, in general hospitals?

DR. SISSON: I think, for the past decade, or thereabouts, there has been regionalization, to a degree, of perinatal and neonatal care in this state.

ASSEMBLYMAN OTLOWSKI: Self-developed?

DR. SISSON: Yes, self-developed, as the need has arisen and it has been developed by, in general, the medical community in response to this need. So, there are centers capable of delivering sophisticated care. There are various levels of care and there are transport and referral systems already in place.

ASSEMBLYMAN OTLOWSKI: Are there federal regulations and guidelines that are inducing the states to come in, to follow those guidelines?

DR. SISSON: Yes sir, there are. There were guidelines that were published in the federal register two years ago which are meant to offer suggested ways of implementing regionalization.

ASSEMBLYMAN OTLOWSKI: Do the New Jersey regulations and guidelines exceed the federal guidelines and go beyond the federal guidelines, in your opinion?

DR. SISSON: They differ, substantially, in some respects, I think, sir, and do exceed the guidelines in other respects too.

ASSEMBLYMAN OTLOWSKI: Doctor, you have misgivings, don't you, about the present state plan? What are your misgivings about the regulations of the State?

DR. SISSON: I am speaking as a representative of the Academy when I say this. We do have reservations and with your permission, sir, I will read the statement of the Academy, which is brief, but does demonstrate our certain disquietude and reservations about the current state plan.

It states that the Committee on Maternal, Child and Perinatal Health of the New Jersey Chapter of the Academy of Pediatrics is in favor of the concept of regionalization of maternal and neonatal care. It opposes centralization of this care to the degree it is foreseen in the current state plan, which will, we feel, be disruptive of good, existing medical practice and costly, rather than cost effective. The committee believes firmly that no state plan should be drawn which does not accept the principles of the national guidelines for regionalization of maternal and neonatal care. The proposals of the original task force, organized and prepared for a state plan for New Jersey, did reflect these guidelines, but were subsequently rejected or altered and we feel that they should be re-examined. The committee urges in strong terms that no state plan should be rigid in its details or implementation, as is the present plan, but rather, should be flexible in both numbers and design. Further, the proliferation of levels of care that has appeared in the present plan should be discarded and, three, sensibly defined levels of care should be adopted with sufficient levels of capability within each level so that individual regional requirements can be met.

Finally and of prime importance, the committee believes that each region in the state differs from the others geographically and economically so that no one inflexible plan is universally suitable. The committee, therefore, urges that each region should be given the authority to modify its statewide plan to fulfill its own needs and to accommodate regionalization to the natural concerns of its own communities and populace. Thank you.

ASSEMBLYMAN OTLOWSKI: Doctor, you are talking about the different levels, level one, two and three. Again, I ask you, you have certain misgivings about these levels. It is my understanding, from a communication that I had from you, that many hospitals would be jeopardized and would be hurt and, as a matter of fact, in some instances, it doesn't even make sense, the levels don't even make sense. Would you tell the Committee what your feelings are about those levels and the relationship with the hospital?

DR. SISSON: We had felt that the plan of the State, as currently designed, tends to reduce the capabilities of many of the hospitals in the state, who are already offering levels of care that are greater than those proposed in the plan and that those hospitals already offering highly sophisticated levels of care will be downgraded and prevented from offering what they already do give to their communities. Also, I might state, they do offer in the way of transport for a wider area than the immediate hospital area. The concerns of the Academy are that the number of units available for this level of care will be reduced to an unworkable degree, thus tending to jeopardize, certainly, the ongoing regionalization and, in some respects, adding to the risks of the infants, many of whom will have to be transported, whereas now they do not need transport because they are capable of care at the hospital of birth. The Academy also has certain misgivings about the number of hospitals at the so-called level one, feeling that this is too unsophisticated a level. Such hospitals will be able to care only for normal deliveries and there should be a better capability in all hospitals than that envisioned in the State plan except, certainly, for those in remote rural areas where transport is difficult and lengthy. The number of levels of care, as envisioned by the National Academy and other interested groups, long since has been three: Level one, a relatively simple type of care, geared to the normal delivery and pregnancy and normal infant; Level two, an intermediate care with a degree of sophistication; and level three, capable of management of the most critically ill, newborn infants and, likewise, the most critically endangered mother, before she delivers. The State plan has added another level in between, a level 2A, between levels 2 and 3, and the Academy is not certain of the utility of four levels rather than the three, which are nationally recognized.

ASSEMBLYMAN OTLOWSKI: Doctor, it is my understanding, based upon your experience, based upon your exposure to this whole subject matter--practically a whole lifetime--that you feel that there should be better and broader use of level 1 and 2. Am I correct in saying that?

DR. SISSON: I believe this is correct.

ASSEMBLYMAN OTLOWSKI: Succinctly, would you just develop the Academy's approach to this subject matter as far as the use of these levels in the better use of hospitals and the broader use of hospitals?

DR. SISSON: I can quite accurately state for the Academy that the Academy feels that current levels of regionalized care and current patterns of transport should be used as the basis for improvement of already standing regionalized care and that the State plan should offer improvements to these customary patterns rather than to just simply overturn what does exist and start virtually anew. I am overstating the case somewhat because, of course, there are institutions already offering sophisticated care that the State plan intends should do so.

ASSEMBLYMAN OTLOWSKI: Assemblyman Lesniak, do you have any questions at this point?

ASSEMBLYMAN LESNIAK: Doctor, did the Academy participate in the Maternal Infant Care Services Committee?

DR. SISSON: Representatives originally did, yes.

ASSEMBLYMAN LESNIAK: Is it fair to state that the Academy's position is in favor of the regionalization concept, but opposed to the specifics of its implementation?

DR. SISSON: That's right.

ASSEMBLYMAN OTLOWSKI: Assemblyman Visotcky?

ASSEMBLYMAN VISOTCKY: Where's this 2A you're talking about? I don't see it in the report, or is this something you're saying? I only see level 1, level 2 and level 3.

DR. SISSON: Well, in recent months, there has come into the picture a separate layer, 2A, which is somewhat below level 3 and above what is planned for level 2.

ASSEMBLYMAN VISOTCKY: Is that true, Commissioner?

COMMISSIONER FINLEY: The plan, of course, was not made by the Health Department. It was made by layers and layers of citizens, HSA's and so forth. It is true that HSA 4, which is the Central Jersey, Monmouth-Ocean in on through Hunterdon County, to deal with various concerns and disputes between institutions over their suggestions, and the committee of the State Health Coordinating Council accepted their suggestion that in some instances there be what you could call a 2A or, at least, that they be allowed to recommend that something that didn't meet all of the qualifications to be a 3 could be called a 2A, which is almost like a 3, except that it would not have research responsibility and it would not have as many teaching or medical school education responsibilities, but it would be able to have the neonatal intensive care beds. I really believe that that was intended to--I think there are problems with it and there have problems that have occurred because of it and to that extent, Dr. Sisson is right. But, on the other hand, in terms of each region being able to deal with its own situation, which he is really, basically, recommending, that was what one or two HSA's felt that they needed to do. So, it does not appear in the State plan, but it is not something that we have said that we would not oppose if that is the way the HSA recommendations came.

ASSEMBLYMAN VISOTCKY: Okay, that's all.

ASSEMBLYMAN OTLOWSKI: Assemblyman Mays?

ASSEMBLYMAN MAYS: Have you seen Assembly Bill A-2252, as passed both houses in the last session?

DR. SISSON: No, sir, I have not. I heard that it did pass.

ASSEMBLYMAN MAYS: Would you like to see it?

DR. SISSON: Yes.

ASSEMBLYMAN OTLOWSKI: Doctor, I would suggest that before you read that that Mr. John Kohler just give you a synopsis of that bill. Can you just give the Doctor a synopsis of that bill?

MR. KOHLER: Yes. Essentially, what it does is it prohibits the automation of hospital health care insurances by the Commissioner of Health or any State official unless there has been a determination that such a health care service is a public health hazard.

ASSEMBLYMAN OTLOWSKI: Doctor, the statement on the bottom may be of help to you.

DR. SISSON: It would appear that this bill would offer an opportunity for reconsideration of a number of the concerns that the Academy has with the Plan, as it exists. The usefulness of such a bill would then, I think, have served its purpose. I can't speak to its use, other than that.

ASSEMBLYMAN OTLOWSKI: I think that answers the question, Doctor. Mr. Mays, I think that you have elicited the answer that you expected. Do you want to continue?

ASSEMBLYMAN MAYS: No, thank you. That's all.

ASSEMBLYMAN OTLOWSKI. Are you satisfied with that?

ASSEMBLYMAN MAYS: Yes.

ASSEMBLYMAN OTLOWSKI: Assemblyman Snedeker?

ASSEMBLYMAN SNEDEKER: Doctor, do you think if the levels of 1 or 2 or 2A, whatever it may have been, or 3 would affect the type of physician that a hospital may attract if you were to limit a hospital to a level A? Do you think you would attract pediatricians and those who specialize in children in a level 1 or 2 hospital?

DR. SISSON: I think, quite clearly, it would affect the caliber of the physicians attracted to an institution. If an institution is unable, because of the plan's designation, to offer high levels of care, then, no way is a qualified physician going to be attracted to an institution where he cannot practice his trade, as it were. A great concern to me as an educator is the fact, because I think doctors can take of themselves, I am concerned that the limitation that we may end up with in training future physicians. Hospital X, previously offering high levels of care and now not permitted to do so, loses its neonatologist, and then, the training of the residents and students who rotate through such a hospital. They do not get the experience that they previously did. I think the educational aspect should be considered. It is not of prime importance to patients, of course, but for New Jersey, which is developing an excellent university system for medical education, the things that might hinder or inhibit some levels of training do concern me, wearing that other hat.

ASSEMBLYMAN SNEDEKER: Do you feel that this would, in any way, affect the type of physician or nurse who might want to be in a level 1 hospital, not just pediatricians, but other types of physicians who could not treat in any way in their hospital a level 3 type child?

DR. SISSON: It would certainly affect obstetrical practice because an aim of regionalization, of course, is to transport the infant in the mother before it is born so we don't have ambulances running back and forth with critically ill infants. Admittedly, to be sure, it is a very small number of infants per annum, but this is a concern of the obstetrical staffs of any hospital and must be a consideration for the community. I would suggest that the pregnant mothers in the community also have certain desires and needs and whether or not we can say by fiat, "You, you and you are going to go across the state because you are in danger of having a sick infant and we want you to deliver there," well, perhaps, this is to her best interest, but she may not see it and may wish to be closer to home to deliver and wish that facility would be closer to home. It is not my role to judge the cost benefit of this, but this is a practical matter and the people themselves do make decisions as to what they wish for their medical care. So, this too is a consideration that I submit we must look at in evaluating any regional plan.

ASSEMBLYMAN SNEDEKER: Thank you.

ASSEMBLYMAN VISOTCKY: What authority, what facts and figures do you have for you to say that the Commissioner or we in New Jersey are going to close down a borderline hospital and they're going to have to go to another state. It's an assumption because right now nothing is happening, right?

DR. SISSON: That's right.

ASSEMBLYMAN VISOTCKY: Now, where are your facts to say that this place or this hospital will be closed? I'd like to see these facts. I'd like to see any facts that will show that these hospitals will be closed, other than the Commissioner's report. It's a ninety day reprieve hearing. Many things can happen in this ninety days. You're talking generalities. Give me specifics. What hospital; why are they going to go; is the Commissioner really going to close that hospital?

DR. SISSON: Sir, I could not answer that question because I do not know what the Commissioner plans. All I know is what the Academy has developed in its knowledge of the regulations that are being published via correspondence with the Commissioner, with the HSA's and so on. So, I really could not give you facts and figures. I cannot personally answer that.

ASSEMBLYMAN VISOTCKY: Well, I don't think that this Legislature or the Commissioner is going to say that, because a hospital only delivers 750 children and does not meet the 1,000 requirement, that they are going to take it away-- let's say it is on the borderline of Pennsylvania--and we're going to push all of our people from New Jersey to go to the Pennsylvania hospital. I don't believe that. She can say it, but what's going to be done is something different too.

COMMISSIONER FINLEY: I haven't said anything yet. I haven't even got the plan.

ASSEMBLYMAN MAYS: Prior to the extension of the 90 days, Friday, down in New Brunswick, they were going to close it; the hospital was going to be closed. So, she must have some kind of proof. I hope she has some kind of proof as to why she wants to close Bayonne Hospital and the other hospitals. I would like to find that out also.

ASSEMBLYMAN OTLOWSKI: Well, the doctor is in no position to answer that.

ASSEMBLYMAN MAYS: He wasn't in any position to answer the other either.

ASSEMBLYMAN OTLOWSKI: Of course he wasn't.

ASSEMBLYMAN LESNIAK: Mr. Chairman, I have one other question.

ASSEMBLYMAN OTLOWSKI: Assemblyman Lesniak?

ASSEMBLYMAN LESNIAK: Doctor, when the Academy adopted its position on the plan, did they consider the cost benefit analysis of the regulations?

DR. SISSON: Yes, sir, of course. I think the reason that we already have certain patterns of regionalization existing is because they are less costly and they make sense. I am not entirely confident that anyone has firm figures as to the cost-benefit ratio. How much is a kid worth? How much is a diabetic woman's pregnancy worth to HSA 4 or Burlington or whatever. There are intangibles that must be put somewhere into this formula, but I must say that I have yet to see any figures at all on the cost of ambulance service and the estimated cost of transport, particularly when compared with the number of beds available and the cost today of securing such vehicles. They are around \$50,000 apiece. This is no mean sum. All of these costs have to be taken into consideration, but there are other reasons for wondering whether the cost has any bearing on the outcome at all.

ASSEMBLYMAN LESNIAK: How about the cost of maintaining facilities that aren't necessary?

DR. SISSON: It depends on who says that they aren't necessary and why.

ASSEMBLYMAN LESNIAK: Given the fact that they may or may not be necessary--

DR. SISSON: If it is already in existence, where is the cost, other than what it has been costing all along. There is no new facility needed. It is simply a matter of letting an institution do what it has been doing.

ASSEMBLYMAN LESNIAK: If that is an excess cost or if that could result in a savings of money without a reduction in the level of care to the community or to the region, wouldn't you agree that that would be something that we ought to try to achieve.

DR. SISSON: Absolutely, sir. I do think, if I may make one further point, there is a consideration that the Academy feels is most pertinent to any plan for regionalization and that is contact between the mother and family and child. If a child is transported a considerable distance and the family is unable to keep in contact with the infant for the number of weeks or months or days in which it is at a transport hospital, this is deleterious to the welfare of the child. It has been amply shown that this bonding between the mother and the infant is extremely necessary and this must occur in the neonatal period. So, this excessive use of transport, separating mother, father and infant, has to be weighed against the damage that this can do. Obviously, some children must be transported whether or not this is going to upset the bonding process. Again, this consideration has not received all the attention it might have.

ASSEMBLYMAN OTLOWSKI: Assemblyman Bassano?

ASSEMBLYMAN BASSANO: No questions.

ASSEMBLYMAN OTLOWSKI: Assemblyman Markert?

ASSEMBLYMAN MARKERT: Thank you, Mr. Chairman. First, I apologize for being a little late. I had a meeting prior to this one. Doctor Sisson, you brought up, through a prior question, the fact that there was no cost factors that were able to be developed in either the case of eliminating the services or in retaining the type of services and, also, you stated that there would be no way that you could put a cost or a price on that type of bond that would be needed between the newborn or the family or the mother. Have there been any savings, with reference to services, that have been created through the hospital associations and the profession itself, on its own, over the past years, in any way? Have you addressed that?

DR. SISSON: We feel so. Again, personally, I do not have the figures. In my previous answer, I meant to say, if I didn't make it clear, that I had not seen the cost figures, which I'm sure that the Department of Health has accumulated and, perhaps, it is still doing so. The Academy and the profession as a whole has been deeply conscious of the need for savings and the proliferation of unnecessary high level nurseries is, of course, foolish. Duplication of effort and duplication of costs is hardly, in today's times, useful for the patient or the profession. However, the change in the practice of neonatology is so rapid, the accumulation of knowledge and expertise among trained neonatologists, the newer technologies that come up every few months, have made a number of institutions automatically upgrading their own efforts at relatively little cost because of the increased training. I would submit that neonatology has, in a decade, progressed so rapidly

that it is almost unrecognizable from what it was ten years ago. Even five years ago, we were offering an entirely different technology and level of care, in general. So, I think it is very difficult to go back five years and say what we knew then is applicable today, in the realm of cost.

ASSEMBLYMAN MARKERT: I have one further question along that line and then I would also like to ask the Commissioner something.

ASSEMBLYMAN OTLOWSKI: We're not asking the Commissioner anything at this point until she is called. We're addressing ourselves to the Doctor at the moment.

ASSEMBLYMAN MARKERT: Then, let me just go on with one other question along the same line, if I may. If we were to uproot or remove from a particular hospital a certain level of care and move that level of care to another hospital, is there much in equipment and services that you feel we might be able to realize in a cost saving?

DR. SISSON: It is difficult for me to answer, Mr. Markert, because each hospital, today, may have a level of technology of which I am unaware and simply transferring effort from one hospital to another may leave a whole bench of equipment and a lot of people who know how to use it with nothing to do. So, simply transferring the load to another hospital who is going to have to buy more equipment.

ASSEMBLYMAN MARKERT: I almost hear you saying that it would probably be, possibly, more costly to transfer the services to another hospital than to leave them where they are.

DR. SISSON: In some instances, sir, it may be, particularly if new beds have to be added to accept a load.

ASSEMBLYMAN MARKERT: So, maybe were not involving a cost factor saving in regionalization in this situation?

DR. SISSON: To some degree, in some areas, it may work against the aim of the plan. I cannot say that statewide it would do so. That would be foolish on my part.

ASSEMBLYMAN MARKERT: Thank you very much, Doctor. Thank you, Mr. Chairman. That's all.

ASSEMBLYMAN OTLOWSKI: Doctor, is there anything you want to say in summary?

DR. SISSON: No, sir. I think my first statement really summarizes the position of the Academy which I am here to represent. Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very much, Doctor. Dr. Finley, are you ready? Doctor, I hope you're not going to read this whole thing. Can you summarize what you have in this. Your statement will be part of the record anyhow. I think we will be better off and, as a matter of fact, you probably could even home in on the subject if you did it extemporaneously and merely used your prepared statement for notes.

DOCTOR JOANNE FINLEY: Okay. I expected you, Mr. Otlowski, to ask for that. I think, first, which is not in my prepared testimony, I have to express some puzzlement at Dr. Sisson's statement because I have with me the letter from the Academy of Pediatrics. Its chairman was a member of the committee that did struggle with the recommendations to the State Health Coordinating Council

and one of the things that Dr. DiSpirito, for the Academy, was critical of, which I can read, was the fact that there were any level 1's in place. In other words, the implication that I get is that the Academy felt that they all should be closed. So, that puzzles me in terms of some of the answers that you got if he is trying to express the official position. In Dr. DiSpirito's letter, he says that they oppose the establishment of level 1 hospitals, when the original plan and standards of neonatal care of the American Academy of Pediatrics proposes phasing out such hospitals and I'm quoting from his letter of the Academy's opposition. So, there is some--

ASSEMBLYMAN LESNIAK: Can we have a copy of that letter for the record?

ASSEMBLYMAN OTLOWSKI: Just a moment please. Assemblyman Lesniak is recognized. Assemblyman, what did you want?

ASSEMBLYMAN LESNIAK: I would like to have the letter that the Commissioner is referring to from the Academy.

ASSEMBLYMAN OTLOWSKI: May we have a copy of that letter so that it is a part of the record and made available to Assemblyman Lesniak particularly?

DOCTOR FINLEY: Yes. Secondly--and a lot of this is in my prepared testimony--the goals of a regionalization plan are exactly the goals that the Academy of Pediatrics representative described except that they are intended to produce this kind of system for New Jersey. In other words, we do not have any designated, regional perinatal centers or level 3's because they are not designated, they cannot be fully reimbursed for these very expensive services and so forth. So, one of the goals is to provide--the major goal is to provide New Jersey with a system.

Again, in the first part of my testimony, I have my own concerns for quality and the fact that I think we should be tired in New Jersey of being a farm system for Pennsylvania and New York hospitals, although many of our doctors have had to send their very sick mothers and babies there. So, the Committee on Perinatal Health, which was sponsored by the National Foundation-March of Dimes and included the American Academy of Pediatrics among its conferees, is that which set the standards for levels, for kind of staffing and so forth and the plan that we are trying to follow in New Jersey. So, we feel that we have faithfully followed the process--we being the process. As I say, most plan has actually reached the Health Department. No recommendations have reached me. Therefore, I am not even in a position to tell you how I would react to recommendations.

ASSEMBLYMAN OTLOWSKI: Doctor, let me just make this recommendation to just make it easy for everyone. I would like to suggest that rather than being concerned with rebuttals at this moment, that you speak to your statement extemporaneously to give us an idea of your approach to this and I suppose we would get that from your statement. Now, if we can get that extemporaneously, if you could give that to us in about six minutes, I think you would be of great help to us.

DOCTOR FINLEY: Well, first, let me define regionalization, especially as it refers to perinatal, which is what you're interested in talking about. The definition comes from this National Committee on Perinatal Health. It is not a New Jersey invention. It is defined the development within a geographic area of a coordinated, cooperative system of health delivery in which, by mutual agreement between providers and based upon population needs, the degree of complexity of services that each facility is capable of providing is identified so as to accomplish the following objectives: highest quality of care; maximum utilization of scarce, highly trained professionals and equipment; and assurance of reasonable cost effectiveness.

Of course, to build this kind of system for New Jersey, it does take planning and designation. Also, it is true that the State process for planning, which, again, as I stress, is not my process, but the process established under federal law. This state is presently in compliance. Millions and millions of dollars in federal funds ride on that compliance and the process is many bodies that make recommendations, can appeal, have veto power over the Health Department and so forth. It is the citizens' process, not the Health Department, per se. But, there is a federal guideline which does require the regionalization of perinatal services amongst others and this is what, since long before I became Commissioner, the planning process has been trying to live up to and various professional societies have always been represented.

There are a lot reasons, both in terms of quality and, yes, Assemblyman Lesniak, in terms of cost effectiveness, that lie behind these national recommendations for regionalization. I do refer, in my testimony, to the study of 8 programs in the country that our own Robert Wood Johnson Foundation is carrying on, which shows a dramatic reduction, when you do regionalize, in maternal mortality, in infant deaths, and in the quality of life of the infants who do get the intensive care when they are born at high risk and I think that is very important too. You can save a lot but still have a very impaired child which can be very costly to society and certainly very emotionally wearing on a family. So, we're just as interested in the quality of the outcome of the sick babies that are saved.

I think, now, I would rather just answer questions about what the various levels, as they are adapted to New Jersey, have to do, about their quality and what they have to do and how they have to be staffed and how they have to be equipped from level 1 on up. That is spelled out in the testimony and it does, again, follow these national guides, which I said professional societies, including pediatricians and obstetricians, developed. They are not New Jersey's invention.

ASSEMBLYMAN OTLOWSKI: Doctor, if you feel that you have developed the subject sufficiently and if you feel that it can be better developed by questions, let's just begin, then, with this question. Are you satisfied to do it that way or do you want to continue.

DOCTOR FINLEY: Well, I certainly would be happy to do it in relation to questions. I do have, in the text, answers with graphs for two of the most specific kinds of questions you keep asking, which I think you should ask. One is the quality relationship of the marginal services and the other is the cost.

ASSEMBLYMAN OTLOWSKI: Let's go into the questioning and then you probably will have an opportunity to develop the subject matter further. In any event, you hear Dr. Sisson point out that these present state guidelines exceeded the federal guidelines and, as a matter of fact, far exceeded them. You keep referring to the fact that you are confirming and elaborating upon the state guidelines. In view of that statement, how do you reconcile the differences?

DOCTOR FINLEY: I can't because he did not point out any specific differences and I do not know of any specific differences where they exceed the guidelines, for example, of the Committee on Perinatal Health, which the federal government adapted and the American College of Obstetrics and Gynecology which are the guidelines by which hospitals get accredited for residency training and so forth. So, unless he would be specific, I can't answer because I don't feel that they are excessive.

ASSEMBLYMAN OTLOWSKI: In any event, you feel that you are conforming to the federal guidelines, that you haven't exceeded the federal guidelines. Is that what you're saying?

DOCTOR FINLEY: The federal guidelines, first of all, require that we submit a regionalization process and that we implement it, and if we fail to do that--

ASSEMBLYMAN OTLOWSKI: Aren't the federal guidelines really broad? Don't they merely outline the concept and the details are left, really, to the individual areas and regions and to the states?

DOCTOR FINLEY: No. They include numbers of deliveries for various levels for what is called an efficient and effective service. They include numbers of intensive care beds per thousand live births. Those are in the federal guidelines.

ASSEMBLYMAN OTLOWSKI: Doctor, where, at the present time, under the federal guidelines, is this system working, in what state?

DOCTOR FINLEY: The whole State of Arizona, for example. I'm now pulling out the studies which Robert Wood Johnson is doing, which were all processes that began before the federal guidelines. In Los Angeles County, in all of the metropolitan areas, Cleveland Ohio. I can't remember. There are eight places that are being studied.

ASSEMBLYMAN OTLOWSKI: All right, you gave three. You gave Arizona, you gave Cleveland, Ohio and you gave Los Angeles in California, Los Angeles County. On the basis of your knowledge, what is the infant mortality rate in those areas, as compared to New Jersey, without the system?

DOCTOR FINLEY: What you have to do is look at trends. In Arizona, which is cited in our state health plan, they cut in half their infant mortality in four years of regionalization, for example. The exact figures, I can supply you with by going back and looking at the Robert Wood Johnson studies.

ASSEMBLYMAN OTLOWSKI: But, generally, you have said that they've been cut in half?

DOCTOR FINLEY: Yes.

ASSEMBLYMAN OTLOWSKI: But, I've asked you for a comparison to New Jersey. The infant mortality in New Jersey, as I understand it, is pretty low, isn't it, in comparison to other states?

DOCTOR FINLEY: It has been declining, but it has not been a dramatic decline like the places where you have had a regionalization plan working. As I said also, it isn't just death figures that you have to look at. You have to do a long-range study of the condition of the babies who are saved. That's the most important thing because saving a life that is deformed or brain damaged or is going to be a perpetually sorrowful, poor-quality life is really the most important issue and, again, I can supply you from the Robert Wood Johnson study, I think we brought enough copies of the report to hand them to you now. They do quote from some of the areas where they are studying the regionalization and their study is still going on. They also quote the dramatic improvement in the quality of the lives of the infants saved and that's the most important part.

ASSEMBLYMAN OTLOWSKI: Doctor, in a state as small as New Jersey, when compared to the size of say Arizona or California or even Ohio, in New Jersey they have developed a pretty good system of general hospitals and in most instances, the general hospitals have their own obstetrics. In those instances, are you ready to say that you would close those down and just concentrate on level 2 and 3 and

you would close these people out who, over the years, have developed a pretty good system and who, if Doctor Sisson is correct in his testimony, has indicated that hospitals, as a result of the rapid knowledge that has been made available in this area that we're concerned with, that hospitals have been trying to keep abreast of that knowledge, would you close them down, notwithstanding the fact that you have a pretty highly sophisticated system of hospitals in New Jersey?

DOCTOR FINLEY: Well, the reason that I read earlier from Dr. DiSpirito's letter is that the New Jersey State plan is a compromise. It does not propose to close down all level 1's. There are three criteria for keeping and designating many, many hospitals as level 1's. One is geographic isolation. There, we have the Bridgetons and the Hunterdons and Warren County and Salem County. We have a number of places where that, in and of itself, where, again, the number of deliveries is not the only thing that you would look at, but you would have to look at the need of people to be able to get there. So, geographic isolation is a condition for keeping one open.

Another is the concept of medical necessity which means, if you are in an area that has, by our own statistics, a lot of high risk births, you need more hospitals and more beds. So, there are a lot of reasons that we keep most level 1's that we would designate.

ASSEMBLYMAN OTLOWSKI: But, I understand that in hospitals that have less than 500 deliveries, there would be immediate closings under your plan, is that so?

DOCTOR FINLEY: First of all, there would no immediate closings of anything. Second of all, these would be whatever the HSA's recommend. Whatever the State Health Coordinating Council approves then will have to be dealt with. But, there is no such thing as closing anything. Somebody on the staff will have to tell me how many level 1's--which some of the professional organizations have been disapproving of--have been recommend, so far, by the HSA's to stay open. Now, there are some, there are a few, actually only five, in terms of the number of deliveries, in urban areas where there are other hospitals nearby that I believe the HSA plans to eventually phase out and I can give you both the quality and the cost reasons for this.

ASSEMBLYMAN OTLOWSKI: Assemblyman Mays?

ASSEMBLYMAN MAYS: In Bayonne Hospital, that's one hospital, they would either have to go to the Medical Center or to Staten Island. Am I right?

DOCTOR FINLEY: No. You have three others very, very nearby. There are three nearby Hudson County hospitals with obstetrical services, besides the Medical Center, that I believes the HSA's plan recommends a designation for.

ASSEMBLYMAN MAYS: What others are nearby?

DOCTOR FINLEY: Christ, St. Mary's and Riverside.

ASSEMBLYMAN MAYS: Christ Hospital is further than the Medical Center and Riverside is way further than the Medical Center. What was the other one?

DOCTOR FINLEY: I don't have the HSA's plan in front of me, but as I remember, the Medical Center is recommended for 2A, in other words, it would have intensive care. Again, these are the HSA's recommendations. The State Health Coordinating Council, as you noted earlier, has not acted on any of the HSA's recommendations. There isn't any set of recommendations before me yet, but my recall is that the HSA recommended and the State Health Coordinating Council review committee, I believe, approved their recommendations.

ASSEMBLYMAN MAYS: If I followed you right, out of these five hospitals that you named, the reason why they are being closed is because they have less than 500 births and it is a saving of money, not health, for the parent or the child?

DOCTOR FINLEY: If you will refer to the testimony that I have given to the members of the committee, there are two bar graphs which show you, they give you the quality in terms of maternal mortality for hospitals with under 500 deliveries and as you will see, those are the hospitals with the highest mortality rate. My staff is presently completing its study on something, fetal death rate, which I don't have before you, but it shows--fetal means that it should have been born alive or was born alive and died immediately. In other words, this is the still birth area. It doesn't refer to the prematures or the others that lived. It refers to proper weight babies and so forth that, really, any obstetrician or pediatrician would tell you should live and the death rate in hospitals with deliveries under 500 in New Jersey is twice, the fetal death rate is twice that of all other hospitals that deliver babies.

ASSEMBLYMAN OTLOWSKI: Of all other hospitals, where? In the country?

DOCTOR FINLEY: No, in New Jersey.

ASSEMBLYMAN MAYS: Figure 1, what dates does that go from? From 1970 to what?

DOCTOR FINLEY: Figure 1 will probably not interest you because it is from Michigan. Figure 2 is New Jersey and these are 1978 figures. Now, I think, since you are asking about the smaller hospitals in areas in which there are other qualified hospitals to perform all of the levels of service, I would like to talk to you about the cost.

ASSEMBLYMAN OTLOWSKI: Just a moment. Let's say, with the Bayonne Hospital, on the basis of the Bayonne Hospital, is it correct that they have less than 500 births a year? Is that correct?

ASSEMBLYMAN MAYS: I can tell you. From 1973, they've 783 births. Then, as of to date, they have had 483 births.

DOCTOR FINLEY: So, as you see, it has been decreasing steadily ever since.

ASSEMBLYMAN MAYS: But, as far as the records go back--I went back to 1973--neither the mother nor child died, there was no infection, nothing. So, why is Bayonne Hospital--

DOCTOR FINLEY: Well, you are incorrectly informed.

ASSEMBLYMAN MAYS: Will you please give me those figures, then, Ma'am?

DOCTOR FINLEY: I have discussed with the Attorney General whether there were any legal impediments to giving you specific data from an institution and I am advised by him that until he reviews this matter I cannot give you specific data from an institution.

ASSEMBLYMAN OTLOWSKI: Excuse me, Doctor, because now you are getting into deep water.

DOCTOR FINLEY: I don't want you to get into deep water either.

ASSEMBLYMAN OTLOWSKI: As a matter of fact, I want to throw you a life preserver. But, in any event, what you have here, under the rules that you have, you say that you would close all hospitals for delivery that have less than 500 deliveries. Isn't that a fact? Isn't that part of your plan? That's part of your plan, if I understand it correctly.

DOCTOR FINLEY: No. I said that the plan comes up from the HSA and they may waive certain elements of the regulations if there is a geographic isolation issue or if there is a medical necessity issue. Now, it is true that the regulations, which are different from the plan and which are adopted by the Health Care Administration Board, which also can refuse to adopt--I believe the Vice-Chairman of the HCAB is here today to explain what their process is--the regulations do require that any hospital that consistently has less than 500 births should plan to phase out.

ASSEMBLYMAN OTLOWSKI: Are you saying that that would be a matter of discretion, then, whether that hospital would be closed under the regulations, that that would be a matter of discretion? Who would have the authority to close that hospital, if they didn't have the 500 deliveries? Who would have the authority to close that hospital, under the regulations, you, a board?

DOCTOR FINLEY: The regulations would give the Commissioner that authority, but there would be an appeal right to the Health Care Administration Board and through the courts.

ASSEMBLYMAN OTLOWSKI: Well, the normal appeal rights that exist are using the courts.

DOCTOR FINLEY: Right.

ASSEMBLYMAN OTLOWSKI: But, the Commissioner, then, would have the right to close the hospital for that service.

DOCTOR FINLEY: Well, you show cause against regulations. Certainly, I would want the quality data to be there because we would then have it and can develop it. You can't close anything. You are familiar with the nursing home process. They can violate standards all over the place, but you have to have a hearing, due process, they can have an appeal and so forth and so on. So, I think we're well supplied, and we should be, with due process in this state.

ASSEMBLYMAN OTLOWSKI: I think, Commissioner, just for a moment, I think what has upset a number of members in the Legislature and probably has upset a number of people whose hospitals in their particular districts have come under a cloud because of the statement that you allegedly made in which you said that some of these hospitals should be closed and if you were to reveal some of the situations, there would probably be criminal charges. Was there a statement like that made by you, at any time?

DOCTOR FINLEY: No.

ASSEMBLYMAN MAYS: Can I ask a question?

ASSEMBLYMAN OTLOWSKI: Well, let me just stay on this subject because I think this is what is a source of contention here and a sore spot here. In any event, Commissioner, of course, I don't expect you to reveal any of the names of the hospitals or any of the details that you say that you are aware of, on the advice of the Attorney General. I expect you to adhere to the advice of the Attorney General. But, I think what seems to be one of the problems here, and maybe it is best to air it at this moment, was the fact that there was a great disturbance by many of the hospitals and, as a result of that, the flack, of course, reached the Assembly and legislative members who are representing hospitals that felt that they came under that cloud. Now, is there anything you want to say about that to clear up that position?

DOCTOR FINLEY: So far, in the recommendations that are yet to be discussed by the State Health Coordinating Council there are five urban facilities delivering less than 600 babies that are recommended for closure eventually, because

of quality reasons, because of lack of need for them and because of cost reasons.

ASSEMBLYMAN OTLOWSKI: Let me ask you this question in that connection.

DOCTOR FINLEY: That is five out of 74 hospitals in New Jersey.

ASSEMBLYMAN OTLOWSKI: Let me ask you this question, then. On the basis of what you just said, those hospitals and what you are saying about their very nature, would their closing come about by the implementation of these regulations or should they be closed on general principle?

DOCTOR FINLEY: They are part of the planning process as far as the HSA's and the State Health Coordinating Council are concerned. I would say, basically, for need and cost effectiveness reasons and so that we can have our level 3's-- we will get into a situation where the dollars won't be for our level 3's if we keep deficit ridden services going. As far as the quality issues, since I presently do not have licensure standards because we have not, heretofore, had levels or requirements, I would not be able to close something for quality reasons until we have licensure standards.

ASSEMBLYMAN OTLOWSKI: Doctor, something immediately occurs to me. Let's assume, you know, that what you are saying, there is some basic truth in the nature and operation of those hospitals for this particular service. Wouldn't it be common sense to upgrade those services with the authority that you have so that those services could be continued and could be upgraded rather than closing them out?

DOCTOR FINLEY: If we were talking about any one of the counties I named where the hospital is the single hospital that is there or if we were talking about an underbedded area with a lot of high risk pregnancies, you would be absolutely right and that is part of what the regionalization plan is all about. We're talking about 5 out of 74 in densely supplied, urban areas and I would like to read why planning considers that necessary. I probably can't find it. So, I will have to remember it out of my head. Developed in another state, Massachusetts, and I tried to adapt them to New Jersey, let us consider what makes an obstetrical service break even. First of all, just in terms of what you absolutely have to have to be capable, you have a cost for just the obstetrical services of between \$800,000 and \$900,000 per year or almost \$1 million. Now, if the per diem rate is only \$192, and most of our per diems are higher than that in New Jersey now, you happen to have to generate 1,200 admissions a year in order to break even. If you have under 600 or under 500, the service loses between \$300,000 and \$400,000 a year. Now, the question is, if you want to upgrade and have level 3's and you want to upgrade and have level 2's in an area where, again, it has been recommended to designate certain institutions that way so that we can have upgraded care, where are you going to get the money from? Are you going to ask the subscribers, Blue Cross, the Medicaid program? All of these pay rates. To pick up that \$400,000 deficit for those less than one baby a day delivered in those marginal hospitals and also to pick up the tab for the millions and millions it costs to upgrade so that you can have level 2's and level 3's, that is the basic planning question. Then, there is a quality issue also. I think there has been wisdom to the recommendations of the HSA's and the State Health Coordinating Council.

ASSEMBLYMAN MAYS: You read a statement from one of the doctors that disagreed with you, Dr. DiSpirito.

DOCTOR FINLEY: On level 1?

ASSEMBLYMAN MAYS: Yes, level 1, did you read that?

DOCTOR FINLEY: Do you wish me to read it again?

ASSEMBLYMAN MAYS: Yes, ma'am.

DOCTOR FINLEY: This is a letter, criticizing or opposing the present plan, from the current President of the New Jersey Chapter of the American Academy of Pediatrics. This is not the only thing they oppose. There are other things, as you will see, that they oppose. But, Point 2 in his letter says, "We oppose the establishment of level 1 hospitals when the original plan and the standards of neonatal care of the American Academy of Pediatrics proposed phasing out such hospitals."

ASSEMBLYMAN MAYS: How did you get the statistics from these hospitals? Did they give them to you?

DOCTOR FINLEY: There is something in New Jersey called the Maternity Reporting System. It is voluntary.

ASSEMBLYMAN MAYS: So, you went to the Attorney General. I went to Bayonne Hospital. They gave me their records and opened up to me and you say that you have to go to the Attorney General.

DOCTOR FINLEY: I only asked him if there were any legal impediments to giving the data of an institution by name. He is reviewing it. He may tell me that there are no legal impediments and then I will be able to give you that information. But, I felt I needed to ask him because it seems to me that this is an ethical problem, a possible liability problem and I don't wish to cause that kind of harm.

ASSEMBLYMAN MAYS: Isn't it possible and likely that the hospitals, maybe a couple of them, who produce only 600 babies a year give better service than the 74 in the State of New Jersey?

DOCTOR FINLEY: I don't think that is what my figures show.

ASSEMBLYMAN MAYS: None of them show that they give better service?

DOCTOR FINLEY: I don't think that that is what the graph that you have in front of you shows or, as I say, the twice as many fetal deaths and I think you really do have to inquire--and I commend some of you for really asking the questions--about the cost effectiveness also because we're talking about trying to upgrade the whole system in New Jersey and I'm asking you, where is the money going to come from. Should we be paying that \$400,000 a year, which includes the Medicaid program. In New Jersey, if you are a DRG hospital, it includes the Medicare program. It includes Blue Cross. They're all paying the rates. They're all paying for the losses of a service that doesn't have enough patients to bring in the revenue to keep it going without a deficit and that takes money away from being able to pay for the upgraded services in the designated hospitals.

ASSEMBLYMAN MAYS: If you regionalize all these hospitals, would you get more money from the federal government?

DOCTOR FINLEY: If we don't follow that which we promised the federal government to be in compliance with, follow the state plan, we would lose a great deal of money.

ASSEMBLYMAN MAYS: That's not the question. If you regionalize, do you get more money?

DOCTOR FINLEY: I don't think the upcoming federal government is going to be giving out very much money at all.

ASSEMBLYMAN SNEDEKER: I think that is supposing by you Commissioner. No one knows, at this point, what the new Administration is going to do.

ASSEMBLYMAN OTLOWSKI: I would suggest that we don't have political speculation as part of the testimony. Assemblyman Lesniak?

ASSEMBLYMAN LESNIAK: Thank you, Mr. Chairman. Commissioner, I'm still waiting for an answer to Chairman Otlowski's question in reference to the maternal mortality rate in New Jersey compared to other states. Can you give a succinct, three or four word answer to that question or do you have that answer?

DOCTOR FINLEY: The goal in the state health plan--

ASSEMBLYMAN LESNIAK: Let's not get into the goal. I have a very simple question. I understand the goal and I understand that you haven't reached it. My question is, in comparison to other states in the urban Northeast, how would you rate New Jersey.

DOCTOR FINLEY: We have cities or metropolitan areas where our maternal death rate, but particularly, again, infant, neonatal and fetal death rates, are worse and you can pick them out: Newark, Camden, the New Brunswick area and so forth, places where we propose putting level 3 centers. I can't give you exact comparisons with other states without going and looking it up. But, I can try to supply you with that.

ASSEMBLYMAN LESNIAK: I have great concern regarding the fact that this controversy regarding the mortality data came out on November 23--today is December 8. I can tell you right now that that is public information and there ought to be and probably will be 80 bills introduced if the Attorney General were to say that it isn't and it certainly is. We've had two weeks. I certainly think you are really remiss in not getting an opinion from the Attorney General regarding the revelation of that information.

I have a couple of questions on your figure 2 charts because they are averages, are they not?

DOCTOR FINLEY: They're rates. In other words, it is per thousand births.

ASSEMBLYMAN LESNIAK: But, they are averages of all the hospitals that fit into that category?

DOCTOR FINLEY: All of the hospitals with under 500 deliveries are aggregated to get a rate, yes.

ASSEMBLYMAN LESNIAK: Do you know what the standard deviation would be for this chart? In other words, if one hospital was really a bad hospital in terms of this service and was three times higher, it certainly would affect that overall rate. There may be hospitals within this group that are providing better care or excellent care, is that correct? Is that a fair statement to make?

DOCTOR FINLEY: No. I can't agree with that. I think if we're going to talk statistics, if this week something is okay, but in general, for all kinds of understandable reasons--

ASSEMBLYMAN LESNIAK: Not all kinds of understandable reasons. In terms of maternal mortality, that's what the chart depicts?

DOCTOR FINLEY: Yes.

ASSEMBLYMAN LESNIAK: And the chart was designed to convey a certain message.

DOCTOR FINLEY: Right.

ASSEMBLYMAN LESNIAK: My point is that that message is somewhat deceptive unless you understand the fact that there could be a standard deviation that is very great in this chart and within that group, there may be hospitals that are unfairly maligned by being placed in that group, which can be providing a very high level of care and may have a maternal mortality ratio that is much lower than this average.

DOCTOR FINLEY: I don't believe that the institutions' specific data will agree with that and this is why I am hoping that I am told that I can make that information available.

ASSEMBLYMAN LESNIAK: But, at this stage we don't know and there very well may be institutions that have a much lower mortality rate that fall into this category.

DOCTOR FINLEY: You are correct in terms of any kind of statistical analysis. There can be one in a group of several that is different. But, I think you will find in the case of New Jersey that that is not true.

ASSEMBLYMAN OTLOWSKI: Doctor, I just wanted to ask you to please make available--I'm not asking you to just give this off the top of your head--but just following Assemblyman Lesniak's line of questioning, will you please make available to this Committee and for the record, the infant mortality rate in New Jersey as compared to the Northeast here? I think this Committee would be interested in looking at those figures and comparisons. We want a very simple and straight answer. We just want the mortality rates in the different states in the Northeast and, as a matter of fact, if you feel that you can be of some help to us to include those figures the perinatal causes or the neonatal causes. I think there is a total figure that should tell the story.

ASSEMBLYMAN LESNIAK: Mr. Chairman, I have one more question. Commissioner, sometimes the cure that we apply is worse than the disease. As a physician, I'm sure that you are aware of that. Has thought been given to the fact that by elimination of services in certain hospitals that that may jeopardize their ability to provide other medical services to that community and how that would affect that community?

DOCTOR FINLEY: I think in the case of OB/GYN, I think it would increase the possibilities of being able to offer gynecologic services because they would not be confined to using for using the beds for what is called clean gynecology. If you have a mixed OB/GYN unit, you can only take non-infection or not even subject to infection cases. If you are able to use the beds for gynecology, both medical and surgical, you could even increase the use of those beds.

ASSEMBLYMAN LESNIAK: I'm looking at the other aspect of that question. Obviously, hospitals are taking in X amount of dollars for providing certain services. When they are no longer allowed to provide those services, that is X amount of dollars less that they will be taking in. Could that jeopardize their ability to provide other services to that community?

DOCTOR FINLEY: I think I have tried to answer that question by saying, if I were a hospital that, as many have, decided to close their loser OB services because they had so few patients, I would use the beds for something different that would not be deficit causing. We are talking about hospitals that are running a \$400 or \$500,000 a year deficit. But, now you can use the same beds, probably, for something that makes you revenue.

ASSEMBLYMAN LESNIAK: I understand, but it's not that simple. That is a very simplistic analysis because we know that you may be running a deficit but still be making more money than if you weren't running at all and it may be economically necessary to continue certain services at a deficit because of the fact that it is a less of a deficit than if you were running the hospital without this service.

DOCTOR FINLEY: I am reminded that East Orange General, for exactly these reasons, did close its OB beds to do something about a deficit because it had a very small number of deliveries and it did turn the beds into gynecologic, both medical and surgical, services and it has now clear up its deficit as a result of that change. So, we can show you that example.

ASSEMBLYMAN LESNIAK: My question was, though, has thought been given to the fact that this could jeopardize a hospital's ability to provide other services in specific instances? I mean, that worked there, but it may not work elsewhere.

DOCTOR FINLEY: I can't imagine, having some experience in running a large public hospital, I can't imagine that getting rid of a loser could cost you money. I'm saying, it helps you make money.

ASSEMBLYMAN LESNIAK: Well, it can happen, Doctor, and I think it must be considered and it concerns me that it hasn't been considered.

ASSEMBLYMAN OTLOWSKI: Assemblyman Lesniak, could you save that question too because I want to develop that question with the New Jersey Hospital Association. I think that that question ought to be pursued further with them when we get them to testify. Assemblyman Visotcky?

ASSEMBLYMAN VISOTCKY: Commissioner, this bill, 2252, that was passed by the Assembly and Senate, do you agree with the bill?

DOCTOR FINLEY: No. I have very serious concerns about it, its constitutionality, because of its conflict with Chapter 83 and the damage it will do to our compliance with the federal requirements and so forth.

ASSEMBLYMAN VISOTCKY: Well, we know this bill can lay on the Governor's desk for a year. So, really, if the Governor don't sign it, it is nothing. You have 90 days in the SHCC Committee before you implement?

DOCTOR FINLEY: 90 days before they make any recommendations to the SHCC.

ASSEMBLYMAN VISOTCKY: Is there any room--and I'm saying this trying to compromise something here so everyone can get together--is there any room with yourself and the hospital association or these particular hospitals in general to sit down and say--and Mr. Lesniak brought a very good point that the mortality rate may be lower in this one particular hospital in the region and maybe making them do it on a voluntary basis, maybe these stats should be shown to the hospital itself and say that they don't have this, this and that before you worry about the Attorney General, before you worry about the Legislature. Everybody is going to be spinning their wheels around here and nobody is going to accomplish anything. I think we have 90 days of real constructive work here.

DOCTOR FINLEY: I think that when the State Health Coordinating Council passed the motion to defer presenting any recommendations to the whole State Health Coordinating Council that that was their plan. Also, I believe that Jerry Riley, who is the Chairman of the Committee of the SHCC--and I'm not a member of that committee incidentally--is here to explain the issues that he intends to take up, which might be some changes in the plan and so forth. That is his committee with a number of New Jersey citizens on it and they plan, I believe, to go ahead and hold hearings

or hold a meeting and talk about several issues of just this nature that you recommend.

ASSEMBLYMAN VISOTCKY: But, some of these things, when you're talking about a hospital--I realize that you want to bring it out in committee and I realize that the Attorney General said this and that. Fine, that's all great. But, I think, again, it behooves you, as the Commissioner, to get to some of these hospitals and say, "Look, here's the stats. What are you doing about this?" They should know about this. There shouldn't be a cloud over all 74 hospitals in New Jersey or these five hospitals or the 21 hospitals. There shouldn't be a cloud over any of them. You say, "Look, we've got a problem here." Shape up or ship out, in other words. I think we're playing games with this thing saying, "Fine, you're not going to do it. I want to be stubborn; you want to be stubborn." We're fighting a losing battle here and the people are getting upset about it.

DOCTOR FINLEY: Privately, in a diplomatic way, together with the Committee on Maternal Mortality of the Medical Society, for example, they do exactly this. They do. They actually review the charts of deaths and sit down with people from the Health Department. The issue was whether to make the data public and, for example, emblazoned in the newspapers. The hospitals are made aware of the fact that there is a voluntary process that goes on with the State Medical Society. That happens all the time.

ASSEMBLYMAN OTLOWSKI: But, the point that Assemblyman Visotcky is making is very, very important. I think that what he is trying to tell you, Doctor, is the fact that before you went public, before you went to the Attorney General, if you sat down with some of the people involved here to try to work out some of the things that he is talking about, I think we wouldn't be where we are now where we are in a pretty heated temperature from the reaction that all of us are getting from the Hospital Association, from hospitals, from doctors and from the mayors in the different towns. I don't think we would have been in that position. So, I think that this is what the Assemblyman is trying to develop here.

ASSEMBLYMAN VISOTCKY: By and far, I don't think there is any person in this room or any person in the State of New Jersey that would say, "That hospital has a real high mortality rate, but keep it open anyway because it serves my mayor or serves my councilman."

DOCTOR FINLEY: That's what you are doing.

ASSEMBLYMAN VISOTCKY: We're not doing that, Commissioner. I beg to differ with you. I voted no on this bill, but I had feelings for it. You can make me change my mind right now. The point is that I think you should have had hearings on this and I think this Committee as a whole and maybe the Senate should have extensive hearings on this. Let the people know the facts. What are we here for, to keep everybody in a back room? We want to tell the people the truth and that is the only way we're going to accomplish this. We're not going to accomplish this with secret meetings and saying, "Don't give the stats out for this and don't give the stats out for that." Tell the people. Let the world know.

ASSEMBLYMAN OTLOWSKI: Assemblyman Visotcky, are you finished?

ASSEMBLYMAN VISOTCKY: Yes.

ASSEMBLYMAN OTLOWSKI: Assemblyman Mays?

ASSEMBLYMAN MAYS: Are these the only five hospitals that are in danger of being closed?

DOCTOR FINLEY: So far as I know, the plans from the HSA's, which

now would not even be presented to the State Health Coordinating Council for 90 more days, recommend only the eventual phasing out of those five hospitals.

ASSEMBLYMAN MAYS: And the reason is why?

DOCTOR FINLEY: The reason is the number of deliveries, which is non-waiverable in the regulations, the lack of any reason to ask to waive because there is no medical necessity, in terms of the areas and the availability and so forth and no geographic isolation and cost.

ASSEMBLYMAN MAYS: Well, you know, talking to Bayonne Hospital, they disagree with you 100%. I don't know whether you have ever been to Bayonne Hospital, but they disagree with you 100%, and they had 783 and now it is down to 483, to date.

DOCTOR FINLEY: And, it was decreasing every year.

ASSEMBLYMAN MAYS: Well, births are decreasing every year right along. So, you cannot say. As women's lib goes down and contraception comes down, so will the births come down. How many people would they serve in the hospital besides that?

DOCTOR FINLEY: Well, I certainly know that they are losing money on the service because we recently financed them with some difficulty because they got a pretty poor bond rating because of the money that they are losing.

ASSEMBLYMAN MAYS: But, they are also serving people not having births, right?

DOCTOR FINLEY: I'm sorry. I don't understand the question. This is the plan that came up from the citizens in your area. It hasn't been approved, but I would think that the SHCC probably would approve it.

ASSEMBLYMAN OTLOWSKI: Commissioner, Assemblyman Mays is under the impression that you are suggesting the closing of the entire hospital or just the maternity section?

ASSEMBLYMAN MAYS: Well, it leads into another section too.

ASSEMBLYMAN OTLOWSKI: I don't think the Commissioner is saying that.

DOCTOR FINLEY: The plan that came up from the regional planning body to the perinatal designation committee--it was between those two practices--as I remember it, recommended that the use of those beds for OB, at that particular hospital, be phased out. That doesn't say that they can't use the beds for something else. It doesn't talk about any other part of the hospital. This is only dealing with the regionalization of the improvement in quality and the providing of our state, at long last, some regional perinatal centers which we also have to find a way to pay for. Now, you can do Newark Beth Israel and St. Josephs and the medical school and something in Camden. You can't do that unless you find the money in the system to pay for those level 3's and I don't know what people want. Do they want to keep marginal, deficit ridden, small services that aren't needed open nor do they want level threes in this State. You can't have both.

ASSEMBLYMAN MAYS: Do you have a breakdown of these five hospitals, how much money each one is losing?

DOCTOR FINLEY: I can get it.

ASSEMBLYMAN MAYS: You should have it here, shouldn't you?

DOCTOR FINLEY: Unless they are DRG. We will have to get that out of the system, but we will try to put it together for you. I can't do it for yours because they had to do a financial feasibility study to get bonded by the Authority for their expansion and they had to do a loss by departments. With some of the other hospitals, we will have to--

ASSEMBLYMAN OTLOWSKI: But, those figures will be available?

DOCTOR FINLEY: We will try.

ASSEMBLYMAN OTLOWSKI: Those five hospitals, will you make them available to the Committee, please?

ASSEMBLYMAN MAYS: I have one last question. Will you give me your reason again why you are against 2252?

DOCTOR FINLEY: It so subverts everything that is in Chapter 83, which this Legislature passed, from planning for quality to planning for cost containment and it so subverts, so ties the Department's and my hands from carrying out a wider law that, as I said, I wonder about its constitutionality.

Secondly, it puts us in enormous jeopardy in terms of compliance with the federal government and the millions and millions of dollars riding on that compliance, including money that goes to our hospitals.

ASSEMBLYMAN MAYS: Have you received one complaint from the citizens of Bayonne about the maternity section of Bayonne Hospital or any one of these hospitals being bad? This is from the citizens now that live there, pay their taxes, want their child born where they live at. Don't you think that plays a part too?

DOCTOR FINLEY: What is the logical conclusion? I think, again, I would like to know and I think that the statesmanlike goal that you have is, what do you want for New Jersey? Do you want us to have a regionalized system? Do you want us to have regional perinatal centers that can take this very sophisticated care of our sick mothers and our sick babies or don't you? Do you want an upgraded system or don't you? If you want it, which I believe you do, how do you propose to get it in terms of the application of resources, of dollars, of Medicaid dollars and Medicare dollars and Blue Cross dollars to get it?

ASSEMBLYMAN MAYS: So, you are interested in money more than health and care?

DOCTOR FINLEY: No. I am interested in a quality system in New Jersey. I'm interested in everything that the national organization wanted. I am interested in getting something for New Jersey where we have had to send our babies and mothers to New York and Philadelphia for this care and I would like to see that end.

ASSEMBLYMAN MAYS: And the people we represent, our taxpayers who we represent in our districts--Bayonne is in my district--say they want this hospital and they're supposed to overlook this. Am I right?

DOCTOR FINLEY: Do you also want the Jersey City Medical Center to be a 2A? You can't do both.

ASSEMBLYMAN MAYS: Jersey City Medical Center doesn't only serve Bayonne. It serves a lot of people in Hudson County.

DOCTOR FINLEY: But, in terms of allocating resources, it is going to take a couple of million more to upgrade the medical center.

ASSEMBLYMAN OTLOWSKI: May we just get testimony into the record without becoming argumentative? Assemblyman Snedeker?

ASSEMBLYMAN SNEDEKER: Dr. Finley, how many hospitals now provide maternity service in the state?

DOCTOR FINLEY: 74. In the last ten years, it was 84. This is out of 108 general hospitals and the 84 went down by 10 in terms of voluntary closures of mostly, again, the very small services--one hospital that delivered more than 1000 voluntarily closed--and then it went up by one in that Riverside in Secaucus is a new hospital that opened and does have a service that would be designated.

ASSEMBLYMAN SNEDEKER: Would it be a fair statement, Commissioner, that under the standards that you promulgated here that the Statewide Health Coordinating Council has to recommend a closing of 21 of the 72 or would that be untrue?

DOCTOR FINLEY: No, that must be untrue

ASSEMBLYMAN SNEDEKER: All right. I'll give you a copy of the letter that I have. I'm sure that you have a list of the New Jersey Hospital Association, which indicates the number.

DOCTOR FINLEY: Well, I would say that it is highly inaccurate and I don't even know how they can say that.

ASSEMBLYMAN SNEDEKER: I would like to have a reply to their letter, then. One other question that you had earlier, you referred to a letter that the Academy recommends no level 1's throughout the state. Do they recommend that they be changed to level 2?

DOCTOR FINLEY: No.

ASSEMBLYMAN SNEDEKER: Have they ever been asked if they recommend that they be upgraded rather than eliminated?

DOCTOR FINLEY: The same person who wrote the letter was a member of the Committee of the SHCC that struggled with the plan and the numbers and so forth and so on. Many of his suggestions were adopted and some of them, his colleagues did not recommend adopting. But, he was a member of the process.

ASSEMBLYMAN SNEDEKER: Would it be an accurate statement to say that we need level 3 hospitals in New Jersey and we don't have them at this time?

DOCTOR FINLEY: Absolutely. I agree with you completely.

ASSEMBLYMAN SNEDEKER: What is the problem of establishing regional level 3 hospitals without disturbing the other hospitals that we now have that provide maternity service, a north, a south, an east, a west or whatever you want to do with it, regionalize four hospitals into level 3 facilities and leave the others as they are?

DOCTOR FINLEY: If you could make a regional system work and if you could pay for it, which I've already discussed several times, if those if's could be answered, there would be some merit in leaving things in place and studying whether or not effective in terms of the goals of a perinatal system, which, of course, are to reduce both death and disability.

ASSEMBLYMAN SNEDEKER: Have you placed that challenge to the State Health Coordinating Council as to trying to do that?

DOCTOR FINLEY: The Health Care Administration Board would have to change the regulations, for example, about the less than 500.

ASSEMBLYMAN SNEDEKER: Is that a difficult thing to do?

DOCTOR FINLEY: Yes. It requires public hearings and it is a long, drawn out process in that instance.

ASSEMBLYMAN SNEDEKER: Commissioner, stop right there. Public hearings are not that difficult to do. You're at one right now.

DOCTOR FINLEY: I don't know what the American College of Obstetrics and Gynecology would say in that instance or even the American Academy of Pediatrics because the ACOG standards are that no hospital--

ASSEMBLYMAN SNEDEKER: You are confusing me with names--

DOCTOR FINLEY: These are national professional bodies which, for example, accredit, you are accredited by the American College of Obstetrics and

Gynecology to, for example, train interns and residents. There are also a number of other things. They publish handbooks of standards of practice, which I have. The ACOG standard for number of deliveries, in order to run an obstetric service, is 1,000 deliveries. In New Jersey, we dropped it by half. That, again, is a quality issue. This is amongst peers. This is an accreditation body amongst physicians of that discipline.

ASSEMBLYMAN SNEDEKER: I don't think the recommendation is to close the facilities, Commissioner, so much as it is to establish the level 3 facilities that this state does not have, at this time. It seems that we're looking at medical costs and eliminating medical service. I don't think that's why we're here today. I think that the Department of Health should be concerned with medical service and medical cost, not cost and service, but service and cost later. I think that is the way we have to look at it.

DOCTOR FINLEY: I think the way we look at it is that way, but the answer is, how do you get and pay for the highest quality of service for New Jersey, which is what we all want.

ASSEMBLYMAN SNEDEKER: I think by studying it two ways and, I think, by looking and, again, going back to the drawing boards and finding out why we can't establish these three levels for maternity care. I think you would have an awful lot of cooperation from the hospitals, from the pediatricians in the state rather than--you know, we're in a civil war now, Commissioner, with the Health Department on one end and pediatricians and hospitals and parents throughout the state on the other end. I'm sure you get the letters--in fact, I know you get the letters. You made a comment to the papers. You get more than I do and I think that, really, you have to go back to the drawing boards on this rather than come up with a 90 day waiting period and then come in with a plan and say, "That's the plan and we're not going to listen to any other ideas." I think we have to listen to other ideas.

DOCTOR FINLEY: I guess the thing that baffles me and I would like to ask you a question--you've been asking me a lot--the thing that baffles me is that this is a process that has been going on for 7½ years. It began a whole year before I became Commissioner. It began with physicians, mostly pediatricians and obstetricians, who recommended the levels, recommended the standards to the, then, State Health Planning Council. As the process changed and you got a State Health Coordinating Council, they adopted this as a number 1 priority. The federal government approved and that's the process that has been going on.

ASSEMBLYMAN OTLOWSKI: But, Commissioner, those same people are saying, "This is not my child."

DOCTOR FINLEY: Well, it is their child and the trouble is that they go back home, and apparently there is something that their specific institution wanted that that specific institution says that they didn't get and I think everybody is losing sight of the goal, which is the quality of health for mothers and babies. I had intended to say here today that for seven and a half years there are the professionals who say one thing when they are setting up standards and another thing when it is their own institution. Who are they? Are they national, statewide, interested in everybody or just interested in their own practice? I don't know. But, I intended to say that if in seven and half years we can't get any farther, perhaps I should recommend to the SHCC that, despite the really rather dreadful consequences for both quality of care and for federal compliance, that maybe we should call the whole thing off.

ASSEMBLYMAN SNEDEKER: I think you would make everyone happy, at this point, Commissioner. You know, if that's your question, I would agree wholeheartedly with you at this point because I don't think that the pediatricians recommended, all their recommendations were bought by everyone. I think what they originally recommended was that we are losing to New York and to Pennsylvania a children's hospital. I used to drive an ambulance, as a volunteer, and we don't have any children's hospital in New Jersey. We have them in Philadelphia and in New York, but we don't have them here and I think that is what concerns the pediatricians in this state. We ought to have in New Jersey some specialized care instead of shipping them out of the state.

DOCTOR FINLEY: That's exactly what we're trying to do.

ASSEMBLYMAN SNEDEKER: Let me finish, Commissioner. I didn't interrupt you. To go further on, to say when we establish these level 3 care facilities, that we look at the others. Don't eliminate them. But, you are eliminating other facilities in the state to take and say that we need level 3 care in New Jersey or we're going to eliminate some level 1 care in this state, some 21 of them from the figures that I have and I don't think that that is the answer to our problem. If you do what you just recommended, I think we can adjourn this meeting and all go home very happy.

DOCTOR FINLEY: I don't get the impression that all the members of the Committee want the process to stop.

ASSEMBLYMAN OTLOWSKI: Commissioner, please, let me run the meeting. Assemblyman Bassano?

ASSEMBLYMAN BASSANO: Commissioner, I just have a few questions. First of all, we're talking about 21 hospitals and not five. The five that we're talking about would be eliminating service completely. It is my understanding that the other 16 hospitals would be reducing some type of service, is that correct?

DOCTOR FINLEY: No, it is not. They would all be upgraded and more money could go to them to meet the standards. In the State Health Plan, you will see what everybody has to be reimbursed to do to be a level 1, 2 or 3. As I said, level 3's, we don't have any in this state, at this point. We are ready if we can get the plan going to designate several, but there are many things that people who would be designated level 1's, for example, don't have now, that are in the standards and they would have to be reimbursed in order to be able to acquire those, in terms of equipment and staffing.

ASSEMBLYMAN BASSANO: So, what you are telling me is that the other 16 hospitals would be upgrading services, then, not reducing them?

DOCTOR FINLEY: That is the goal of the plan.

ASSEMBLYMAN BASSANO: Can you give me and the rest of the Committee the names of those other 16 hospitals? We seem to have the names of the five hospitals, but the other 16 haven't been discussed. I don't have that information.

DOCTOR FINLEY: That is the Hospital Association's list. I have not seen it. I don't know what they are talking about.

ASSEMBLYMAN BASSANO: I have no list before me regarding that.

DOCTOR FINLEY: I can give you the Perinatal Designation Committee recommendations, which the SHCC hasn't even considered yet because it has been deferred and that goes region by region and it recommends the designation of a whole number of hospitals for level 1, 2 or 3.

ASSEMBLYMAN BASSANO: I would appreciate that information and I'm

sure that the other Committee members would also appreciate that information.

DOCTOR FINLEY: But, it is not an adopted plan.

ASSEMBLYMAN BASSANO: I understand that. With regard regions and geographical areas, how many geographical areas has the state been broken down into?

DOCTOR FINLEY: For planning purposes, five health systems agencies.

ASSEMBLYMAN BASSANO: That would be on the plan that you would get to us, is that correct?

DOCTOR FINLEY: You would get it by health systems agency region, yes.

ASSEMBLYMAN OTLOWSKI: Excuse me. I just want to refer back to Assemblyman Lesniak. There was a question that he had that was a follow-up question.

ASSEMBLYMAN LESNIAK: Mr. Chairman, I think it is important that we enter this into the record because this can, to a certain extent, clear the air in reference to the chart supplied by the Commissioner. Not all the hospitals that have 500 or less live births fit into the category of having over the average of maternal deaths, as that chart may lead some people to believe. As a matter of fact, they run higher and they run lower and are not identified by hospital. They are the Department's own statistics.

ASSEMBLYMAN OTLOWSKI: Your request is what, Assemblyman?

ASSEMBLYMAN LESNIAK: I would like to enter this report of the New Jersey Department of Health into the record referring to New Jersey hospitals in 1979, which gives a statistical breakdown by hospital code number, not the hospital itself, of births in that hospital and the number of fetal deaths and newborn deaths in hospitals and other deviations from the normal delivery service. I think that ought to be entered into the record. Commissioner, I want to assure you that this Committee and particularly myself, speaking for myself, do not want to scrap the plan; far from it. But, we also have an obligation to offer constructive criticism and an obligation to offer an opportunity for the health care delivery services industry to offer those comments in public and afford the legislators who drafted the laws of the State of New Jersey an opportunity. So, please, I don't think a hostile attitude towards what we're trying to do helps anybody.

DOCTOR FINLEY: I really felt that some of you were encouraging--when Assemblyman Visotcky asked the question--were encouraging the SHCC and its committee to go on and that is why I thought twice and did not say what is in writing at the end of my testimony. I felt that I really should ask you if that was not the case, that you were encouraging them to go on. I think they plan to. I'm tired and I have a kind of half-hearted inclination to ask them not to go on, but they're the ones that will make the decision.

ASSEMBLYMAN OTLOWSKI: Commissioner, can we get back to Assemblyman Bassano for just a minute?

ASSEMBLYMAN BASSANO: I have one last question, Commissioner. The SHCC plan which you will get to us, can you also provide information to us as to what hospitals are presently in each region at the present time?

DOCTOR FINLEY: Yes.

ASSEMBLYMAN BASSANO: I would appreciate that.

DOCTOR FINLEY: That will be broken down into--you mean what hospitals that provide maternity services or do you want all of the hospitals?

ASSEMBLYMAN BASSANO: Yes.

DOCTOR FINLEY: All the hospitals that provide maternity service and then, amongst those, there are some that did not ask for designation, which means that they plan to close anyhow. So, we'll try to break it down that way.

ASSEMBLYMAN BASSANO: Thank you.

ASSEMBLYMAN OTLOWSKI: Assemblyman Markert?

ASSEMBLYMAN MARKERT: Thank you, Mr. Chairman. Commissioner, I just have a couple of questions, first, about an article by Joan Whitlow from the Sunday Star-Ledger on the 23 of November. In that you were asked some questions and evidently you made a statement that you have "damaging" information on the maternal death rates in New Jersey hospitals which justify the state's plan to shut down some maternity units and designate the level of care which others can provide. Do we have that type of information available to us?

ASSEMBLYMAN OTLOWSKI: Excuse me.

DOCTOR FINLEY: First of all, I was not quoted accurately.

ASSEMBLYMAN OTLOWSKI: Commissioner, please, let me make a judgement about the question. I think that we've gone into that question. We've gone into it very thoroughly and, as a matter of fact, I wish you would go to the next question.

ASSEMBLYMAN MARKERT: Thank you, Mr. Chairman. Another thing that I am very, very concerned about because I realize that you are now taking a slightly different position, maybe, that you originally took with reference to the proposal, but I understand that when the State Health Coordinating Council postponed for 90 days any action on this plan that you were opposed to deferring action on that plan, is that right?

DOCTOR FINLEY: Yes. I voted against the deferral.

ASSEMBLYMAN MARKERT: Then, really, you feel that this plan, as it is, is probably what you would like to see materialize.

DOCTOR FINLEY: My main concern is fairness to the hospitals that are ready to be designated level 3 because this is what we need in this state and, also, the hospitals, most of them, where the recommended designations are satisfied and want to get on with it in terms of gearing up and such. In other words, there are more hospitals that want to get on with it than there are like the five that seem to be upset.

ASSEMBLYMAN MARKERT: So, you felt that we should not have had a 90 day moratorium here, that we should have gone into it headstrong as the plan proposed?

DOCTOR FINLEY: After seven and a half years, yes.

ASSEMBLYMAN MARKERT: My next question, in St. Joseph's, didn't we come up with a lot of equipment and money to be able to establish a level that we could basically call, now, level 3?

DOCTOR FINLEY: They had a conditional certificate of need to get on with it, yes.

ASSEMBLYMAN MARKERT: What is the proposal for St. Joseph's now? Do you know offhand?

DOCTOR FINLEY: To become a level 3 as soon as possible.

ASSEMBLYMAN MARKERT: I have something wrong then.

ASSEMBLYMAN OTLOWSKI: Commissioner, excuse me. I'm being admonished on all sides and being reminded about the power of the Speaker and I'm going to be carried out by the Sargeant-at-arms in another minute. We're going to recess this hearing and all of you will amply notified when we're going to call the hearing

back and we'll continue with Assemblyman Markert's questions at that time. At that time, will you please come back. You will be the first one on and we'll continue with the list that we have.

ASSEMBLYMAN MARKERT: Could I have that question answered first,
Mr. Chairman.

DOCTOR FINLEY: St. Joseph's is recommended by the HSA for a level
3.

ASSEMBLYMAN OTLOWSKI: All right, we stand recessed.

(Hearing Recessed)

TESTIMONY
BEFORE THE NEW JERSEY ASSEMBLY COMMITTEE
ON INSTITUTIONS, HEALTH AND WELFARE

BY
JOANNE E. FINLEY, M.D., M.P.H.
COMMISSIONER, NEW JERSEY DEPARTMENT OF HEALTH

December 8, 1980

Mr. Chairman, thank you very much for giving me the opportunity to participate in your hearing today. I am sorry that we mutually did not have this chance before the introduction and passage of A-2252. I know that you would have liked to have it otherwise.

Before getting on to the issue at hand, I would like to discuss some general misconceptions relating to the health planning here in New Jersey. This is a citizens' process with hundreds of people from all over the State involved. It is not "my" process - or even the Health Department standing alone. Therefore, I would like to take a very brief time to describe some of these mandated planning bodies which the Legislature has required; often these laws have also been written to conform to Federal requirements. And, if we have an approved set of organizations that meet these requirements, and we do, this brings millions of funds into the State, and to our hospitals and health agencies. If an act of the Legislature, or other failures on our part puts us out of compliance, we lose these funds.

You have established a Health Care Administration Board, whose 11 members are appointed by the Governor and approved by the Senate. I cannot issue one regulation relating to standards, planning, Certificate-of-Need or rate-setting without the approval of this Board. Any denials of Certificates-of-Need must be approved by this Board or can be rejected by it. The vice-chairman of the HCAB is here today to explain who makes up this Board and the process by which regulations are

reviewed and approved.

Second, you have required by legislation that the Statewide Health Coordinating Council, which is made up of 34 citizen consumers and providers from every part of the State of New Jersey, be responsible for making Certificate-of-Need recommendations to me and also for developing a State Health Plan consistent with Federal legislation. Federal Guidelines issued in 1978 mandate that obstetrical services and neonatal intensive care be planned and implemented on a regionalized basis.

This Council, under Federal law, reviews and approves most health monies being applied for including by the private sector. The vice-chairperson of that Council is here today to explain the very open regional and statewide citizen process that plans reviews and Certificates-of-Need go through. I know that this will sound somewhat ponderous but one person's red tape is another person's due process.

For hospital-rate setting you have established a Hospital Rate Setting Commission, which reviews the hospital's cost base and approved the hospital's rates. The existence of these various groups is a direct outgrowth of the concern of the health professional groups and trade associations that no one individual in the Executive branch make decisions or determinations without citizen review and input and sometimes even veto.

I have often been charged with being interested only in containing costs. I won't apologize for this interest because

it is a role assigned to me or any other Health Commissioner under New Jersey law. I need not regale you with the fantastic increase in costs of health care services since you, as legislators, have to face that problem every session. Right now, you are grappling with a very legitimate need for additional funds for the Medicaid program. The burden of the vast inflation in hospital costs even in a State where we have kept these increases well under the national average, is one of the reasons. However, I am a physician first, last, and always. I am therefore very concerned about the quality of the care our citizens receive. In fact, this is my over-riding dedication.

So, I have in my tenure, with the help of these various boards and commissions, regional planning Health Systems Agencies and even special advisory committees made up of experts from outside the Department, done the following:

1. Through the Health Care Administration Board I have proposed and they have adopted standards for many kinds of health care services. When I became Commissioner a large number of services and facilities which are required to be licensed by law had no standards against which to issue a license! Yet the law requires they be licensed in order to be reimbursed.

2. The Department runs a very fair but tough inspection program. As a result, our program which was openly criticized by the Federal government in 1974, now passes Federal scrutiny with ease and with praise. More important, the State of

New Jersey has not been tainted with any scandals like those which have rocked other states.

3. Finally, I recognized that New Jersey hospitals, in effect, operated as a "farm system" to out-of-state medical centers, especially for specialized care. I recognized that we needed to develop our own centers of excellence. This, then, gets us to the issue at hand -- regionalization of services.

Regionalization is defined as the development within a geographic area of a coordinated, cooperative system of health delivery in which, by mutual agreement between providers, and based upon population needs, the degree of complexity of services that each facility is capable of providing, is identified so as to accomplish the following objectives: highest quality of care, maximum utilization of scarce, highly trained professionals and equipment, and assurance of reasonable cost effectiveness. What this means is that you designate certain hospitals as the apex of a network to deal with very difficult and exotic medical problems; it recognizes that the cost of the service is so high and the number and quality of needed specialists is so small that it would not be possible or practical for every hospital in the State of New Jersey to offer these services. The types of services we are talking about include care and treatment of very badly damaged babies or their mothers whose condition makes them high risk for producing damaged babies; care and treatment of very difficult cardiac cases requiring surgery; of burn victims; unusual cancers; hemophiliacs; those in need of specialized rehabilitation, etc.

Dollars are limited, so we must make some difficult decisions. Some facilities must be designated as these special centers. Others which are not meeting the criteria established by national professional groups or advisory groups to the Health Department must be asked not to attempt those highly specialized services or to try to acquire and man unusual specialized equipment. A few facilities just cannot attract the scarce skills necessary or perform enough procedures to keep a high quality level, or the low volume of cases results in a very high cost. After all an intensive care program, especially in perinatology, must be fully staffed and ready at all hours.

That brings me specifically to the issue of regionalization of perinatal services. Perinatal refers to the care of the mother and baby generally "surrounding the time of birth." Fortunately, at least 90% of the births in this State are normal without unusual complications. There are perhaps 10% of all pregnancies (totally about 90,000 births annually in New Jersey), in which there are some or major complications. Major complications may include anything from severe new-born pulmonary or cardiac difficulties, to a major but correctible deformity, or the non-existence of certain organs, to the delivery and necessity for separation of Siamese twins. Certain kinds of rare problems are more likely to happen to mothers with special problems of their own. To handle these kinds of problems, and try to save the infants, and the quality of their lives, we need something called a Level III or Regional Perinatal Center.

This center may not actually take care of all these problems but it must agree to be available 24 hours a day, through an immediate communication system to advise other doctors. There must be full-time specially trained Directors of Perinatology and Neonatology. The Regional Center must perform a constant regional educational function to reinforce the skills of doctors, technicians and special nurses who will work with high risk mothers and babies. It must be responsible for arranging a regional transport system to bring in the mothers and their babies before permanent damage occurs.

There is a definitive study of 8 regional perinatal programs being conducted by John Hopkins University under a grant from the Robert Wood Johnson Foundation, and there are a number of other studies and reports which tend to support the concept of regionalization of perinatal services. One most often cited shows a dramatic decrease in infant mortality under a Statewide program in Arizona. In addition, researchers at the University of Southern California, in reviewing a regionalization program in three separate areas of Los Angeles, reported that mortality for infants born weighing less than 3 lbs., 5 oz. decreased by 30% over a five-year period. According to the research team "the most striking change is the decrease of definitely abnormal infants, the overall neurological and developmental outcome for the small, premature infant is much more favorable in the past and is still improving."

While some hospitals in New Jersey have been able to handle a number of these kinds of cases, it is a fact that our own New Jersey doctors have sent a fairly significant number in the past to Philadelphia and New York. It is my hope that the vast majority of poorly born babies from high-risk pregnancies can be handled in New Jersey. However, at issue is the number and location of Level III centers appropriate and needed for New Jersey. This is a very prestigious service and it is also a very, very expensive one for which all of us will have to share the burden either through health insurance premiums or through taxes. A 1978 Robert Wood Johnson report puts the cost of building and equipping a neonatal intensive care unit at 1.5 million; 2.6 million annually to operate. The patient cost then was about \$500 a day. All these costs have increased. Another study I have from Pediatric Research puts the cost for specialized care of low birth weight infants who survive at \$40,283. In my pediatric graduate training I personally helped care for babies where the bill ran a quarter of a million dollars.

We do not plan to stint on meeting our needs in New Jersey, but these costs and the difficulty of getting the trained specialists to direct the programs, mean we should not have more than we need. And if the regionalization concept works, by early identification of most problems and preventive management, we reduce the numbers in need of specialized care even further.

There are other levels of perinatal services which can and should be able to turn to the Regional Perinatal Center. Our

plan has described many Area Perinatal Centers that can handle all of the normal deliveries plus the vast majority of complicated procedures. In terms of percentages, it would probably be fair to say that they could handle 96 or 97% of mothers and babies who use that particular hospital.

Finally there is the so-called Community Perinatal Center, or Level I. This hospital, in my view, represents the basic in best community service. It must be able to do everything with capability including handle the occasional unexpected problem and perform Caesarian Sections. According to the American College of Obstetrics and Gynecology (ACOG) such a hospital should deliver at least 1,000 babies to maintain a level of quality and proficiency. In the long run, it is ACOG's position that hospitals functioning at a Level I standard should exist only in rural or under-serviced areas. While I do not disagree with this position, it is unrealistic to think that we can phase out a number of our hospitals operating at the Level I standards or that this standard of ACOG's fits the existing situation in New Jersey where most of our hospitals give good basic care. There are some hospitals like Hunterdon, Bridgeton, Burdette Tomlin that are either the only ones in their counties or are sufficiently remote from others so that they should be allowed to remain in service. The State Plan developed by the HSA's and the SHCC provides for this.

In fact, as you are well aware, the suggestion by a subcommittee of the SHCC, appointed by its chairman, a physician, and

not by me, that only 5 hospitals in urban areas which are delivering under 600 babies phase-out over time has met with protests and the introduction and passage of A-2252. Remember, it is the position of ACOG that hospitals which are located in urban areas where there is ready accessibility to other hospitals and which are doing less than 1,000 births should be phased out. Our own statistics on such things as maternal mortality rates generally bear out the wisdom of this recommendation. (See Figures 1 and 2)

My job is also to think about the whole State. I know that our Blue Cross subscribers and our taxpayers who support Medicaid really do not want to bear the cost of keeping a marginal service in one community that may deliver only one baby a day or less open forever. As I have already said, to be a Level I, there are necessary minimums in staffing, equipment and capability that must be on hand at all hours to avoid preventable problems. The total annual cost to maintain such capability is at least \$800,000 to \$900,000 a year. At only \$720 per admission or a \$192 per diem, both figures which are from the past, the unit has to generate about 1,200 admissions a year or operate at a loss. If there are only 500 admissions a year, the unit is going to lose more than \$300,000. The hospital insurance rates of all subscribers from all over the State, and all taxpayers for Medicaid, cover these losses, not just the rates paid by the users of the facilities with low admissions.

I do not believe that all our citizens want their dollars misdirected into underutilized services. In effect, this would

deprive their families of the possibility of at least one Regional Perinatal Center with awesome responsibilities in each of our Health Systems areas. It is my clear sense, since the Perinatal Plan came up from the people in each region, that our consumers want the high quality programs at St. Joseph's and at Newark Beth Israel, at our College of Medicine and Dentistry, at St. Peter's and the growing development of a joint program for all of South Jersey to be able to be Regional Perinatal Centers. This is what they want their health insurance dollars to pay for. This is the kind of system envisioned in the State Plan.

The SHCC, of course, does not take any of this lightly. Perinatal regionalization began with the SHCC before I became Commissioner. But this body is so concerned about making fair and correct decisions that it has postponed for 90 days its original target date of November 21, 1980 to make designation recommendations to me. That decision was made prior to the introduction of A-2252.

However, my purpose in appearing today is not to react specifically to A-2252 or to outline possible harmful consequences to the State of enacting this bill in terms of non-compliance with Federal law and therefore losses of most federal health project monies, and some Medicare and Medicaid funds, although there would be such consequences if the plan cannot be implemented in timely fashion.

Rather, I wanted to explain the concept of regionalization and its relation to quality. I wanted to explain the fact that

because resources are limited, the consequences of upgrading our perinatal care means that some seldom used services at a few hospitals might have to be eventually discontinued. There is no other way for society to financially support the improvement process, and to protect the citizens from the continuation of under-utilized services which also sometimes are of less than high quality.

I can empathize with the statement made in the Robert Wood Johnson Foundation Special Report on Regionalized Perinatal Services. Said the author, "Implementing a regionalized perinatal program -- altering as it does traditional patterns of health care -- is an exercise fraught with hazards. Those who are doing it are generally a hardy breed of medical practitioners who try to inspire, reason, cajole and convince physicians, hospital administrators and others to agree to accept the give and take of regionalization." One doctor is quoted as saying that the process was "very fatiguing". That is precisely how we feel -- fatigued. I find that generally everyone agrees with the concept of regionalization but no one can agree on the translation into a smoothly operating, cooperative network system for New Jersey.

I personally am saddened by the call of various organizations and facilities for letter writing campaigns based on the deceit that a well planned system is intended to take something away from people, when its true goal is to upgrade every program that by virtue of its record and capabilities and, yes, cost effectiveness, should be in the business of delivering babies. The goal

is to make New Jersey the safest place in the nation to have a baby, even if you are a high-risk mother. I am terribly troubled that, because of in-fighting between our hospitals, we have painfully lost sight of this goal.

I want to say that we should be less concerned about institutional labels and instead concentrate on what really raises and preserves the health of our future generations. That is: good prenatal care, good and equal nutrition, and attention and education for all our mothers whether rich or poor, protection of them while they are working from unclean and toxic threats, and equal access to the best of obstetrical care during labor and delivery. It means the skill and continuing education of health care providers so that patients want to come to them early in pregnancy, so that much time will be spent listening to them, and particularly in thoroughly assessing the mother and the developing baby. In places like Los Angeles, California, indeed, in the Watts section, perinatal regionalization includes outreach and assessment several times during pregnancy. High risk pregnancies are well detected, and the number of poorly born, damaged babies has been reduced to 5% of all the pregnancies in this underprivileged community. It is these mothers who go to the specialized centers before they deliver. The 50% unexpected poor outcomes quoted by one of our New Jersey professionals just do not happen, because the system in L.A. does not let it happen.

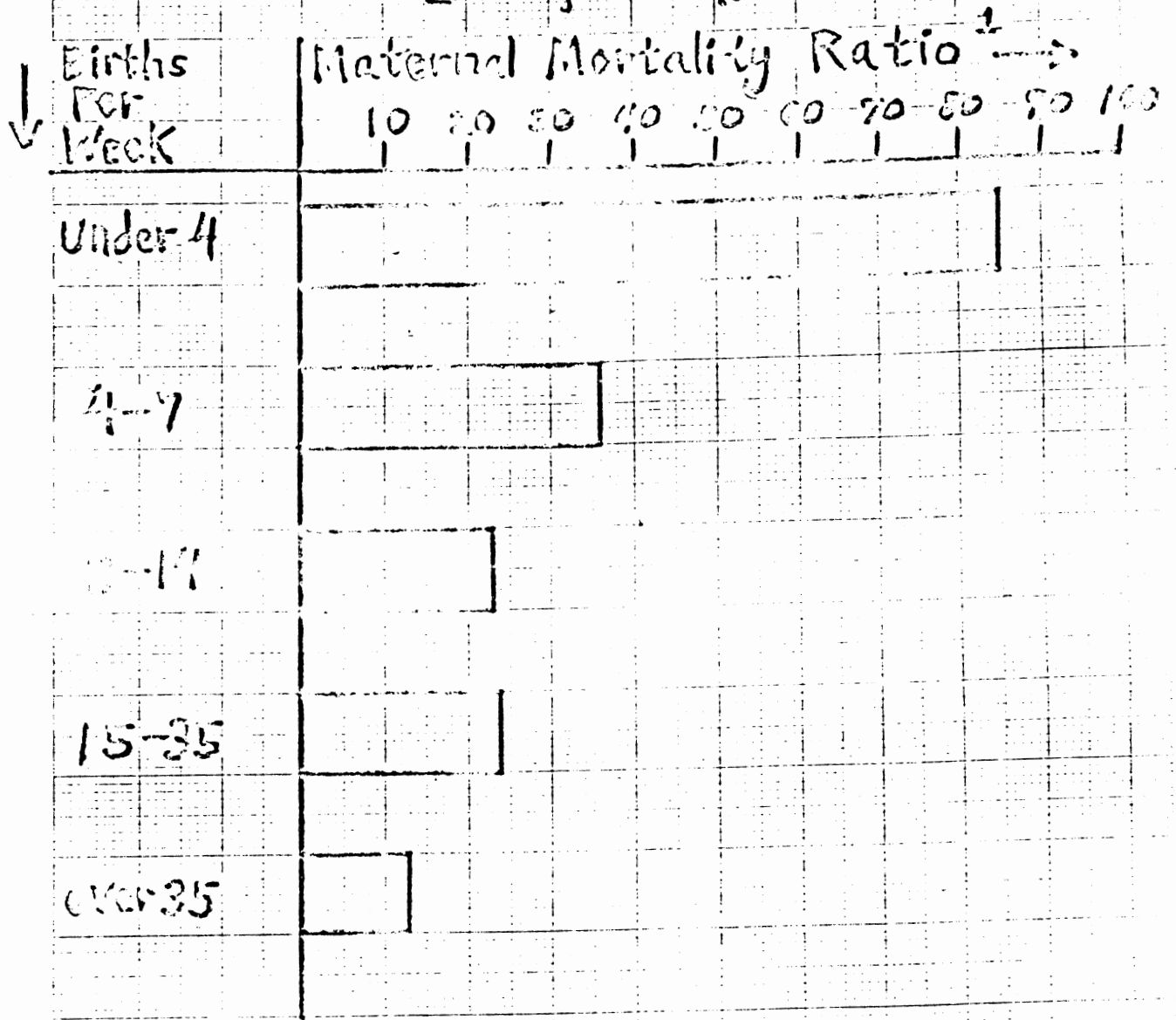
To tell the truth, in New Jersey, our maternal mortality rate and our newborn death rate have been declining. But that

is not the only measure of poorly born. We do not know if our failure to regionalize has saved babies who can also go on to live unimpaired. But the death rates have declined without anyone having a special label -- like a Level III. I attribute this more to better education of our professionals and to the federally assisted, traditional Maternal and Child Health programs which our Department oversees. These must reach out and beat down doors to find our high risk pregnant women, to assess them, to plan with them, and to do everything possible to make their pregnancies healthy. These are the reasons for better mortality statistics more than any single institutions' specialization or status.

I am personally and professionally concerned that we seem to be tearing ourselves apart on this issue. I continue to support regionalization of perinatal services and truly believe we will have better outcomes for high-risk mothers and babies if we can do it. Unfortunately, many tend to forget that the planning and implementation process is always evolving. Decisions made at this moment are only to get a system started. Times, circumstances and information will change and our decisions will roll forward. Decisions on the conservative side can be corrected but decisions which give too much and cost too much are difficult to retrieve. It is my inclination, therefore, at this time, in the interests of harmony, but with sadness because I had hoped New Jersey's professionals would rise above self-interest, to recommend to the Statewide Health Coordinating Council that we call off the regionalization of

perinatal services. I am sadly aware of the several consequences, both in terms of grants to our State, and for mothers and babies, of this decision.

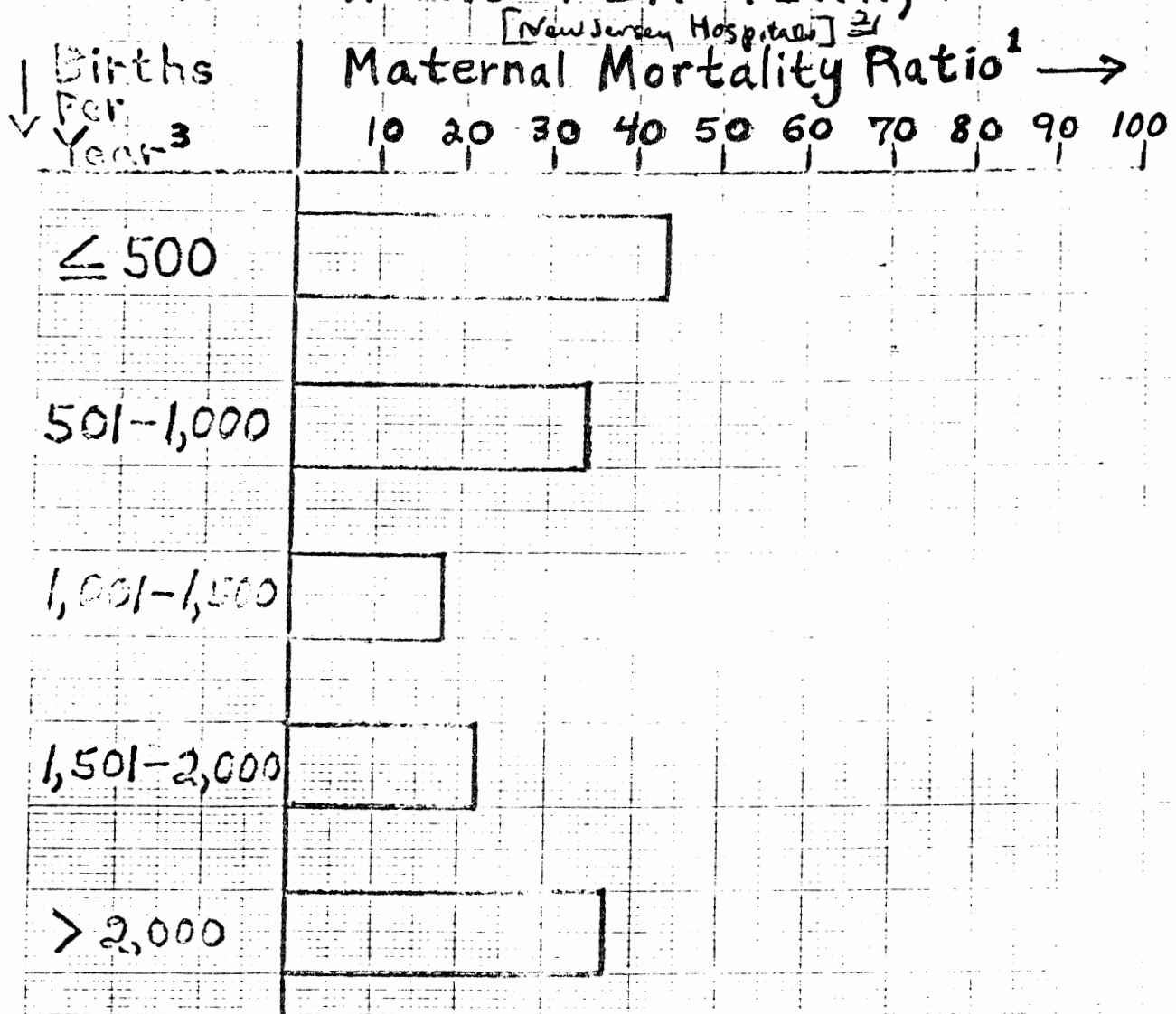
FIGURE 1
 MATERNAL MORTALITY RATIOS¹
 IN HOSPITALS, BY NUMBER OF
 LIVE BIRTHS PER WEEK²
 (Michigan Study)²



1. Direct maternal deaths per 100,000 live births;
2. Based on data from Schaffner WB, Federspiel CS, Fulton ML, et al: Maternal Mortality in Michigan: an epidemiologic analysis, 1950-1971. Am J Public Health 1977; 67: 821-828.

FIGURE 2

MATERNAL MORTALITY RATIOS¹
 IN HOSPITALS, BY NUMBER OF
 LIVE BIRTHS PER YEAR, 1975-1979²



1. Maternal deaths per 100,000 live births

2. Based on births reported in the Maternity Service Reports of New Jersey hospitals, and the maternal death records of the New Jersey State Department of Health

3. Live births per hospital in 1978

170 MA Maternal - published by
and Child-Health, Dept of Health N.J.

DP. NC. XMHQFEPT-01 06/21/80

STATE OF NEW JERSEY TOTALS

NEW JERSEY DEPARTMENT OF HEALTH
MATERNITY SERVICE QUARTERLY REPORTS FOR N.J. HOSPITALS
FOR THE QUARTER ENDING 12/31/79

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(SECTIONS 1, 3, 4, AND 5 ARE PERCENTAGES OF MOTHERS DELIVERED;
FOR SECTIONS 2, 6A-1, 6-3, AND 8A ARE PERCENTAGES OF BABIES (LIVE AND STILLBORN).
SECTIONS 6B, 6C, 6D, 6-2, AND 8B ARE PERCENTAGES OF LIVE BIRTHS.)

1. PREGNANCY CENSUS		3. OTHER PROCEDURES		5. MATERNAL COMPLICATIONS		
TOTAL NUMBER OF MOTHERS DELIVERED	90,982	1,217	A. ELECTIVE INDUCTION	1.34%	5,423 A. PREMATURE RUPTURE MEMBRANES	5.96%
PRIMIPARA	35,673	39.21%	2,798 B. INDICATED INDUCTION	3.08%	2,054 B. BOW RUPTURED MORE THAN 24 HRS.	2.26%
MULTIPARA	55,309	60.79%	22,921 C. STIMULATION OF LABOR	25.19%	703 C. ANTEPARTUM INFECTIONS	0.77%
89,991 A. SINGLE	98.91%	22,435 D. ANTEPARTUM OXYTOCICS	24.66%	610 D. POSTPARTUM MORBIDITY	0.67%	
980 B. TWINS, SET(S) (EQUALS ONE DELIVERY)	1.08%	13,843 E. AMNIOTOMY (EX. THOSE DONE WITHIN 2 HRS OF DELIVERY)	15.22%	1,563 E. MORBID. AFT. CESAREAN SECT.	1.72%	
9 C. TRIPLETS, SETS(S) (EQUALS ONE DELIVERY)	0.01%	7,076 F. TUBAL LIGATION	7.78%	2,382 F. ANEMIA (HGB < 10 GMS.)	2.62%	
2 D. OTHER One set conjoined twins One set quadruplets	0.00%	26 G. POSTPARTUM HYSTERECTOMY	0.03%	1,846 G. PRE-ECLAMPSIA	2.03%	
2. DELIVERIES		243 H. POSTPARTUM D & C	0.27%	66 H. ECLAMPSIA	0.07%	
TOTAL NUMBER OF BABIES	91,983	71 I. POSTPARTUM PACKING	0.08%	328 I. OTHER TOXEMIA	0.36%	
54,938 A. SPONTANEOUS (VERTEX)	59.73%	35 J. POSTPARTUM ART. LIGATIONS	0.04%	424 J. PLACENTA PRAEVA	0.47%	
15,922 B. LOW FORCEPS	17.31%	20,235 K. INHALATION ANAESTHESIA	22.24%	706 K. ABRUPTIO PLACENTA	0.76%	
2,580 C. MID FORCEPS	2.80%	29,717 L. CONDUCTION ANAESTHESIA (CAUDAL, SADDLE, ETC.)	32.66%	349 L. UTERINE ATONY	0.38%	
17 D. HIGH FORCEPS	0.02%	36,529 M. LOCAL ANAESTHESIA	40.15%	638 M. POSTPARTUM HEMORRHAGE	0.70%	
10,604 E. PRIMARY CESAREAN	11.52%	980 N. PARACERVICAL ANAESTHESIA	1.08%	7,035 N. LACERATIONS WITHOUT HEMORRHAGE	7.73%	
6,085 F. REPEAT CESAREAN	6.62%	6,227 O. NO ANAESTHESIA	6.84%	241 O. LACERATIONS WITH HEMORRHAGE	0.26%	
12 G. CESAREAN HYSTERECTOMY	0.01%	938 P. MATERNAL TRANSFUSION(S)	1.03%	206 P. HEART DISEASE	0.23%	
1,139 H. BREECH, SPONTANEOUS/ ASSISTED	1.24%	5,815 Q. RH IMMUNE GLOBULIN	6.39%	573 Q. DIABETES	0.63%	
300 I. BREECH EXTRACTION	0.33%	1,244 R. OTHER	1.37%	2,515 R. FETAL DISTRESS	2.76%	
28 J. VERSION AND EXTRACTION	0.03%	4. SPECIAL MATERNAL INFORMATION (OBTAIN FROM RECORD ROOM)		198 S. ISOLIMMUNIZATION	0.22%	
206 K. OTHER	0.22%	344 A. ADMITTED AFTER DELIVERY	0.38%	888 T. PREV. MAJOR UTERINE SURGERY	0.98%	
		5,015 B. ABORTED COMPL. OR INCOMPL.	5.51%	1,762 U. ARRESTED PROGRESS	1.94%	
		616 C. EXTRAUTERINE PREGNANCY	0.68%	4,406 V. FETUPELVIC DISPROPORTION	4.84%	
		50 D. HYDATID MOLE AND CHORIOCARCINOMA	0.05%	1,244 W. MALPRESENTATION	1.37%	
				13 X. RUPTURED UTERUS	0.01%	
				15 Y. DIED IN HOSP, DEL OR UNDEL	0.02%	
				2,456 Z. OTHER	2.70%	

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NEW JERSEY DEPARTMENT OF HEALTH
MATERNITY SERVICE QUARTERLY REPORTS FOR N.J. HOSPITALS
FOR THE QUARTER ENDING 12/31/79

STATE OF NEW JERSEY TOTALS

(SECTIONS 1, 3, 4, AND 5 ARE PERCENTAGES OF MOTHERS DELIVERED;
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SECTIONS 6B, 6C, 6D, 6-2, AND 8B ARE PERCENTAGES OF LIVE BIRTHS.)

INFORMATION ON INFANTS

6. TOTAL BORN IN HOSPITAL: * 6 (2) SHOULD EQUAL 8 B

WEIGHT AND APGAR	LIVE BIRTHS (1)		DIED IN HOSPITAL (2) *		FETAL DEATHS (STILLBIRTHS) (3)	
A. TOTAL (A=B+C+D)	91,203	99.15%	574	0.63%	780	0.85%
B. LESS THAN 2501 GMS.	5,913	6.48%	482	0.53%	560	0.61%
(1) APGAR 6 CR LESS	1,682	1.84%	XXXXXXXXXXXXXX		XXXXXXXXXXXXXX	
(2) APGAR 7 CR MORE	4,231	4.64%	XXXXXXXXXXXXXX		XXXXXXXXXXXXXX	
C. 2501 GMS OR MORE	84,819	93.00%	90	0.10%	217	0.24%
(1) APGAR 6 CR LESS	4,212	4.62%	XXXXXXXXXXXXXX		XXXXXXXXXXXXXX	
(2) APGAR 7 CR MORE	80,607	88.38%	XXXXXXXXXXXXXX		XXXXXXXXXXXXXX	
D. WEIGHT UNKNOWN	471	0.52%	2	0.00%	3	0.00%
(1) APGAR 6 CR LESS	73	0.08%	XXXXXXXXXXXXXX		XXXXXXXXXXXXXX	
(2) APGAR 7 CR MORE	398	0.44%	XXXXXXXXXXXXXX		XXXXXXXXXXXXXX	

7. INFANTS NOT BORN IN HOSPITAL

WEIGHT	TOTAL ADMITTED AFTER BIRTH	TOTAL WHO DIED
A. LESS THAN 2501 GMS.	143	29
B. 2501 GMS. OR MORE	285	3
C. WEIGHT UNKNOWN	26	2

8. NEWBORN COMPLICATIONS OF BABIES DELIVERED IN HOSPITAL
(IN COLUMN B, ENTER DEATHS ON LINE WHICH NAMES
PRIMARY CAUSE ON DEATH CERTIFICATE)

	A. TOTAL		B. * TOTAL
A. CONGENITAL DEFECTS NON-REFERRABLE	619	0.67%	31
B. CONGENITAL DEFECTS REFERRABLE	955	1.08%	43
C. RESPIRATORY	2,261	2.46%	90
D. INFECTIONS	629	0.68%	16
E. JAUNDICE BILIRUBIN < 10	8,642	9.40%	2
F. JAUNDICE BILIRUBIN 10 +	209	11.10%	0
G. RH HEMOLYTIC DISEASE	437	0.48%	2
H. EXCHANGE TRANSFUSION	164	0.18%	0
I. CORD LESS THAN 3 VESSELS	52	0.10%	2
J. OTHER INFANT COMPLICATIONS	2,728	2.97%	32
K. IMMATURITY - PREMATURITY	4,134	4.49%	356

NEW JERSEY DEPARTMENT OF HEALTH
 BIRTHS IN NEW JERSEY HOSPITALS, 12/79
 (REPORTS FROM MATERNITY SERVICES BY HOSPITALS)
 HOSPITALS WITH 500 OR LESS LIVE BIRTHS

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLUCULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
050 -	328	17	40	2	176	1	2	4	12	0	13	3
	58.80%	5.15%	12.05%	0.61%	53.33%	0.30%	0.61%	1.20%	3.66%	0.0%	3.96%	0.91%
077 -	448	26	19	2	46	0	5	7	21	0	8	6
	58.46%	5.76%	4.18%	0.44%	10.20%	0.0%	1.11%	1.54%	4.69%	0.0%	1.79%	1.34%
335 -	158	12	16	0	69	1	0	1	15	1	11	6
	99.37%	7.65%	10.06%	0.0%	43.59%	0.64%	0.0%	0.63%	9.49%	0.63%	6.96%	3.80%
460 -	266	7	31	5	107	0	1	1	15	1	17	3
	59.63%	2.64%	11.61%	1.89%	40.38%	0.0%	0.38%	0.37%	5.64%	0.36%	6.39%	1.13%
455 -	212	13	28	4	68	3	0	2	8	2	9	5
	59.07%	6.13%	13.08%	1.89%	32.08%	1.42%	0.0%	0.93%	3.77%	0.94%	4.25%	2.36%
502 -	208	27	31	5	82	4	2	2	5	0	6	1
	59.05%	10.53%	14.76%	2.35%	39.23%	1.91%	0.96%	0.95%	2.40%	0.0%	2.88%	0.48%
505 -	274	12	24	0	2	2	0	5	30	3	39	9
	98.21%	4.35%	8.60%	0.0%	0.72%	0.72%	0.0%	1.79%	10.95%	1.09%	14.23%	3.28%
608 -	393	24	53	1	51	0	6	3	19	2	13	6
	99.24%	6.14%	13.38%	0.26%	13.04%	0.0%	1.53%	0.76%	4.83%	0.51%	3.31%	2.04%
665 -	426	19	33	47	131	1	1	7	17	2	10	5
	58.38%	4.42%	7.62%	10.93%	30.47%	0.23%	0.23%	1.62%	3.99%	0.47%	2.35%	1.17%
885 -	280	12	44	0	113	0	0	1	21	1	0	4
	59.74%	3.20%	11.55%	0.0%	30.13%	0.0%	0.0%	0.26%	5.53%	0.26%	0.0%	1.05%

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NEW JERSEY DEPARTMENT OF HEALTH
 BIRTHS IN NEW JERSEY HOSPITALS, 12/79
 (REPORTS FROM MATERNITY SERVICES BY HOSPITALS)
 HOSPITALS WITH 501 - 1,000 LIVE BIRTHS

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
075 -	783	47	57	74	263	3	28	4	55	4	9	10
	97.45%	5.99%	7.24%	9.44%	33.55%	0.38%	3.57%	0.51%	7.02%	0.51%	1.15%	1.28%
100 -	751	46	134	2	176	6	7	8	80	5	16	21
	99.60%	5.84%	16.77%	0.38%	22.36%	0.76%	0.89%	1.00%	10.11%	0.63%	2.02%	2.65%
105 -	820	71	57	8	121	3	6	10	80	5	58	31
	98.81%	8.55%	6.79%	0.96%	14.58%	0.36%	0.72%	1.19%	9.64%	0.60%	6.99%	3.73%
215 -	908	93	105	2	302	2	6	12	46	8	65	18
	98.70%	10.18%	11.41%	0.33%	33.04%	0.22%	0.66%	1.30%	5.07%	0.88%	7.16%	1.98%
275 -	665	35	58	5	325	0	3	3	25	7	8	7
	99.55%	5.28%	8.68%	0.75%	49.02%	0.0%	0.45%	0.45%	3.76%	1.05%	1.20%	1.05%
305 -	823	52	93	3	75	2	19	7	20	3	50	6
	99.16%	6.32%	11.20%	0.36%	9.11%	0.36%	2.31%	0.84%	2.43%	0.36%	6.08%	0.73%
470 -	738	63	122	21	173	4	2	6	33	6	27	11
	99.19%	8.56%	16.40%	2.85%	23.51%	0.54%	0.27%	0.81%	4.47%	0.81%	3.66%	1.49%
490 -	848	82	29	35	261	2	2	6	55	5	27	19
	99.30%	9.70%	3.40%	4.14%	30.89%	0.24%	0.24%	0.70%	6.49%	0.59%	3.18%	2.24%
500 -	526	34	142	6	78	5	11	12	92	2	24	15
	98.72%	3.68%	15.14%	0.65%	8.45%	0.54%	1.19%	1.28%	9.94%	0.22%	2.59%	1.62%
520 -	851	37	83	4	339	28	2	1	33	1	11	3
	100.00%	4.34%	9.75%	0.48%	40.26%	3.33%	0.24%	0.12%	3.88%	0.12%	1.29%	0.35%

NEW JERSEY DEPARTMENT OF HEALTH
 BIRTHS IN NEW JERSEY HOSPITALS, 12/79
 (REPORTS FROM MATERNITY SERVICES BY HOSPITALS)

ICH-12

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
545 -	621	39	90	30	121	1	3	5	40	2	33	12
	59.20%	6.33%	14.38%	4.87%	19.64%	0.16%	0.49%	0.80%	6.44%	0.32%	5.31%	1.93%
643 -	919	83	92	5	179	4	1	2	47	5	46	12
	59.78%	9.12%	9.99%	0.99%	19.67%	0.44%	0.11%	0.22%	5.11%	0.54%	5.01%	1.31%
650 -	700	60	61	21	290	5	5	3	56	8	36	16
	59.57%	8.56%	8.68%	3.00%	41.37%	0.71%	0.71%	0.43%	8.00%	1.14%	5.14%	2.29%
655 -	906	60	174	2	166	2	3	9	24	4	49	9
	59.02%	6.59%	19.02%	0.22%	18.22%	0.22%	0.33%	0.98%	2.65%	0.44%	5.41%	0.99%
670 -	891	24	135	25	211	7	1	15	57	5	22	12
	58.34%	2.67%	14.90%	2.78%	23.44%	0.78%	0.11%	1.66%	6.40%	0.56%	2.47%	1.35%
675 -	593	30	68	15	149	4	0	3	27	4	13	3
	59.50%	5.05%	11.41%	2.53%	25.08%	0.67%	0.0%	0.50%	4.55%	0.67%	2.19%	0.51%
680 -	604	25	57	5	61	22	2	11	78	4	58	23
	58.21%	4.13%	9.27%	0.83%	10.07%	3.63%	0.33%	1.79%	12.91%	0.66%	3.60%	3.81%
695 -	537	47	34	8	146	1	9	3	30	6	14	8
	59.44%	8.80%	6.30%	1.50%	27.34%	0.19%	1.69%	0.56%	5.59%	1.12%	2.61%	1.49%
887 -	667	65	84	0	213	5	12	1	38	2	35	12
	59.85%	9.54%	12.21%	0.0%	31.28%	0.73%	1.76%	0.15%	5.53%	0.29%	5.09%	1.75%

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DP. NL. XPHJEFT-C* 06/21/80
MCF-12

NEW JERSEY DEPARTMENT OF HEALTH
BIRTHS IN NEW JERSEY HOSPITALS, 12/79
(REPORTS FROM MATERNITY SERVICES BY HOSPITALS)
HOSPITALS WITH 1,001 - 1,500 LIVE BIRTHS

PAGE 1

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 5 OR LESS	PREMATURE WITH APGAR 6 OR LESS
035 -	1,129	34	145	7	265	6	3	4	40	2	73	12
	99.65%	3.00%	12.69%	0.62%	23.37%	0.53%	0.26%	0.35%	4.21%	0.18%	6.41%	1.05%
040 -	1,316	44	163	0	201	3	6	19	129	17	44	44
	99.58%	3.33%	12.21%	0.0%	15.19%	0.23%	0.45%	1.42%	9.80%	1.29%	3.34%	3.34%
080 -	1,339	57	198	7	133	12	10	11	83	5	40	17
	99.15%	7.24%	14.67%	0.52%	9.93%	0.90%	0.75%	0.81%	6.20%	0.37%	2.99%	1.27%
097 -	1,436	158	78	19	497	5	6	9	60	0	62	21
	99.38%	11.11%	5.40%	1.34%	34.95%	0.35%	0.42%	0.62%	4.18%	0.42%	4.32%	1.46%
122 -	1,130	45	91	14	451	4	11	7	58	2	11	11
	99.38%	3.99%	8.00%	1.24%	39.95%	0.35%	0.97%	0.62%	5.13%	0.18%	0.97%	0.97%
155 -	1,009	83	123	9	305	2	4	7	67	9	27	13
	99.31%	8.27%	12.11%	0.90%	30.38%	0.20%	0.40%	0.69%	6.64%	0.89%	2.68%	1.29%
175 -	1,326	95	172	1	326	13	12	11	82	10	135	29
	99.18%	7.15%	12.86%	0.08%	24.55%	0.98%	0.90%	0.82%	6.18%	0.75%	10.18%	2.19%
180 -	1,445	24	176	55	551	0	4	8	88	12	39	21
	99.36%	1.67%	12.10%	3.83%	38.34%	0.0%	0.28%	0.55%	6.09%	0.83%	2.70%	1.45%
220 -	1,275	100	162	5	171	0	8	7	97	11	30	24
	99.45%	7.92%	12.64%	0.40%	13.54%	0.0%	0.63%	0.55%	7.61%	0.86%	2.35%	1.88%
250 -	1,171	100	90	2	428	7	15	5	52	9	28	9
	99.57%	8.57%	7.65%	0.17%	36.68%	0.60%	1.29%	0.43%	4.44%	0.77%	2.39%	0.77%

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NEW JERSEY DEPARTMENT OF HEALTH
BIRTHS IN NEW JERSEY HOSPITALS, 12/79
(REPORTS FROM MATERNITY SERVICES BY HOSPITALS)

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
415 -	1,173	40	149	53	327	6	6	13	105	8	79	31
	99.90%	3.39%	12.56%	4.50%	27.74%	0.51%	0.51%	1.10%	8.95%	0.68%	6.73%	2.64%
445 -	1,179	83	190	86	233	7	10	14	73	2	77	22
	98.83%	7.04%	15.93%	7.29%	19.76%	0.59%	0.85%	1.17%	6.19%	0.17%	6.53%	1.87%
485 -	1,407	46	119	1	210	4	1	14	70	5	91	28
	99.61%	3.26%	8.37%	0.07%	14.89%	0.28%	0.07%	0.99%	4.98%	0.36%	6.47%	1.99%
540 -	1,183	71	126	21	659	4	6	22	85	10	32	22
	98.17%	5.95%	10.46%	1.76%	55.19%	0.34%	0.50%	1.83%	7.19%	0.85%	2.70%	1.86%
550 -	1,104	68	69	3	165	5	10	7	59	3	61	23
	99.37%	6.19%	6.21%	0.27%	15.03%	0.46%	0.91%	0.63%	5.34%	0.27%	5.53%	2.08%
555 -	1,404	93	172	0	292	20	5	10	91	9	77	29
	99.29%	6.62%	12.16%	0.0%	20.78%	1.42%	0.36%	0.71%	6.48%	0.64%	5.48%	2.07%
560 -	1,421	157	80	3	309	7	4	10	76	9	85	20
	99.21%	11.00%	5.55%	0.21%	21.65%	0.49%	0.28%	0.69%	5.31%	0.63%	5.94%	1.40%
570 -	1,221	120	121	87	397	10	13	4	63	7	90	22
	99.70%	9.18%	9.13%	6.66%	30.37%	0.77%	0.99%	0.30%	4.77%	0.53%	6.81%	1.67%
600 -	1,019	87	114	0	378	1	7	9	61	3	109	18
	99.12%	8.61%	11.09%	0.0%	37.33%	0.10%	0.69%	0.88%	5.99%	0.29%	10.70%	1.77%
609 -	1,374	77	300	35	593	12	3	10	63	2	65	22
	99.28%	5.64%	21.68%	2.56%	43.43%	0.88%	0.22%	0.72%	4.95%	0.15%	4.73%	1.60%

NEW JERSEY DEPARTMENT OF HEALTH
BIRTHS IN NEW JERSEY HOSPITALS, 12/79
(REPORTS FROM MATERNITY SERVICES BY HOSPITALS)

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RF IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRHAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
645 -	1,230	77	175	3	191	17	3	13	84	5	60	20
	58.95%	6.25%	14.08%	0.24%	8.20%	1.38%	0.24%	1.05%	6.83%	0.41%	4.88%	1.63%
705 -	1,475	136	171	38	261	10	33	13	47	5	117	17
	99.13%	9.18%	11.49%	2.57%	17.62%	0.68%	2.23%	0.87%	3.19%	0.34%	7.93%	1.15%

NEW JERSEY DEPARTMENT OF HEALTH
BIRTHS IN NEW JERSEY HOSPITALS, 12/79
(REPORTS FROM MATERNITY SERVICES BY HOSPITALS)

HOSPITALS WITH 1,501 - 2,000 LIVE BIRTHS

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 5 OR LESS	PREMATURE WITH APGAR 6 OR LESS
025 -	1,552	55	105	11	517	27	18	27	136	7	92	55
	58.29%	3.53%	6.65%	0.71%	33.29%	1.73%	1.15%	1.71%	8.76%	0.45%	5.93%	2.13%
055 -	1,740	0	453	9	339	55	51	31	229	29	62	83
	58.25%	0.0%	25.56%	0.51%	19.38%	3.14%	2.92%	1.75%	13.16%	1.67%	3.56%	4.77%
115 -	1,549	89	145	12	141	8	4	13	178	18	57	53
	59.17%	5.78%	9.28%	0.78%	9.16%	0.52%	0.26%	0.83%	11.49%	1.16%	3.68%	3.42%
243 -	1,675	161	182	18	404	0	4	8	47	10	30	19
	59.52%	9.70%	10.91%	1.08%	24.35%	0.0%	0.24%	0.48%	2.81%	0.60%	1.79%	1.13%
270 -	1,841	115	263	10	669	2	4	11	87	12	89	27
	59.41%	6.27%	14.20%	0.54%	36.46%	0.11%	0.22%	0.59%	4.73%	0.65%	4.83%	1.47%
333 -	1,575	57	293	5	354	6	0	10	87	5	71	34
	59.37%	3.64%	18.49%	0.32%	23.23%	0.33%	0.0%	0.63%	5.52%	0.32%	4.51%	2.16%
385 -	1,738	84	193	7	489	8	2	13	93	7	110	35
	59.26%	4.86%	11.02%	0.40%	28.27%	0.46%	0.12%	0.74%	5.35%	0.40%	6.33%	2.01%
440 -	1,551	104	214	22	568	9	5	21	112	8	167	44
	58.73%	6.72%	13.62%	1.42%	36.63%	0.58%	0.32%	1.34%	7.22%	0.52%	10.77%	2.84%
465 -	1,702	124	210	13	677	7	38	8	82	9	73	21
	59.53%	7.33%	12.28%	0.77%	40.04%	0.41%	2.25%	0.47%	4.82%	0.53%	4.29%	1.23%
475 -	1,693	105	174	15	517	26	19	14	172	12	68	28
	59.18%	6.25%	10.19%	1.13%	30.79%	1.55%	1.13%	0.82%	7.21%	0.71%	4.02%	1.65%

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NEW JERSEY DEPARTMENT OF HEALTH
 BIRTHS IN NEW JERSEY HOSPITALS, 12/79
 (REPORTS FROM MATERNITY SERVICES BY HOSPITALS)

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 6 OR LESS	PREMATURE WITH APGAR 6 OR LESS
480 -	1,685 59.12%	48 2.85%	155 9.12%	0 0.0%	77 4.58%	32 1.90%	7 0.42%	15 0.88%	250 14.84%	31 1.84%	48 2.85%	64 3.80%
508 -	1,946 58.58%	133 6.83%	188 9.56%	9 0.46%	602 30.94%	10 0.51%	11 0.57%	20 1.02%	149 7.66%	14 0.72%	133 6.83%	40 2.06%
510 -	1,891 59.58%	154 8.19%	229 12.06%	21 1.12%	766 40.74%	15 0.80%	8 0.43%	8 0.42%	94 4.97%	9 0.48%	191 10.10%	34 1.80%
602 -	1,789 59.00%	153 8.57%	193 10.68%	35 2.18%	378 21.19%	8 0.45%	11 0.62%	18 1.00%	69 3.86%	10 0.56%	13 0.73%	14 0.78%
610 -	1,818 59.62%	156 8.65%	197 10.79%	51 2.83%	649 36.00%	2 0.11%	12 0.67%	7 0.38%	78 4.29%	2 0.11%	151 8.31%	35 1.93%
660 -	1,691 58.49%	154 9.07%	140 8.15%	4 0.24%	417 24.56%	27 1.59%	9 0.53%	26 1.51%	205 12.12%	29 1.71%	72 4.26%	43 2.54%
700 -	1,648 59.16%	155 9.37%	177 10.65%	25 1.75%	4 0.24%	0 0.0%	32 1.93%	14 0.84%	71 4.31%	4 0.24%	63 3.82%	30 1.82%
800 -	1,601 59.65%	145 9.13%	138 8.59%	3 0.19%	59 3.71%	2 0.13%	13 0.82%	5 0.31%	83 5.18%	5 0.31%	36 2.25%	13 0.81%

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NEW JERSEY DEPARTMENT OF HEALTH
 BIRTHS IN NEW JERSEY HOSPITALS, 12/79
 (REPORTS FROM MATERNITY SERVICES BY HOSPITALS)

HOSPITALS WITH 2,001 - OVER LIVE BIRTHS

HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLUCURIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATHS	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 5 OR LESS	PREMATURE with APGAR 6 OR LESS
420 -	2,800	0	322	4	378	29	10	33	197	3	46	27
	98.84%	0.0%	11.33%	0.14%	13.50%	1.04%	0.36%	1.16%	7.08%	0.25%	1.64%	0.96%
455 -	2,225	216	203	38	370	5	12	21	209	22	42	43
	99.10%	9.74%	8.65%	1.64%	16.00%	0.39%	0.52%	0.90%	8.99%	0.95%	1.81%	1.85%
640 -	3,010	197	446	15	991	25	35	20	169	34	127	61
	99.34%	6.59%	14.72%	0.64%	33.17%	0.84%	1.17%	0.66%	5.61%	1.13%	4.22%	2.03%
685 -	2,124	105	413	17	279	0	4	23	219	27	123	74
	98.93%	4.96%	19.24%	0.80%	10.81%	0.0%	0.19%	1.07%	10.31%	1.27%	5.79%	3.48%
830 -	2,415	178	375	40	958	10	4	15	108	3	85	21
	99.38%	7.41%	15.43%	1.67%	39.89%	0.42%	0.17%	0.62%	4.47%	0.12%	3.52%	0.87%
857 -	2,235	135	254	25	610	19	6	19	112	10	104	33
	99.16%	6.04%	11.27%	1.12%	27.28%	0.85%	0.27%	0.84%	5.01%	0.45%	4.65%	1.48%

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NEW JERSEY DEPARTMENT OF HEALTH
 BIRTHS IN NEW JERSEY HOSPITALS, 12/79
 (REPORTS FROM MATERNITY SERVICES BY HOSPITALS)

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HOSPITAL CODE NUMBER	TOTAL LIVE BIRTHS	RH IMMUNE GLOBULIN	PRIMARY C/S	ELECTIVE INDUCTION	STIMULATION OF LABOR	P.P. MORBIDITY	P.P. HEMORRAGE	FETAL DEATH	BIRTHS UNDER 2501 GMS.	NEW BORN DEATHS IN HOSPITALS	FULL TERM WITH APGAR 5 OR LESS	PREMATURE WITH APGAR 6 OR LESS
TOTALS	51,203	5,915	840	1,217	22,921	610	638	781	5,913	57*	4,212	1,882
	99.15%	6.39%	11.78%	1.34%	25.19%	0.67%	0.70%	0.85%	6.48%	0.63%	4.62%	1.84%

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